SCOTTISH PUBLIC SERVICES OMBUDSMAN

People Centred | Improvement Focused

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: Glasgow

Case ref: 202207986, Greater Glasgow and Clyde NHS Board - Acute Services Division

Sector: Health

Subject: Hospitals / Clinical treatment / diagnosis

Summary:

The complainant (C) complained to my office about the treatment provided to their late parent (A) by Greater Glasgow and Clyde NHS Board - Acute Services Division (the Board).

A had a number of pre-existing health conditions and had previously had a laryngectomy (the surgical removal of the larynx (voice box) which disconnects the upper airway (nose and mouth) from the lungs). A had a laryngectomy 'larytube' stoma and cannula in situ (where the trachea (windpipe) is cut and then the open end is stitched onto the front of the neck).

On 20 April 2021, A had a fall at home and was taken to the Emergency Department (ED) at Glasgow Royal Infirmary (the hospital) via ambulance. A was admitted to the Acute Medical Receiving Unit (AMRU). A Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Order was put in place (meaning a patient does not receive resuscitation where their heart stops beating or their breathing stops).

On 21 April 2021, A indicated that they felt that their larytube was blocked. A student nurse provided laryngectomy care to A and was unable to replace the larytube. A experienced respiratory arrest (where breathing stops) followed by a cardiac arrest (where the heart stops beating) and sadly died.

The Board carried out a Significant Adverse Event Review (SAER). In their SAER, and their written response to C's complaint, the Board's overall conclusion was that the care provided to A was both appropriate and competent despite some failings having been identified.

C complained to my office about aspects of A's laryngectomy care, including the decision to put a DNACPR Order in place and the conclusions reached by the SAER investigation.

During my investigation I sought independent advice from Consultant Physician in Acute Medicine and a Consultant Ear, Nose and Throat (ENT) Surgeon. Having considered and accepted the advice I received, I found that:

- Appropriate equipment was not available at A's bedside for laryngectomy care.
- It was unreasonable that A did not receive humidified oxygen in the Emergency Department and did not receive humidification in accordance with National Tracheostomy Safety Programme (NTSP) guidelines. This may have prevented the blockage in A's larytube from happening.
- A student nurse acted without supervision in providing laryngectomy care to A.
- In the circumstances, given A's complex co-morbidities, it was reasonable for the medical team to put a DNACPR in place without discussion with the family. Notwithstanding this, it was unreasonable (both in placing the DNACPR order and in following it through) that no distinction was made between the context of an expected death/sudden cardiorespiratory arrest and an unforeseen event/ readily reversible cause. As a result, it was unreasonable that ventilation/ resuscitation was not attempted.
- Airway help was not sought immediately when the larytube could not be reinserted.
- There was a failure to activate the duty of candour process in this case.
- There was a failure to undertake a reasonable SAER that identified key learning and improvements. This included recording conclusion Code 2 (Issues identified but they did not contribute to the event) when conclusion Code 3 (Issues identified which may have caused or contributed to the event) would have been more appropriate.

Taking all of the above into account, I upheld C's complaints.

Redress and Recommendations

The Ombudsman's recommendations are set out below:

What we are asking Greater Glasgow and Clyde NHS Board - Acute Services Division to do for the complainant:

Rec. number	What we found	What the organisation should do	What we need to see
1.	Under complaint point (a) I found: • it was unreasonable that appropriate equipment was not at A's bedside. • it was unreasonable that A did not receive adequate humidification. • it was unreasonable that the student nurse acted without supervision in providing laryngectomy care to A. • unreasonable that airway help was not sought immediately when the laryngectomy cannula could not be reinserted.	Apologise to C and her family for: • The failure to ensure appropriate equipment was at A's beside. • The failure to administer adequate humidification to A. • The student nurse acting without supervision in providing laryngectomy care to A. • The failure to attempt ventilation/ resuscitation of A. • The failure to activate the duty of candour process. • The failure to undertake a reasonable Significant Adverse Event Review that identified key learning and improvements. This included	A copy or record of the apology. By: 19 March 2025

Rec. number	What we found	What the organisation should do	What we need to see
	• it was unreasonable that ventilation/ resuscitation was not attempted. Under complaint point (b) I found: • there was a failure to activate the duty of candour process in this case. • there was a failure to undertake a reasonable Significant Adverse Event Review that identified key learning and improvements. This included recording conclusion Code 2 (Issues identified but they did not contribute to the event) when conclusion Code 3 (Issues identified which may have caused or contributed to the event) would have been more appropriate.	recording conclusion Code 2 rather than conclusion Code 3. The apology should be specific and meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets	

We are asking Greater Glasgow and Clyde NHS Board - Acute Services Division to **improve the way they do things**:

Rec. number	What we found	Outcome needed	What we need to see
2.	Under complaint point (a) I found it was unreasonable that A did not receive adequate humidification.	Patients with laryngectomies should receive appropriate humidification as set out in The National Tracheostomy Safety Programme (NTSP) guidelines.	Evidence that: • these findings have been fed back to relevant staff in a supportive manner that encourages learning, including reference to what that learning is (for example, a record of a meeting with staff; or feedback given at one-to-one sessions). • the learning from these events is reflected in policy/ guidance and staff training with details of how this will be disseminated to relevant staff. By: 19 August 2025
3.	Under complaint point (a) I found it was unreasonable that airway help was not sought immediately when the laryngectomy cannula could not be reinserted.	Where there is a difficulty reinserting laryngectomy cannulas, airway help should be sought without delay.	
4.	Under complaint point (a) I found it was unreasonable that ventilation/ resuscitation was not attempted in the circumstances of A's case.	Decisions in relation to ventilation/ resuscitation when a DNACPR is in place should be taken in line with relevant national guidance. Where a decision is taken not to follow relevant national guidance this decision, and the reasons for it, should be clearly recorded.	

