SPSO decision report

Case: **202405247, 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 to their parent (A). A had dementia and had suffered several falls. C complained that the board failed to reasonably investigate A's fall and that they failed to reasonably consider carrying out a Significant Adverse Event Review (SAER).

We took independent advice from a consultant geriatrician (a doctor specialising in medical care for the elderly) and a registered nurse. We found that the board should have identified ambiguous and confusing language was used to describe A's fall in its investigation. It should also have established that the fall was unwitnessed. We upheld this complaint.

In relation to a SAER, the board were able to demonstrate that they had followed the guidelines in place at the time for determining if an SAER was required. In the period following the incident, local guidelines governing the holding of an SAER were superseded by national ones. We did not uphold this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C and their family for failing to provide a clear explanation about A's fall at the time, or in the subsequent complaint investigation. The apology should meet the standards set out in the SPSO guidelines on apology available at HYPERLINK "http://www.spso.org.uk/meaningful-apologies" www.spso.org.uk/meaningful-apologies .

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.