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: Central Scotland

Case ref: 202300512, Lanarkshire NHS Board

Sector: Health

Subject: Hospitals / Clinical treatment / diagnosis

Summary

The complainant (C) complained to my office about the care and treatment provided to their late grandparent (A) by Lanarkshire NHS Board (the Board).

A arrived at the Emergency Department of University Hospital Monklands by ambulance in the afternoon of 11 June 2022 and was admitted to hospital in the early hours of 12 June 2022.

While in hospital, A's condition deteriorated. Over the course of the evening of 12 June 2022, A became seriously unwell. A vomited, developed abdominal pain, and had a distended abdomen. A received abdominal x-rays and input from the surgical team, and staff attempted to stabilise A.

A small bowel obstruction (narrowing or blockage in the bowel, which usually requires urgent treatment) was identified in the early hours of 13 June 2022. Sadly, A died a short time later.

C complained to me (having been though the Board's complaint process) about the events preceding A's death. In particular, C complained about events relating to the assessment of A on admission and that communication with A's family prior to A's death was unreasonable.

The Board reviewed this case again after receiving notification of my investigation and identified some areas for improvement. They determined that further investigation through a Significant Adverse Event Review (SAER) was not required.

During my investigation I took independent advice from a consultant in acute and general medicine. Having considered and accepted the advice I received, I found that:

Care and treatment

- An abdominal x-ray should have been carried out when A was admitted to hospital in the early hours of 12 June 2022 on the basis of A's presentation

and also as part of an assessment for Clostridium difficile (C. diff, an infectious disease) as set out under relevant national prescribing guidelines.

- It was unreasonable that there was no record of an abdominal examination by a consultant on the morning of 12 June 2022 given an abdominal examination should have been carried out and documented based on A's presentation.

- The Board's failure to carry out an abdominal x-ray on admission and the lack of evidence that an abdominal examination was carried out by the consultant on the morning of 12 June 2022 means that the opportunity to detect signs of bowel obstruction was missed at an earlier stage when A was stable enough to undergo life-saving treatment. Therefore, there is a prospect that A might have survived.

Communication

- On balance, I found that the Board's communication with A's family was reasonable.

Taking all of the above into account, I upheld C's complaint about A's care and treatment. I did not uphold C's complaint about the Board's communication.

I was also critical that a SAER was not held in this case given it related to an unexpected death and given the Board's review had identified three specific points where consideration should be given to escalating to a SAER.

Finally, I found the Board's handling of C's complaint was unreasonable.

Further comment

It is of concern to me that I have made similar findings regarding Health Boards not carrying out adverse event reviews in other recent public reports (case references 202100979; 202209575; 202100560; 202101928; 202105840; 202200588). I intend to write to the Scottish Government and Health Improvement Scotland to draw their attention to the findings and recommendations I have made in relation to adverse event reviews in recent cases, including this one.

Recommendations

The Ombudsman's recommendations are set out below:

What we are asking the Board to do for C:

Rec number	What we found	What the organisation should do	What we need to see
1	Under complaint point a) I found the Board's care and treatment fell below a reasonable standard. In particular I found the Board should have: i. carried out an abdominal x-ray when A was admitted to hospital in relation to A's presentation and as part of screening for C. diff. ii. carried out an abdominal examination on the consultant ward round the morning after A's hospital admission and appropriately documented the results of the examination. There is no evidence that this happened which is unreasonable.	Apologise to C for the failings identified in this investigation. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/meaningful-apologies	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
	iii. the Board's own review, which was only carried out after I decided to investigate, did not identify all of the significant failings in care and areas for improvement including that this was a potentially preventable death. This was unreasonable. iv. the Board did not appropriately consider carrying out a SAER. v. In relation to complaint handling, I found that the Board's complaint investigation was unreasonable. In particular the Board failed to update about delays to the		

Rec number	What we found	What the organisation should do	What we need to see
	final response and to provide a full and informed response to the complaint about A's care and treatment.		