Rec. number	What we found	Outcome needed	What we need to see
5.	Under complaint point (b) I found that there was a failure to activate the duty of candour process in this case.	When an incident occurs that falls within the duty of candour legislation, the Board's Duty of Candour processes should be activated without delay.	Evidence that the Board have reviewed their Duty of Candour processes, including their process for identifying and activating the process. By: 19 May 2025
6.	Under complaint point (b) I found that there was a failure to undertake a reasonable Significant Adverse Event Review that identified key learning and improvements.	Local and Significant adverse event reviews should be reflective and learning processes that ensure failings are identified and any appropriate learning and improvement taken forward. Adverse event reviews should be held in line with relevant guidance.	Evidence that the Board have reviewed their process for carrying out adverse event reviews to ensure these reviews properly investigate, identify learnings, and develop system improvements to prevent similar incidents occurring. By: 19 May 2025
7.	Under complaint point (b) I found that the Board unreasonably recorded a conclusion of Code 2 (Issues identified but they did not contribute to the event) on the SAER when a conclusion of Code 3 (Issues	Conclusion codes on adverse event reviews should reflect the findings.	Evidence that the Board have noted the incorrect conclusion code on the SAER report and have ensured this is a matter of record either by reissuing a revised SAER report, or by

Rec. number	What we found	Outcome needed	What we need to see
	identified which may have caused or contributed to the event) would have been more appropriate.		issuing an addendum, in line with any relevant Healthcare Improvement Scotland guidance and advice. By: 19 May 2025

We are asking Greater Glasgow and Clyde NHS Board - Acute Services Division to **improve their complaints handling**:

Rec. number	What we found	Outcome needed	What we need to see
8.	There was a failure to fully investigate and identify the significant failings in this case in accordance with the Board's complaint handling procedure and the NHS Model Complaints Handling Procedure. There was also a failure to apologise to C as part of the complaint response.	Complaints should be investigated and responded to in accordance with the Board's complaint handling procedure and the NHS Model Complaints Handling Procedure. Complaints investigators should fully investigate and address the key issues raised, identify and action appropriate learning and apologise where issues have been identified.	Evidence that: • the Board have carried out a review of the management of this case from a complaint handling perspective • these findings have been fed back to relevant staff in a supportive manner that encourages learning, including reference to

Rec. number	What we found	Outcome needed	What we need to see
			what that learning is (for example, a record of a meeting with staff; or feedback given at one-to-one sessions). By: 19 May 2025

Feedback

Response to SPSO investigation

The Board's response to our enquiries initially provided us with the accounts of different specialists employed by the Board which differed in opinion on some significant points, without providing the Board's overall view. This resulted in delays to our investigation while we established what the Board's overall view was. When responding to SPSO enquiries, the Board should ensure that their response reflects the Board' overall position. I am including this as feedback for the Board to reflect on.

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service in Scotland, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial, and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as C and the aggrieved as A. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. C complained to my office about the care and treatment provided to their late parent (A) by Greater Glasgow and Clyde NHS Board - Acute Services Division (the Board).

2. A had a number of pre-existing health conditions and had previously had a laryngectomy (the surgical removal of the larynx (voice box) which disconnects the upper airway (nose and mouth) from the lungs). A had a laryngectomy 'larytube' stoma and cannula in situ (where the trachea (windpipe) is cut and then the open end is stitched onto the front of the neck).

3. On 20 April 2021, A had a fall at home and was taken to the Emergency Department (ED) at Glasgow Royal Infirmary (the hospital) via ambulance. A was admitted to the Acute Medical Receiving Unit (AMRU). A Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Order was put in place (meaning a patient does not receive resuscitation where their heart stops beating or their breathing stops).

4. On 21 April 2021, A indicated that they felt that their larytube was blocked. A student nurse provided laryngectomy care to A and was unable to replace the larytube. A experienced respiratory arrest (where breathing stops) followed by a cardiac arrest (where the heart stops beating) and sadly died.

5. The Board carried out a Significant Adverse Event Review (SAER) and provided C with a complaint response. C remained dissatisfied with the outcome of the Board's review and complained to my office.

6. C complained about aspects of A's laryngectomy care, including the decision to put a DNACPR Order in place and the conclusions reached by the SAER investigation.

7. The complaint from C I have investigated is that:

   (a) the Board failed to provide A with reasonable care and treatment (**upheld**); and

   (b) the Board failed to carry out a reasonable Significant Adverse Event Review (**upheld**)

Investigation

8. In order to investigate C's complaint, my complaints reviewer and I carefully reviewed the documentation provided by C and by Greater Glasgow and Clyde NHS Board - Acute Services Division in response to enquiries made of them. During my investigation I took independent advice from two appropriately qualified medical advisers, a Consultant Physician in Acute Medicine (Adviser 1) and a Consultant Ear, Nose and Throat (ENT) Surgeon (Adviser 2). Each adviser had full access to the available relevant medical records and the complaint correspondence.

9. I have decided to issue a public report on C's complaint given my concerns about the serious and multiple failings in this case, and the significant personal injustice caused by the failings identified. I also consider that there is the potential for wider learning from the complaint.

10. This report includes the information that is required for me to explain the reasons for my decision on this case. It also contains some technical medical terms and descriptions which I have considered necessary to include in order to provide the appropriate level of detail in relation to both A's condition and the advice I have received and taken into account. Wherever possible, explanations for these terms are provided in the report and/ or in annex 1.

11. Please note, while I have not included every detail of the information considered, my complaints reviewer and I have reviewed all of the information provided during the course of the investigation. C and the Board were given an opportunity to comment on a draft of this report.

(a) The Board failed to provide A with reasonable care and treatment

Concerns raised by C

12. C raised concerns:

i. that there was no proper equipment to deal with a laryngectomy cannula (or larytube) beside A's bed.
ii. that a student nurse was left to deal with a laryngectomy blockage, without supervision. C considers that this event led to A's death.
iii. about the decision to put a DNACPR Order in place, without any discussion with A's family.
iv. about the lack of communication with their family after their parent's death.

