SPSO decision report

Case: **202008527, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the care and treatment provided by the board to their parent (A), who was admitted to hospital with a suspected liver problem. Ascites (a build-up of fluid in the abdomen) was diagnosed and paracentesis (a drain of the fluid) was performed, during which it was noted that A had accidentally bumped the drain. The following day A reported being in pain and, after a CT scan, it was determined that A was suffering from an un-operable arterial bleed. Shortly thereafter A died.

C complained that A's consent was not properly obtained, that staff had failed to carry out the drain procedures reasonably, that A's pain was not managed appropriately, that a CT scan was delayed, that communication from the board had been poor and inconsistent and that the level of review undertaken after the incident was not sufficient.

We took advice from an independent medical adviser in gastroenterology (medicine of the digestive system and its disorders). We found that the timescale for the CT scan was reasonable, that pain medication was appropriate, that the case had ultimately been appropriately reviewed and that the drain procedure appeared to have been carried out by appropriately trained staff under adequate supervision.

However, we found a number of failings. Firstly, the board had obtained verbal consent but failed to adequately record this. Secondly, the board's complaints response had unreasonably focused on A having bumped the drain as being the cause of the arterial bleed. This was something that could not have been known with any certainty. Additionally, this explanation was not consistent with the post-mortem examination and internal case review, both of which found that the more likely cause of the bleed was as a recognised complication of the drain insertion. Therefore, we upheld these aspects of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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

- Patients and their families should be given clear, consistent and accurate information about the patient's care and treatment, including any complications. Complaint responses should be accurate, and evidence based.
- In future, the board will get formal written consent from patients for this type of procedure. They will also prepare a consent booklet, which will be reviewed by their gastro clinical governance group and their clinical guidelines group.

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.