SPSO decision report

Case: **201901038, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the actions of the board in respect of their late parent (A). After being examined by their GP due to stomach pains and an irregular heartbeat, A was admitted to hospital. A was initially admitted to the hospital's Initial Assessment Unit (IAU). C stated that, when A was examined in the IAU, the family informed the doctor about A's history of having an abdominal aortic aneurysm (AAA, a bulge or swelling in the aorta, which is the main blood vessel that runs from the heart down through the chest and stomach).

A was transferred to a ward for further investigation. During this time, A's stomach pain increased. Clinical staff initially considered this as the result of constipation. On speaking with C, a doctor stated they were not aware of A's history of AAA. After further investigation, the doctor told the family that complications with the AAA could be ruled out. Shortly afterwards, A's condition deteriorated and a CT scan showed a leaking AAA. It was decided that it was not appropriate to operate and A died later that day.

C complained about the treatment A received and, in particular, that clinical staff unreasonably delayed diagnosing a leaking or ruptured AAA despite being informed of A's history. In addition to this, C complained that the doctor they spoke with after A's death did not report the matter to the Procurator Fiscal despite giving the impression they had done so. Finally, C complained about the fact that the same doctor did not write to them following A's death, after telling them this would happen.

In respect of the first complaint, we took independent advice from a specialist in acute medicine. We found that, given A's presentation at the time, the actions and decision-making of clinical staff was reasonable. The records showed that the possibility of a ruptured AAA was considered after A was transferred to the ward. However, given the outcomes of examinations and investigations carried out, this diagnosis was considered unlikely. Instead, an alternative diagnosis of pneumonia was initially pursued, with a secondary complaint of abdominal pain attributed to known constipation. We found that these conclusions were reasonable and justified by the recorded evidence. We also found that there was not sufficient evidence to reach a conclusive view on whether the IAU doctor was aware of A's history of AAA. We, therefore, did not uphold this complaint.

In respect of the second complaint, we noted that The Crown Office & Procurator Fiscal Service has produced guidance called Reporting Deaths to the Procurator Fiscal: Information and Guidance for Medical Practitioners. One situation where deaths should be reported is where the nearest relatives of the deceased raise concerns that the medical treatment given to the deceased may have contributed to their death. Given the evidence available about the conversation between C and the doctor following A's death, we could not reach a conclusive view on whether the Procurator Fiscal should have been informed at this point. However, another situation where deaths should be reported to the Procurator Fiscal is where a death certificate has already been issued and a complaint is later received which suggests an act or omission by medical staff caused or contributed to the death. This did not happen in this case and, therefore, we upheld this complaint.

The final complaint related to the doctor who spoke with C following A's death and their failing to contact C about

the outcome of a meeting that was to take place. We noted that the doctor had acknowledged there was an unacceptable delay in writing to C. However, we did not consider the board's stage 2 response to contain an explanation for such a delay or indicate that any reflection had taken place about what went wrong. We reviewed the statement provided by the doctor as part of the board's complaint investigation and considered this to provide far more context about what happened. If the board had provided a fuller response that reflected the doctor's statement, C may have had a better understanding of what happened and considered this aspect of the complaint closed. We upheld this complaint because there was a clear failing, which had already been acknowledged by the board. We also provided feedback to the board about the importance of providing open and transparent explanations when acknowledging failings in complaint responses.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to inform the Procurator Fiscal of A's death, following the complaint made by C. 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:

- In line with the guidance issued by the Procurator Fiscal, deaths should be reported where, at any time, a death certificate has been issued and a complaint is later received by a doctor or by the health board, which suggests that an act or omission by medical staff caused or contributed to the death.

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.