SPSO decision report

Case: **202407000, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Admission / discharge / transfer procedures
Decision: some upheld, recommendations

Summary

C complained about the care and treatment of their parent (A). A had bowel cancer and was undergoing chemotherapy when they developed abdominal pain and took advice from a cancer helpline. They were admitted to the Beatson Cancer Centre, where a CT scan confirmed a bowel blockage. A transfer to Glasgow Royal Infirmary for surgery was planned, but delayed due to lack of available beds.

The transfer was further delayed and during this time, A's condition worsened significantly. A scan confirmed a perforated bowel requiring emergency surgery. A was transferred and operated on but complications followed. Further surgery was deemed unlikely to be successful, treatment was withdrawn and A later died.

A Significant Adverse Event Review (SAER) found that the delayed transfer directly contributed to A's death. However, further clinical advice identified multiple additional failings in A's care and these cumulative failures led to substandard care.

We took independent advice from an colorectal surgeon adviser. While the board acknowledged the delayed transfer, we found that poor overall clinical management also played a significant role. As a result, we upheld the complaints that the board did not provide reasonable care and treatment to A and did not reasonably administer their transfer.

C also complained about delays and shortcomings in the SAER process. Although the board apologised for delays, we found that the review was too narrow in scope, focusing mainly on the transfer issue and failed to address broader concerns about earlier care and decision-making. This limited the potential for wider learning. We upheld this aspect of the complaint.

Regarding the handling of C's complaint, although there were delays, the board maintained communication, provided updates, and progressed the complaint alongside the SAER. Given the complexity of the case, the time taken to provide a response was reasonable and we did not uphold this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A's family for the additional failings we found. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/meaningful-apologies.

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

- Patients with potential surgical issues in a non-surgical setting should have early consideration of surgical input and/or transfer to reduce the risk of misdiagnosis. Patients with a diagnosis of bowel obstruction and risk of perforation should be escalated for urgent consideration of surgery, even where observations and

bloods are stable.

- There needs to be provision of same day and out of hours CT scanning of patients presenting with acute symptoms. Reporting of urgent CT scans needs to be timely and in real time to ensure prompt treatment.
- CT scan reports should be clear and detailed to guide diagnosis and treatment.
- Unwell patients should have ongoing daily input at consultant level, including weekends.
- Adverse event reviews should be broad enough to identify areas of missed learning, rather than focussed on the obvious cause.
- The board should ensure the SAER recommendations fully address the failings found.

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.