SPSO decision report

Case: **201804556, Ayrshire and Arran NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mrs C complained about the care of her late father (Mr A) at University Hospital Ayr. Mr A underwent surgery to remove bowel cancer and required further surgery due to a complication. He remained unwell thereafter and, due to his poor nutrition and weight loss, a decision was made to start nasogastric (NG) tube feeding (where a tube is placed through the nose into the stomach). However, the NG tube was mistakenly inserted into Mr A's lungs instead of his stomach and this was not recognised prior to commencement of NG feeding. This error caused a severe deterioration in Mr A's condition and he died just over a week later. The board carried out a Significant Adverse Event Review (SAER) and the Crown Office and Procurator Fiscal Service (COPFS) also looked into the circumstances of the death. As Mrs C was unhappy with the outcome of the board's SAER and response to her subsequent complaint, she contacted the SPSO.

We took independent advice from a consultant gastroenterologist (a physician who specialises inthe diagnosis and treatment of disorders of the stomach and intestines)(a physician who specialises inthe diagnosis and treatment of disorders of the stomach and intestines). We considered that the board's SAER process was reasonable and recommended appropriate policy changes to prevent a similar future recurrence. It was identified that there were some departures from existing policy but these did not contribute to Mr A's death. These included record-keeping deficiencies and a failure to take all advised steps to obtain an aspirate (where a small amount of stomach content is sucked through the tube and the acidity checked to confirm correct placement of the tube). As the tube was incorrectly placed in this case, the further advised steps would have been unsuccessful anyway and an x-ray would still have been required. The significant failing was a consultant surgeon's incorrect interpretation of the x-ray and consequent failure to identify the misplacement of the NG tube. This misinterpretation occurred out-of-hours when the consultant was in theatre preparing for surgery. The new policy position is that NG feeding will not be commenced overnight, and will only commence after a consultant radiologist has reviewed the x-ray and confirmed the correct placement of the tube.

We raised concerns that the board issued an initial death certificate which failed to record that Mr A died of aspiration pneumonia due to a misplaced NG feeding tube, when this was quite clear. COPFS subsequently amended the cause of death to include 'misplaced NG tube and NG feed'. We upheld this complaint. While we were satisfied that appropriate steps had been taken to address the significant failing which contributed to Mr A's death, we made some recommendations for the board to take additional steps.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr A's family for the failure to issue a death certificate accurately recording that he died of aspiration pneumonia due to a misplaced NG feeding tube. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/informationleaflets

What we said should change to put things right in future:

- The board should remind relevant medical staff that, when issuing a death certificate, careful consideration needs to be given to ensuring it accurately reflects the cause and circumstances of the death, regardless of how that might be viewed or interpreted.
- The board should inform the Ombudsman what steps were taken following the SAER, or what steps they intend to take now, to ensure future adherence to local policy regarding obtaining an aspirate and keeping records of the NG tube insertion process.