SPSO decision report

Case: **201808205, Grampian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mr C complained about the treatment his mother (Mrs A) received at Aberdeen Royal Infirmary. Mrs A was admitted to hospital to investigate heart concerns and was diagnosed with three vessel disease (a type of heart disease). An operation was carried out, but Mrs A died during the operation. Mr C was concerned about the board's response to Mrs A's reports of discomfort to nursing staff and the subsequent treatment she received. Mr C complained that the delay to take Mrs A's complaint seriously and call a doctor, contributed to her death.

We took independent medical advice from a consultant cardiologist (a doctor who specialises in the heart and blood vessels). We found that Mrs A was regularly assessed by both nursing and medical staff, and with the exception of the lack of ECGs on a particular date, appropriate actions were taken when she reported pain. The triple vessel bypass operation was initially successful, however, due to an uncommon complication which could not have been predicted, she died. We did not uphold this aspect of the complaint.

Mr C also complained that there were discrepancies between what he was told verbally by staff on the day after the operation and the written response to his complaint. We found that the board's response was an accurate account of events as documented in the medical records. However, while the board provided a reasonable explanation of the treatment provided to Mrs A, they did not reasonably reflect that there were two instances where ECGs were not carried out, which was out with normal process. On balance, we upheld this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C for inaccuracies in the complaint response. 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:

- Share the outcome of this investigation with relevant staff to ensure complaint responses are comprehensive and accurate.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.