SPSO decision report

Case: **202112069, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C's adult child (A) was awaiting surgery for germ cell cancer when they became unwell and were taken to A&E. A was transferred to a ward where C raised concerns about the treatment that A was receiving. C felt that A was deteriorating and requested on a number of occasions that A be transferred to the High Dependency Unit (HDU) or another hospital. A number of reviews were undertaken and a transfer to HDU was agreed and actioned. Acute deterioration of A was noted and they were intubated and invasive mechanical ventilation began. It was also decided that A should be transferred to a different hospital. The transfer took place following the surgical removal of the catheter. A sustained a subdural haematoma (when blood escapes from a blood vessel, leading to the formation of a blood clot that places pressure on the brain and damages it), and developed multi organ failure and right and left ventricle failure. A died just over two weeks later.

C raised complaints with the board regarding A's care and treatment, including concerns that information C had sought to provide staff, and requests that they had made about A's treatment, had been ignored. The board's response concluded that generally A's care and treatment had been reasonable. C was dissatisfied with this and raised their complaints with us.

We took independent advice from a consultant emergency physician adviser. We found that a significant adverse event review (SAER) would have been justified in the circumstances. We advised the board of this and they indicated that they intended to undertake an SAER regarding A's care and treatment. In the circumstances, we suspended our investigation whilst the SAER was undertaken. We became concerned about the time that was being taken to progress and finalise the SAER and when we began to progress the investigation again, the finalised SAER report was provided to C shortly afterwards. A later meeting led to a revised SAER report being provided.

We found that the conclusions in the revised SAER, which acknowledged specific actions in the assessment, care and treatment of A, had not been reasonable and upheld this aspect of C's complaint. We found that the actions the board have taken, or have committed to taking, to address the learning points and areas for improvement were reasonable.

We found that the gathering of staff views, accuracy and initial failure to identify the need to conduct an SAER in the board's investigation and review of their actions was not reasonable and we would normally expect the SAER process to take within the 24 working weeks from commissioning to final approval estimated in the relevant national framework. We considered that the time taken in this case was unreasonable and, therefore, we upheld C's complaint about the board's response to their complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C that they unreasonably failed to initially identify the need to conduct an SAER into their

actions regarding the assessment, care or treatment of A. 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:

- The board implement recommendations 1-7 found at Section 7 of the SAER report.

In relation to complaints handling, we recommended:

- The board take steps to ensure SAERs are undertaken when appropriate.

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.