We are asking the Board 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 the Board's care and treatment fell below a reasonable standard. In particular I found the Board should have: i. carried out an abdominal x-ray when A was admitted to hospital in relation to A's presentation and as part of screening for C. diff. ii. carried out an abdominal examination the morning after A's	Patients presenting with diarrhoea and vomiting should have their symptoms fully assessed and be appropriately examined in a timely manner in line with relevant guidance.	Evidence the findings of my investigation has been shared with relevant staff in a supportive manner for reflection and learning. By: 16 April 2025 Evidence that the Board have reviewed their guidance for the screening of C. diff to ensure it is in line with national guidance in relation to the carrying out of an x-ray with details provided of any changes and how

Rec number	What we found	Outcome needed	What we need to see
	hospital admission and appropriately documented the results of the examination. There is no evidence that this happened which is unreasonable.		this will be disseminated to staff. Evidence that the Board have reviewed their guidance for clinical staff in the medical assessment unit in relation to the carrying out of abdominal examinations and x-rays and the recording of findings with details provided of any changes and how this will be disseminated to staff. By: 16 May 2025
3	The Board's review into A's case following notification of my investigation did not identify all of the significant failings in care and areas for improvement, including that this was a potentially preventable death.	Reviews into patient care should be undertaken at the right time, identify failings and good practice, and findings and recommendations are followed up, to demonstrate learning. Where adverse event(s) occur a significant adverse	Evidence the findings of my investigation has been shared with relevant staff in a supportive manner for reflection and learning. By: 16 April 2025 Evidence that the Board's systems for

Rec number	What we found	Outcome needed	What we need to see
	The Board did not appropriately consider carrying out a SAER.	event review should be held in line with the Board's protocols and national guidance to ensure there is appropriate learning and service improvements that enhance patient safety.	carrying out significant adverse event reviews have been reviewed to ensure they are carried out in line with the Board's protocols and national guidance. By: 16 May 2025

We are asking the Board to improve their complaints handling:

Rec number	What we found	Outcome needed	What we need to see
4	The Board's complaint handling was unreasonable. In particular I found the Board should have: i. updated about delays to the final complaint response. ii. identified the failings that occurred and areas for improvement during the complaint investigation,	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.	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). By: 16 April 2025

Rec number	What we found	Outcome needed	What we need to see
	prior to contact from my office. iii. provided a full and informed response to their complaint about A's care and treatment.		

Evidence of action already taken

The Board told me they had already taken action to address the issues and provided me with an action log which I am satisfied are reasonable. I will ask them to confirm that all actions are now complete and for an explanation about how they will assess their effectiveness going forward. (By 16 April 2025)

Feedback

<u>Points to note</u>

In the advice I took (and accepted), the Adviser said that:

1. the Emergency Department Nursing Record (which recorded a history of diarrhoea and vomiting) provided very useful additional information that - had it been used - may have guided the team towards earlier investigation and management;

2. the record made by a junior doctor who admitted A to the MAU included a picture of a hexagon to signify the abdomen, with an arrow through it, to indicate everything was fine. The Adviser said this record is not detailed, does not address bowel sounds and does not record what the doctor found, only showing that nothing was abnormal. The Adviser said that, while not unreasonable, this is a concern; and

3. A should have been nursed in a side room until potentially infective diarrhoea or vomiting was excluded.

I am drawing these points to the Board's attention and encourage them to consider and reflect on them, and whether there is scope for further learning from them.

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, 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. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. The complainant (C) complained to me about the care and treatment provided to their late relative (A) by Lanarkshire NHS Board (the Board).

2. A arrived at the Emergency Department of University Hospital Monklands by ambulance around 16:00 on 11 June 2022. A was admitted to the Medical Assessment Unit around 02:00 on 12 June 2022.

3. While in hospital, A's condition deteriorated. Over the course of the evening of 12 June 2022, A became seriously unwell. Around 19:00, A vomited, developed abdominal pain, and had a distended abdomen. A received abdominal x-rays and input from the surgical team, and staff attempted to stabilise A.