The Board's response to C's complaint

13. As noted above, in response to C's complaint, the Board carried out a SAER, the findings of which were referred to in the Board's complaint response to C on 8 December 2021. I have summarised the main points from the Board's response as follows:

i. A did not have bedside signage displaying guidelines for emergency laryngectomy airway management (algorithm), as is recognised best practice for this patient group. The Board also acknowledged that there was no 'Trachy-box' containing a cannula and cleaning products at the bedside as is recommended, but rather, this was held in the ward store cupboard. They did not consider that this omission had a negative influence on the final outcome. The Board said that when A's condition deteriorated, high flow oxygen was administered to the laryngectomy site.

ii. They recognised that the student nurse acted outwith their scope of practice when they provided laryngectomy care to A without supervision. However, they considered that the student nurse's actions did not cause the problem with A's breathing, and they explained the reasons for their view.

iii. The DNACPR order was not discussed with A as it was believed that A was somewhat confused at the time of admission, and it was felt that such a discussion would only cause distress. It was not felt appropriate to contact family members late at night to discuss the DNACPR order, particularly as A was stable at that time and it was considered that a telephone conversation would be better placed the following morning. Nevertheless, the Board acknowledged it would have been preferable to have discussed the DNACPR with the family at the time and they apologised that medical staff did not have the opportunity to do this. Given the DNACPR order was in place and A's multiple co-morbidities, cardiopulmonary resuscitation (CPR) would not be in A's best interests. The Board concluded the DNACPR order was clinically appropriate.

iv. The Board acknowledged that the family experienced considerable difficulty in attempting to gather information from staff in the days following A's death. They apologised for this. They also apologised that there was a period of six days before confirmation was provided to the family that a SAER would take place.

v. The Board concluded that the clinical care afforded to A in the ward was both appropriate and competent.

The Board's response to my office

14. The SAER identified recommendations, and in response to my enquiries, the Board provided the following information and evidence:

i. Regarding equipment and signage at the bedside, a Standard Operation Procedure was introduced in January 2022 (my office was provided with a copy) which details that every patient with a tracheostomy or laryngectomy must have the appropriate bed head sign and associated emergency algorithm displayed above the bed. It also states the 'blue trachi-case' containing equipment for use in the case of an emergency must remain with the patient at all times.

ii. The Board provided a list of the contents of the Emergency Trachi-Case and internal email evidence of the introduction of trachi-cases from 24 January 2022. They have introduced a Housekeepers Process for tracking Blue Tracheostomy Boxes regarding stock in the ward and who this is monitored by. The Board provided a copy of the Trache Tube Care Plan which is used across the Board and confirmed that there is ongoing work on the development of a laryngectomy specific care plan. The Board also provided a copy of the bed head signage for tracheostomy and laryngectomy, including the emergency algorithm flowcharts.

iii. Regarding staff awareness and education, the Board provided evidence that a Senior Resuscitation Officer held a workshop with Newly Qualified Nurses going to work in the AMRU. This workshop covered how to put out a 2222 cardiac arrest crash call, how to get the Intensive Care Unit airway doctor, bedside suction, the difference between a tracheostomy and laryngectomy, the requirement for bed head signage and the equipment in the trache-case. The Board also provided my office with a copy of the National Tracheostomy Safety Programme (NTSP) Guidelines for Trache Bedside Equipment and Trache Humidification. The Board confirmed that staff had been signposted to NTSP resources.

iv. The Board provided a copy of the AMRU Local Huddle Sheet which aims to assist in identifying patients with 'front of neck' airway on admission to hospital.

v. They also provided a poster which has been developed to identify how to request an Intensive Care Unit (ICU) Airway Doctor for advanced airway management.

vi. Regarding communication with families, the Board provided a copy of the Standard Operation Procedure introduced in December 2022. This introduces the plan to have one contact number during staffed clerical hours that has a call waiting system and an information message, with the switchboard forwarding all relatives queries for the AMRU to this new number. The Board also provided a copy of their procedure where a death certificate cannot be completed straight away in the AMRU and evidence that this had been fed back to relevant staff.

15. In addition, the Board:

i. Reiterated that it would not be regarded as normal practice for a student nurse to carry out a laryngectomy blockage procedure unsupervised. By undertaking to carry out unsupervised larytube care, the Board said that the nurse acted out with their scope of practice. They confirmed that the nurse no longer works for the Board.

ii. accepted that limited resuscitation attempts could have been attempted despite the presence of the DNACPR. As a learning point, the Board said they will ensure clarity is given that DNACPR decisions usually apply only in the context of an expected death or a sudden cardiorespiratory arrest, and not to an unforeseen event such as a blocked airway.

iii. said that the lack of communication with the family following A's death has been recognised in the SAER report and as part of the complaint response to the family.

iv. there is no reference in the SAER report that A did not receive appropriate assessment and humidification in line with The National Tracheostomy Safety Programme (NTSP) guidelines on humidification. They said when an aspect of a patient's clinical care is not referenced in a SAER Report it should be presumed that it was appropriate and reasonable and in line with relevant guidelines and policies.

16. In a letter sent to C's sibling on 28 March 2024, the Board apologised for what happened to A while under their care and for the distress this had caused the family. They said there had been important learning from the SAER investigation which resulted in a number of actions that have been progressed.

Guidance

17. The Advisers, in providing their advice (set out below), had regard to the following documents:

18. The British Medical Association guidance on decisions relating to CPR, 2016, states that:

i. Occasionally, some people for whom a DNACPR decision has been made may develop cardiac or respiratory arrest from a readily reversible cause such as choking, a displaced or blocked tracheal tube, or blocked tracheostomy tube. In such situations CPR would be appropriate, while the reversible cause is treated, unless the person has made a valid refusal of the intervention in these circumstances. To avoid misunderstandings it may be helpful, whenever possible, to make clear to patients, and those close to patients, that DNACPR decisions usually apply only in the context of an expected death or a sudden cardiorespiratory arrest and not to an unforeseen event such as a blocked airway.

