SPSO decision report

Case: **202302813, Grampian NHS Board**
Sector: Health
Subject: Complaints handling
Decision: upheld, recommendations

Summary

C complained about the process followed by the board in commissioning and completing a Level 1 Significant Adverse Event Review (SAER) with respect to the care provided to their partner (A), after they had been diagnosed with Barrett's oesophagus (a condition where some of the cells in the oesophagus grow abnormally). The SAER was commissioned following the death of A.

C complained to the board about their lack of inclusion and involvement in the SAER process. In response to the complaint, the board concluded that whilst the SAER was carried out appropriately and C had been involved in the process, they failed to adhere to their own and published national guidelines in a number of ways. The lack of an appropriate Family Liaison contact had negatively impacted communication with C during the process.

C was dissatisfied with the board's complaints response and brought their complaint to our office. We took independent advice from a consultant hepatologist (medical doctor who specialises in diagnosing and treating liver disease) and gastroenterologist (a medical doctor who specialises in conditions affecting your digestive system)

We found that in conducting the SAER, the board had acted in the spirt of national policy and guidance with respect to including C in the SAER process. However, the board's own policy sets more concrete standards about how communication should be managed. We found that overall C's level of involvement with the SAER process was reasonable, but that there was issues with respect to miscommunication and managing C's expectations in this regard. Whilst the board responded to C's requests to meet relevant members of the SAER team, again the communications were not always consistently responded to by the board.

Issues with communication were impacted by the board's failure to follow process and appoint an appropriate point of contact to assist C and provide them with support. Given the failure to follow process, and issues with respect to communication, we upheld the complaint.

Recommendations

What we asked the organisation to do in this case:

- The board should provide the complainant with confirmation that the apologies highlighted in Recommendations 2 and 3 of the SAER will be provided.

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

- Problems identified in the management of the adverse event review will be collated and used to create a Shared Learning Notice to ensure learning is board wide.
- Work following this complaint will include that family members must be involved at the earliest point to agree the TOR and are provided with ongoing support for any review, in accordance with the board's

procedures. They must support those identified to take on the role of Family Liaison Manager to have adequate time to carry out this role to a high standard. All staff involved in the adverse event review process will be reminded, via a Shared Learning Notice, of the need to be vigilant and accurate in recording communications in relation to adverse event review management.

- A flowchart had been developed to assist staff with the management of Level 1 adverse events.

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.