4. A small bowel obstruction (narrowing or blockage in the bowel, which usually requires urgent treatment) was identified in the early hours of 13 June 2022. A passed away a short time later, around 02:30.

5. C complained to me about the events preceding A's death. In particular, that the Board's complaint response did not refer to vomiting as a reason for A's admission, that A was not reasonably assessed for Clostridium difficile (C. diff, an infectious disease) and that communication with A's family prior to A's death was unreasonable.

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

   (a) the Board failed to provide reasonable care and treatment to A in the period from their attendance at hospital on 11 June 2022 and death on 13 June 2022 (***upheld***); and

   (b) the Board failed to provide reasonable communication with A's family in the period from their attendance at hospital on 11 June 2022 and death on 13 June 2022 (***not upheld***).

Investigation

7. In order to investigate C's complaint, my complaints reviewer and I considered all of the documentation submitted to us by C and by the Board, including A's medical and nursing records, and complaint correspondence. I also obtained medical advice from an appropriately qualified medical adviser (the Adviser: a consultant in acute and general medicine). The Adviser had full access to A's relevant medical records and the complaint correspondence.

8. I have decided to issue a public report on C's complaint given my concerns about the serious and multiple failings in this case, including the Board's decision not to carry out a Significant Adverse Event Review (SAER). I also consider there is the potential for wider learning from the complaint.

9. This report includes the information that is required for me to explain the reasons for my decision on this case. Please note, 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.

10. Explanations for the medical terms referred to are provided in Annex 1 and/ or the report.

Key events (compiled from information provided by both C and the Board)

Date of event	Details of event
11 June 2022	16:00. A arrived at the Emergency Department (ED) of University Hospital Monklands by ambulance. A stool sample was reported which was negative for C. diff.
12 June 2022	02:00. A was admitted to the Medical Assessment Unit (MAU) due to diarrhoea following a course of antibiotics. A was clinically dehydrated and blood results showed a severe acute kidney injury (a sudden decline in kidney function). A was screened for infectious causes of diarrhoea, including C. diff. 02:31. A chest x-ray was carried out. 9:46. A kidney ultrasound (a type of medical imaging) was carried out, showing kidneys looked normal. 10:00. A was reviewed by a consultant physician. 12:20. A's family member was updated on the ward. 14:20. A's blood pressure and heart rate had improved with intravenous fluids.

Date of event	Details of event
	19:00. A vomited and developed abdominal pain. A's abdomen was distended. Abdominal x-rays and a surgical opinion were arranged. 19:30. A's family member left the ward when A was very agitated and asked for A to be reviewed by a doctor. 21:09. An abdominal x-ray was carried out. 22:00. A's family member contacted the ward for an update. 22:21. A was reviewed by a surgeon and found to be very unwell and agitated. A's abdomen was distended, and a bowel obstruction was suspected. A CT scan (a type of medical imaging) was arranged. A's condition deteriorated and their care was discussed with a consultant physician. A member of the medical team, staff from the Intensive Treatment Unit (ITU) and the surgeon attended to A. Staff attempted to stabilise A. 23:00. A's family was informed A was unstable, and the family should attend the hospital. 23:30. A chest x-ray was carried out.
13 June 2022	01:47. An abdominal CT scan showed acute small bowel obstruction. 02:20. A's family was present with A. 02:30. A died.

(a) The Board failed to provide reasonable care and treatment to A in the period from their attendance at hospital on 11 June 2022 and death on 13 June 2022

Concerns raised by C

11. The following paragraphs set out the concerns C raised.

12. C questioned why the Board's complaint response did not refer to vomiting on A's admission to hospital. C said that A was unable to have any form of oral intake without vomiting for the week prior to their admission.