19. The National Tracheostomy Safety Programme (NTSP) guidelines on humidification states that:

i. 'dry' oxygen should never be given to someone with a tracheostomy or laryngectomy. The type of humidification will be dictated by the needs of the patient.
ii. Inadequate humidification can result in a number of physiological changes which can be serious to the patient and potentially fatal. As a result, humidification must be artificially supplemented to assist normal function and facilitate secretion removal. Failure to adequately humidify could result in tube or stoma blockage as secretions become dry and viscous.
iii. The assessment of a patient with a tracheostomy should include management of their secretions and should identify the effectiveness and adequacy of the current humidification of that patient.
iv. A tracheostomy tube can become completely blocked by thick secretions leading to a respiratory arrest but this can be prevented by regular and effective assessment of the patient's humidification, regular inner cannula

care and suctioning.

v. Patient assessment should include:
    - Frequency of suctioning and/ or cleaning or inner cannula
    - Tenacity of secretions
    - Evidence of airflow via tracheostomy
    - Respiration rate
    - Use of accessory muscles
    - Patient coughing (ineffective or excessive)
    - Requirement for supplementary oxygen.

vi. High risk patients include those with reduced or thickened secretions and those with a longer length and/ or single lumen tube. These patients should be cared for with extra vigilance in order to minimize the risk of tube blockage.

vii. In terms of documentation, it states:
    - Record the method of humidification in use in the patient's care plan or clinical record as per local procedure.
    - Record evidence of evaluation and instigation of action taken in the patient's care plan or clinical record as per local procedure.
    - Record signature for accountability of care for each shift as per local procedure.
    - Record date and time that devices are changed and/ or are due to be changed.

Advice received

<u>Equipment at the bedside</u>

20. Adviser 1 told us that it was unreasonable that the appropriate equipment, including the emergency algorithm, was not at A's bedside and noted that this has been acknowledged by the Board. Adviser 1 noted that the Board have taken reasonable action to address the issue of appropriate equipment at the bedside.

21. Notwithstanding this, Adviser 1 said that humidified oxygen should have been used in the ED. Adviser 1 said that the use of unhumidified oxygen may have increased the risk of dry secretions and could have contributed to the mucous plug that was the presumed cause of death. Adviser 1 noted that nebulised salbutamol had been administered to A (nebulised salbutamol was administered several times through A's admission, including at approximately 00:20 hours and 02:45 hours on 21 April 2021). They considered that this would not have been sufficient to overcome problems created by the use of non-humidified oxygen. Adviser 1 considered that

the Board ought to have optimised the management of A's secretions and cough, which would have included administering humidified oxygen. Adviser 1 noted that the Board appears not to have taken any action on this point.

22. Adviser 2 considered that as per the NTSP guidelines (set out above), A should have received humidified oxygen. Adviser 2 said that the care provided regarding humidification was unreasonable and that this should have been acknowledged in the SAER report (this is considered under complaint point b). Adviser 2 said that the lack of humidification could have contributed significantly to the outcome.

Lack of supervision of a student nurse

23. Adviser 1 said it was unreasonable for a student nurse to have acted without supervision in providing laryngectomy care to A. Adviser 1 said that laryngectomy care should only be provided by someone who has done appropriate training/ has sufficient experience. Any nurse or student nurse not qualified should only provide this type of care under direct supervision (with the supervising nurse physically at the bedside observing and ready to step in).

24. Adviser 1 noted that a nurse with appropriate experience might have more quickly recognised that A's distress was not due to the tube being removed and difficulty with its reinsertion, but had another cause. In this case, Adviser 1 said that other steps might have been taken, such as calling for assistance (other nurses, medical staff, airway assistance) at a much earlier stage. Adviser 1 explained it is then possible that either the cause for A's distress could have been found and treated or might have been handled differently. Adviser 1 considered it is plausible, as suggested in the Board's response, that A may still have died as a result of the acute event or because of the other harms suffered as a result of the fall. That said, Adviser 1 said that there was a significant chance that the outcome might have been different.

DNACPR

25. Adviser 1 said that it was reasonable for the medical team to put a DNACPR in place without discussion with the family. Adviser 1 explained that A had complex co-morbidities and then presented with a fall after lying on the floor for a prolonged period. Adviser 1 noted that examination and investigation revealed multiple acute problems, including profound physiological and electrolytic disturbances. A also had tachycardia (where the heart beats faster than usual), hypotension (abnormally low blood pressure), hypothermia (having a lower body temperature than normal), evidence of infection, evidence of rhabdomyolysis (a breakdown of skeletal muscle)

with acute renal failure (kidney failure) and hyponatraemia (abnormally low sodium levels). Adviser 1 said given A's co-morbidities, CPR would be inappropriate on the grounds of futility.

26. Adviser 1 stated that the NHS Scotland DNACPR Integrated Adult Policy is clear that decisions around DNACPR should be undertaken with the patient. The situation where these conversations are unable to happen with patients are more nuanced. Adviser 1 noted that there is an obligation to seek the views of the next of kin/ families with regard to what the patient would want, rather than informing the family or them being responsible for decisions. Adviser 1 said that if family members are not immediately available, then it is reasonable for decision makers to apply a DNACPR with the intention of speaking with the Next of Kin at the earliest available opportunity. Adviser 1 also said that the clinical notes imply that the decision around DNACPR took place after A had been moved to the Acute Medical Unit and their family had gone home. Adviser 1 considered it was reasonable for the family to not have been informed immediately, as there was most likely an intention to discuss this with them the following day.

