# SPSO decision report

**Case:** **201903767, Greater Glasgow and Clyde NHS Board - Acute Services Division**
**Sector:** Health
**Subject:** Clinical treatment / diagnosis
**Decision:** upheld, recommendations


## Summary

C complained about the care and treatment their late relative (A) received at Glasgow Royal Infirmary. A was admitted to hospital for an elective keyhole procedure (a surgical procedure that allows a surgeon to access the inside of the abdomen and pelvis through a small hole in the skin) to remove part of their bowel due to cancer. Shortly after, their condition began to deteriorate due to what was later found to be a bowel obstruction and they died. C said that clinicians failed to diagnose A's bowel obstruction within a reasonable time and that their communication with the family was not reasonable in light of A's deteriorating condition and their treatment decisions.

We took independent advice from a general and colorectal surgeon (a surgeon who specialises in conditions in the colon, rectum or anus). We found a number of failings in the diagnostic process that meant clinicians failed to diagnose and treat A's condition (including kidney function) in a reasonable way. These failings included: lack of CT scan; not recognising symptoms indicated a bowel obstruction; continuing treatment unreasonably based on early x-ray findings of constipation; lack of clear evidence in medical records that the importance of the nasogastric tube (a tube passed through your nose and down into your stomach) was discussed with A. We also found that communication between the relevant healthcare professionals and A's family was not reasonable given the potentially catastrophic consequences of A's refusal of a relatively straightforward and potentially lifesaving intervention. We upheld both of C's complaints.


## Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to provide A with a reasonable standard of medical care and treatment and for failing to ensure medical staff communicated with A's family in a reasonable way. 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:

- Review the clinical failings to ascertain: how and why the failings occurred; any training needs; and what actions will be taken (or since then have been taken) to prevent a future recurrence. Before doing so, the board should consider why a previous review failed to identify the failings.
- Ensure record-keeping by healthcare professionals is of a reasonable standard.
- Ensure timely and appropriate communication between clinicians and family members when there is a threat to life.

In relation to complaints handling, we recommended:

- Ensure board investigations identify and address incidents covered by the duty of candour with the

relevant Scottish Government guidance.

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.