27. That said, Adviser 1 highlighted a concern about the failure of the medical team (both in placing the DNACPR order and in following it through) to distinguish the appropriateness of DNACPR for a 'natural death' (a further deterioration of A's underlying conditions) versus an unexpected event that was potentially reversible (for example where the tube were to become dislodged). Adviser 1 said the question of 'natural death' versus 'accidental death' is not usually necessary when it comes to decisions around DNACPR. However, patients with tracheostomies/ laryngectomies are at high risk of death from choking. Adviser 1 referred to the joint guidance on decisions relating to CPR from the British Medical Association (BMA), the Resuscitation Council and the Royal College of Nursing which is clear that dislodged tracheostomy and/ or mucous plugging is one of the rare instances where it is not only ethical, but desirable, to ignore a DNACPR order.

28. Adviser 1 said that it was unreasonable for both the medical registrar who made the original DNACPR decision and the medical registrar who attended the arrest to have not considered the difference between A dying as a direct result of the fall and the serious risks posed by having a laryngectomy. Adviser 1 considered this ought to have been either caveated on the DNACPR order and/ or CPR to have been started and then continued until the Anaesthetic Registrar arrived.

29. Adviser 1 said that it was unreasonable not to attempt ventilation via A's laryngectomy stoma. Adviser 1 stated it is possible that if A had been ventilated via

the stoma, full cardiac arrest and death might have been avoided. Adviser 1 said that there is a possibility that the cause of A's respiratory distress might have been discovered and managed (such as clearing a mucous plug). Equally, Adviser 1 noted that it is possible that A might have died anyway, but ventilation via the stoma until the arrival of an anaesthetist with advanced airway skills would have given A a chance of survival. Adviser 1 noted that A's death was inevitable without it.

30. Adviser 1 considered that it was also unreasonable that airway help was not sought immediately when the larytube could not be reinserted. Adviser 1 noted that this was a failure to follow the emergency laryngectomy algorithm[1]. Adviser 1 considered it is likely that seeking appropriate assistance with the airway might have averted the respiratory and then full arrest.

Communication with the family after A's death

31. Adviser 1 considered that the Board appears to have taken appropriate action to address the general issues around communication identified. Adviser 1 noted that the Board is clear that changes were made to the ways that the hospital manages communication with families as a result of COVID-19 and they have taken steps to address gaps.

32. However, Adviser 1 was concerned that no full apology was provided to the family until 28 March 2024. Adviser 1 noted that the letter of 28 March 2024 is a general apology and does not contain any specifics about where care might have gone wrong. Nor does the hospital acknowledge its failings and responsibilities in the matter of A's death. Adviser 1 considered this to be an inadequate response to the complaints made by the family.

(a) Decision

33. The basis on which I reach conclusions and make decisions is 'reasonableness'. My investigation looks at whether the actions taken, or not taken, were reasonable in the circumstances and in light of the information available to those involved at the time.

34. C has complained to me that the Board failed to provide A with reasonable care and treatment. In investigating thecomplaint and reaching my decision, I recognise that these events must have been incredibly distressing for A, C and their family. They have my utmost and heartfelt sympathy. I am also mindful that these events

[1] Emergency Algorithm-Laryngectomy- National Tracheostomy Safety Project

will have been distressing for the staff involved and that reading this report will be difficult for them too.

35. As part of my investigation, I took independent professional advice from the advisers (as outlined above). I have carefully considered this advice, which I accept. In summary, the advice I accept is that:

i. It was unreasonable that appropriate equipment was not at A's bedside.
ii. It was unreasonable that A did not receive humidified oxygen in the ED and did not receive humidification in accordance with the NTSP guidelines. I note that this may have prevented the blockage in A's larytube from happening.
iii. It was unreasonable that the student nurse acted without supervision in providing laryngectomy care to A.
iv. In the circumstances, given A's complex co-morbidities, it was reasonable for the medical team to put a DNACPR in place without discussion with the family. Notwithstanding this, I accept Adviser 1's comments that it was unreasonable (both in placing the DNACPR order and in following it through) that no distinction was made between the context of an expected death/ sudden cardiorespiratory arrest and an unforeseen event/ readily reversible cause in line with the BMA's guidance on decisions relating to cardiopulmonary resuscitation. As a result, it was unreasonable that ventilation/ resuscitation was not attempted.
v. It was unreasonable that airway help was not sought immediately when the larytube could not be reinserted.

36. I acknowledge that the Board's SAER and complaint investigation accepted that there were failures regarding equipment and signage at the beside, the student nurse acting outwith their scope of practice and the communication difficulties the family experienced following A's death. I welcome this.

37. I also welcome that during my investigation the Board have reflected further and accepted that limited resuscitation attempts could have been attempted despite the presence of the DNACPR given that the circumstances were an unforeseen event.

38. Although the Board have acknowledged some failings, I am clear that there have been a number of systemic failures in the care provided to A that have not been fully addressed as noted above, in particular the failure to provide A with adequate humidification. It is clear to me that the lack of humidification may have contributed significantly to the outcome. In addition, while the Board have accepted that limited resuscitation attempts could have been attempted despite the presence of the DNACPR, I do not consider that they have acknowledged the extent and impact of

these failings particularly given the advice (which I accept) that it is possible, if A had been ventilated via the stoma, full cardiac arrest and death might have been avoided.

39. I am also concerned that assistance was not immediately sought when the larytube could not be reinserted. Had the student nurse been supervised and, as noted above, had ventilation occurred when A was in respiratory arrest, there is a significant chance that the outcome might have been avoided. I recognise this will make difficult reading for C and A's family, and they have my profound sympathy.

40. Taking into account the advice I have received and, in view of the failings identified, I uphold this complaint.

41. Regarding the points at paragraph 35i and 35iii, and in relation to communication issues, I am satisfied that the Board have taken appropriate and sufficient action to support learning and improvement from these issues and have provided me with evidence of the action they have taken (as detailed at paragraph 14). While this addresses the failings identified by the Board, I have made recommendations to address the serious failings my investigation has found in relation to A not receiving adequate humidification, that assistance was not immediately sought when the larytube could not be reinserted and the DNACPR process, including that ventilation/ resuscitation was not attempted.

42. It is also of considerable concern to me that the apology letter to the family dated 28 March 2024 was general and did not contain any specific apology for the issues identified. I have therefore asked the Board to provide a more specific apology to C. I have also considered this further (including Adviser 2's comments above) under complaint handling at the end of this report

(b) The Board failed to carry out a reasonable Significant Adverse Event Review

Concerns raised by C

43. C raised concerns:

i. the SAER falls short when it comes to the issues of accountability and apology.
ii. the SAER conclusion code was 2 rather than 3. C does not agree that the issues identified did not contribute to the event (A's death).

The Board's response to C's complaint

44. In summary, the Board's complaint response of 8 December 2021 explained it is necessary that all investigations will conclude with one of the following investigation causation codes:

1 Appropriate care: well planned and delivered

2 Issues identified but they did not contribute to the event

3 Issues identified which may have caused or contributed to the event

4 Issues identified that directly related to the cause of the event

45. The Board's complaint response also:

i. said the review group considered which conclusion code should be assigned to the report and after careful deliberation determined that code 2 was most appropriate. The opinion of the review group was that the removal of A's larytube did not lead to their clinical deterioration, and ultimately cardiac arrest. They said that A's pre-existing medical conditions contributed significantly to the risk of an acute deterioration and they did not think the actions of the student nurse added to that risk.

ii. apologised that C was not made aware of the expected delay in preparing the SAER report.

The Board's response to my office

46. In response to my enquiries, the Board said:

i. that the purpose of the SAER review is to determine whether there are learning points or improvements for the service and wider organisation. The reports are anonymised and factual. A commitment was given to the family to complete the review and share the report by 8 October 2021. It is clear that in focussing on the importance of sharing the report with the family on the date agreed, there was no apology letter issued at the time. The Board acknowledged that this is an omission in the usual process and has been rectified with a letter sent to the family on 28 March 2024.

ii. the SAER team was robust and included a senior ENT Consultant Surgeon along with appropriate multi-disciplinary representation.

iii. regarding the Review Conclusion Code, they accepted that there continues to be a difference of senior clinical views between specialities on the findings and outcomes of the stage 2 complaint investigation. The Board said it is not normal practice to review/ change the clinical information provided in a SAER or change the final SAER Report (including the review conclusion code), unless there was an evident factual inaccuracy i.e. incorrect date referenced. They said that when an aspect of a patient's clinical care is not referenced in a SAER report it should be presumed that it was appropriate and reasonable and in line with relevant guidelines, policies etc.

iv. their overall position is that all key requirements for the SAER and stage 2 complaint investigation were met with the exception of a covering letter being issued with the SAER report. They said that the omission was addressed in the formal complaint response.

Guidance

47. In considering this complaint, I have had regard to the following documents:

48. The Healthcare Improvement Scotland Learning from adverse events through reporting and review, A national framework for Scotland, December 2019 which highlights the review outcome codes that can be used to indicate the findings of the review in relation to the link between care and outcome.

49. *The Organisational Duty of Candour guidance, March 2018*

i. This states that organisations (as responsible persons) must activate the duty of candour procedure as soon as reasonably practicable after becoming aware that:

- an unintended or unexpected incident occurred in the provision of the health, care or social work service provided by the organisation as the responsible person;
- in the reasonable opinion of a registered health professional not involved in the incident:
  (a) that incident appears to have resulted in or could result in any of the outcomes mentioned in the guidance. The relevant outcomes include the death of the person.

(b) that outcome relates directly to the incident rather than to the natural course of the person's illness or underlying condition.

ii. In addition to any apology provided at the time of the incident, as part of the duty of candour procedure the organisation must offer the relevant person a written apology (this can be by electronic communication if that is the relevant person's preferred means of communication) in respect of the incident.

iii. The organisation must invite the relevant person to attend a meeting and give them the opportunity to ask questions in advance. The organisation must take reasonable steps to ensure that the meeting is accessible to the relevant person, having regard to their needs.

50. *General Medical Council (GMC) The professional duty of candour*

i. This states that every health and care professional must be open and honest with patients and people in their care when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. This means that health and care professionals must:

- tell the person (or, where appropriate, their advocate, carer or family) when something has gone wrong
- apologise to the person (or, where appropriate, their advocate, carer or family)
- offer an appropriate remedy or support to put matters right (if possible)
- explain fully to the person (or, where appropriate, their advocate, carer or family) the short and long term effects of what has happened.

ii. Health and care professionals must also be open and honest with their colleagues, employers and relevant organisations, and take part in reviews and investigations when requested. They must also be open and honest with their regulators, raising concerns where appropriate. They must support and encourage each other to be open and honest, and not stop someone from raising concerns.

Advice received

51. Adviser 1 noted that the process of investigation is clearly recorded in the SAER and the record of the events is very detailed. That said, Adviser 1 considered the SAER conclusion code of 2 was unreasonable. They considered the SAER had acknowledged that there had been major deficiencies in care. Adviser 1 also noted

that if A had received reasonable care, there is a reasonable chance that A might have survived the acute event. Adviser 1 also said part of the rationale for a code 2 seems to be that A would have died anyway as a consequence of the fall. While A was certainly very unwell at the time of presentation, and death was a possibility, Adviser 1 considered that A's condition was treatable and that A had a chance of recovery with appropriate medical care.

52. Adviser 1 noted the conclusion of the SAER was that the clinical care provided to A on the ward was 'appropriate and competent'. This was despite the SAER's acknowledgement that a member of staff was practising outside their scope and that standards of best practice were not met. Adviser 1 considered that this was unreasonable and that there was a failure of the SAER to come to a conclusion commensurate with its own findings.

53. The SAER report identified that this case was not an organisational duty of candour event. Adviser 2 considered that this case met the threshold for duty of candour activation based on the GMC guidance as set out above. Adviser 2 said that it was unreasonable that the duty of candour procedure was not activated.

(b) Decision

54. C complained to my office that the Board failed to carry out a reasonable SAER in relation to the conclusions it reached including the outcome code and also in relation to issues related to duty of candour.

SAER conclusions/ outcome code

55. While I note that the SAER identified some failings, it is troubling that it did not identify all the significant failings that occurred in A's case. As noted under complaint point a), Adviser 1 identified that attempts should have been made to ventilate/ resuscitate A when they went into respiratory arrest. Both Adviser 1 and Adviser 2 also identified that A did not receive adequate humidification. These issues were not identified as part of the SAER investigation. I consider that there were serious failures in the management of A's care which should have been identified and explored as part of the SAER process.

56. It is unreasonable that the Board's review of these events did not appropriately identify what went wrong and the extent of the failings that occurred, particularly given the national guidelines that apply in this case.

57. Turning to the SAER's conclusions, I note that the SAER concluded that the care provided to A was 'appropriate and competent'. This was despite the fact that

the SAER found a member of staff was practising outside their scope and that standards of best practice were not met. It is troubling that in reaching its conclusions that care was appropriate and competent, the SAER appears to have ignored its own evidence and findings. This is unreasonable.

58. In addition, it is of particular concern to me that the SAER did not recognise the consequences of the cumulative failures that occurred in A's case and that the outcome may have been different. In this respect, based on the advice I have received, I question the SAER's view in relation to outcome that A would have died as a consequence of thefall. My investigation has established that if A had received reasonable care, there is a reasonable chance that A might have survived the acute event. Given this I consider the SAER conclusion code is unreasonable.

Duty of Candour

59. The Board's SAER Briefing Note (completed when deciding if the incident would progress to a SAER) identified that this was a duty of candour incident. Despite this, the SAER report itself identified that this case was not an organisational duty of candour event.

60. The overall purpose of the duty of candour is to ensure that organisations are open, honest, and supportive when there is an unexpected or unintended incident resulting in death or harm. It is a legal duty and, as detailed above, organisations are required to apologise and to meaningfully involve the relevant person in a review of what happened.

61. I am extremely critical that the duty of candour procedure was not activated in this case, and more so given the SAER briefing note identified this as a duty of candour incident. As a result, the requirements of the duty of candour process were not met. This included failing to invite C and the family to attend a meeting as part of the SAER process, and as acknowledged by the Board, there was also a failure to provide a written apology.

Overall conclusions

62. In view of the above issues, I consider the Board failed to carry out a reasonable SAER. As such, I uphold this complaint.

63. Although I recognise the significant time that has passed since these events, I believe my findings and recommendations, if implemented, should lead to lasting improvements in laryngectomy care and in the way SAERs are carried out by the Board. I also believe they may generate wider learning and improvement in these

important areas for other health boards. I hope that this brings some comfort to C and their family. My recommendations for action are set out below. I consider the issue of the lack of an apology as part of the SAER under complaint handling below.

Complaints handling

64. Section 16 G of The Scottish Public Services Ombudsman Act 2002 requires the Ombudsman to monitor and promote best practice in relation to complaints handling. As part of my investigation, I have considered certain aspects of the Board's handling of C's complaint below and the way the Board responded to enquiries made by my office.

65. While noting the purpose of the SAER process, as detailed above, the complaints handling procedure also provides an opportunity to identify issues that may have occurred and to support learning and improvement. I can see that the SAER findings were relied upon when responding to C's complaint. While it is appropriate to take account of the outcome of other investigations, like SAERs, when responding to a complaint, it is important that the SAER does not replace the complaints investigation which should be objective, evidence based, and weight and balance the evidence. It is not apparent that this occurred in this case because a further opportunity to identify the issues highlighted above was missed.

66. Although the SAER found failings in the clinical care provided to A, the Board's complaint response did not specifically apologise for these. The Board only issued an apology after my office became involved which was more than two years after they responded to C's complaint. In addition, the Board did not apologise for the specific failings identified and instead only provided a general apology. As a result, there was a lost opportunity from the outset for the Board to be open about the issues that had been identified in the SAER and apologise to the family for these fully. This is wholly unacceptable.

67. In response to my enquiries, the Board said that they are overseeing a review of the management of this case to determine if there is organisational learning that can be identified for the purpose of improving complaint handling.

68. I welcome this action, and I have asked the Board to provide evidence of the outcome of this review in my recommendations at the end of this report.

69. I also consider that there is learning for the Board in relation to how they responded to enquiries made by my office as part of my investigation. The Board's response to our enquiries initially provided us with the accounts of different

specialists employed by the Board which differed in opinion on some significant points, without providing the Board's overall view (bearing in mind it is the Board that is under my jurisdiction). This resulted in delays to our investigation while we established what the Board's overall view was.

70. When responding to SPSO enquiries, the Board should ensure that their response reflects the Board's overall position. I have included this as feedback for the Board to reflect on at the end of this report.

Organisation: Greater Glasgow and Clyde NHS Board - Acute Services Division

SPSO ref: 202207986

Recommendations

Learning from complaints

The Ombudsman expects all organisations to learn from complaints, and the findings from this report should be shared throughout the organisation. The learning should be shared with those responsible for the operational delivery of the service as well as the relevant internal and external decision-makers who make up the governance arrangements for the organisation, for example elected members, audit or quality assurance committee or clinical governance team.

What we are asking Greater Glasgow and Clyde NHS Board - Acute Services Division to do **for the complainant**:

Rec. number	What we found	What the organisation should do	What we need to see
9.	Under complaint point (a) I found: • it was unreasonable that appropriate equipment was not at A's bedside. • it was unreasonable that A did not receive adequate humidification.	Apologise to C and their family for: • The failure to ensure appropriate equipment was at A's beside. • The failure to administer adequate humidification to A.	A copy or record of the apology. By: 19 March 2025

Rec. number	What we found	What the organisation should do	What we need to see
	• it was unreasonable that the student nurse acted without supervision in providing laryngectomy care to A. • unreasonable that airway help was not sought immediately when the laryngectomy cannula could not be reinserted. • it was unreasonable that ventilation/ resuscitation was not attempted. Under complaint point (b) I found: • there was a failure to activate the duty of candour process in this case. • there was a failure to undertake a reasonable Significant Adverse Event Review that identified key learning and improvements. This included recording conclusion Code 2 (Issues identified but they	• The student nurse acting without supervision in providing laryngectomy care to A. • The failure to attempt ventilation/ resuscitation of A. • The failure to activate the duty of candour process. • The failure to undertake a reasonable Significant Adverse Event Review that identified key learning and improvements. This included recording conclusion Code 2 rather than conclusion Code 3. The apology should be specific and meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.	

Rec. number	What we found	What the organisation should do	What we need to see
	did not contribute to the event) when conclusion Code 3 (Issues identified which may have caused or contributed to the event) would have been more appropriate.		

We are asking Greater Glasgow and Clyde NHS Board - Acute Services Division to **improve the way they do things**:

Rec. number	What we found	Outcome needed	What we need to see
10.	Under complaint point (a) I found it was unreasonable that A did not receive adequate humidification.	Patients with laryngectomies should receive appropriate humidification as set out in The National Tracheostomy Safety Programme (NTSP) guidelines.	Evidence that: • these findings have been fed back to relevant staff in a supportive manner that encourages learning, including reference to what that learning is (for example, a record of a meeting with staff or
11.	Under complaint point (a) I found it was unreasonable that airway help was not sought immediately when the laryngectomy cannula could not be reinserted.	Where there is a difficulty reinserting laryngectomy cannulas, airway help should be sought without delay.	

Rec. number	What we found	Outcome needed	What we need to see
12.	Under complaint point (a) I found it was unreasonable that ventilation/ resuscitation was not attempted in the circumstances of A's case.	Decisions in relation to ventilation/ resuscitation when a DNACPR is in place should be taken in line with relevant national guidance. Where a decision is taken not to follow relevant national guidance this decision, and the reasons for it, should be clearly recorded.	feedback given at one-to-one sessions). • the learning from these events is reflected in policy/ guidance and staff training with details of how this will be disseminated to relevant staff. By: 19 August 2025
13.	Under complaint point (b) I found that there was a failure to activate the duty of candour process in this case.	When an incident occurs that falls within the duty of candour legislation, the Board's Duty of Candour processes should be activated without delay.	Evidence that the Board have reviewed their Duty of Candour processes, including their process for identifying and activating the process. By: 19 May 2025
14.	Under complaint point (b) I found that there was a failure to undertake a reasonable Significant Adverse Event Review that identified key learning and improvements.	Local and Significant adverse event reviews should be reflective and learning processes that ensure failings are identified and any appropriate learning and	Evidence that the Board have reviewed their process for carrying out adverse event reviews to ensure these reviews properly investigate, identify

Rec. number	What we found	Outcome needed	What we need to see
		improvement taken forward. Adverse event reviews should be held in line with relevant guidance.	learnings, and develop system improvements to prevent similar incidents occurring. By: 19 May 2025
15.	Under complaint point (b) I found that the Board unreasonably recorded a conclusion of Code 2 (Issues identified but they did not contribute to the event) on the SAER when a conclusion of Code 3 (Issues identified which may have caused or contributed to the event) would have been more appropriate.	Conclusion codes on adverse event reviews should reflect the findings.	Evidence that the Board have noted the incorrect conclusion code on the SAER report and have ensured this is a matter of record either by reissuing a revised SAER report, or by issuing an addendum, in line with any relevant Healthcare Improvement Scotland guidance and advice. By: 19 May 2025

We are asking Greater Glasgow and Clyde NHS Board - Acute Services Division to **improve their complaints handling**:

Rec. number	What we found	Outcome needed	What we need to see
16.	There was a failure to fully investigate and identify the significant failings in this case in accordance with the Board's complaint handling procedure and the NHS Model Complaints Handling Procedure. There was also a failure to apologise to C as part of the complaint response.	Complaints should be investigated and responded to in accordance with the Board's complaint handling procedure and the NHS Model Complaints Handling Procedure. Complaints investigators should fully investigate and address the key issues raised, identify and action appropriate learning and apologise where issues have been identified.	Evidence that: • the Board have carried out a review of the management of this case from a complaint handling perspective • these findings have been fed back to relevant staff in a supportive manner that encourages learning, including reference to what that learning is (for example, a record of a meeting with staff or feedback given at one-to-one sessions). By: 19 May 2025

Feedback

Response to SPSO investigation

The Board's response to our enquiries initially provided us with the accounts of different specialists employed by the Board which differed in opinion on some significant points, without providing the Board's overall view. This resulted in delays to our investigation while we established what the Board's overall view was. When responding to SPSO enquiries, the Board should ensure that their response reflects the Board's overall position. I am including this as feedback for the Board to reflect on.

Terms used in the report **Annex 1**

Adviser 1	the consultant physician in acute medicine who provided independent advice on this case
Adviser 2	the consultant ear, nose and throat (ENT) surgeon who provided independent advice on this case
the Board	Greater Glasgow and Clyde NHS Board - Acute Services Division
Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)	where a patient does not receive resuscitation where their heart stops beating or their breathing stops
laryngectomy cannula (or larytube)	where, following surgical removal of the larynx (voice box) the trachea (windpipe) is cut and then the open end is stitched onto the front of the neck
A	the aggrieved
C	the complainant
the hospital	Glasgow Royal Infirmary
SAER	Significant Adverse Event Review

List of guidance/ guidelines considered **Annex 2**

The British Medical Association guidance on decisions relating to cardiopulmonary resuscitation, 2016

The National Tracheostomy Safety Programme (NTSP) guidelines

The Healthcare Improvement Scotland Learning from adverse events through reporting and review, A national framework for Scotland, December 2019

The Organisational Duty of Candour guidance, March 2018

General Medical Council (GMC) The professional duty of candour