13. C was concerned that A became gravely ill in a short period of time; between 19:30 and 22:00 on 12 June 2022.

The Board's complaint response

14. The Board offered their sincere condolences.

15. The Board said A was admitted to the MAU at approximately 02:00 on 12 June 2022 due to diarrhoea following a recent course of antibiotics from their GP. Blood results showed a severe acute kidney injury, and an ultrasound was arranged. This showed the kidneys looked normal.

16. Clinical probability pointed to antibiotic-induced diarrhoea leading to dehydration and severe acute kidney injury. Initial management focussed on rehydration with intravenous fluids.

17. A was screened for infectious causes of diarrhoea, including C. diff as a result of antibiotic use. The results of a stool sample were available on 11 June 2022 and showed the sample was negative for C. diff. The Board said that because this result was prior to A's admission to the MAU on 12 June 2022, there was no need to isolate A. A was admitted into a four-bed room. The Board said it is normal practice to exclude C. diff when testing stool samples for other causes. Testing for C. diff was requested because A had been on antibiotics, and antibiotics can increase the risk of a patient developing C. diff.

18. At 14:30 on 12 June 2022, A's blood pressure and heart rate had improved with intravenous fluids.

19. At 19:00 on 12 June 2022, A vomited and developed abdominal pain. A junior doctor assessed A and identified a distended abdomen. Abdominal x-rays were arranged, and the opinion of the surgical team was sought.

20. A was reviewed by a surgeon at 22:21. By this time, A was very unwell with agitation. The surgeon confirmed a distended abdomen and suspected a bowel obstruction. A CT scan was planned.

21. A's deterioration was recognised as critical. A's case was discussed with the on-call consultant physician, and A was attended to by a senior member of the

medical team, a doctor from the ITU and the surgeon. Attempts were made to stabilise A.

22. A CT scan was carried out at 01:47 on 13 June 2022, which showed a small bowel obstruction. The doctor from ITU was present with A for over two hours. A continued to deteriorate, despite attempts to stabilise A.

23. A died at 02:30 on 13 June 2022. The diagnosis of ischaemic bowel (a condition where blood flow to the bowel is blocked) explains A's rapid deterioration.

The Board's response to our enquiries

Wait for medical review upon arrival

24. We asked the Board about the length of time A waited for treatment after arriving at hospital. The Board acknowledged that A had a long wait from the time of arrival in the ED until a medical review and said this was due to the wait for an available bed in the MAU.

25. The Board said A arrived at the ED at 16:12 on 11 June 2022. A nursing assessment was carried out at 16:45 and A's NEWS score was 5 (National Early Warning Score, a tool used to detect clinical deterioration in adults, where a score of 5 indicates medium risk requiring urgent review[1]). Blood samples were taken, and fluids were administered. The Society for Acute Medicine recommend triage within 30 minutes of arrival. A's triage was completed just outside this timeframe, and this small delay would not have materially affected the subsequent course of A's treatment.

26. A's observations were next recorded at 00:20 on 12 June 2022, when A's NEWS score was 2. The Board acknowledged the rechecking of A's NEWS score was significantly delayed. In the intervening time, A had a COVID-19 test, a screening test for delirium, personal care and offers for food and fluids.

27. NEWS 2 guidance recommends repeated observations within one hour for a NEWS score of 5 or more. The Board acknowledged there was no documented recognition of the severity of this case. The Board said that given the subsequent improvement in A's observations, it is unlikely that the lack of adherence to guidance in this case would have materially altered the outcome.

[1] https://www.nice.org.uk/advice/mib205/chapter/The-technology

Admission to shared room

28. We asked the Board about A's admission to a shared room when the cause of A's diarrhoea was not confirmed. The Board explained that there was no need to isolate A due to a potential C. diff infection on admission, because a stool sample was reported on 11 June 2022, prior to admission, and the sample was negative for C. diff.

Records of vomiting

29. We asked the Board about records of A's vomiting. The Board said A's presenting complaint in the ED record did not mention vomiting, and the only mention of vomiting at this point was later in the ED nursing record, which referred to 'D&V' (diarrhoea and vomiting).

30. The Board said the dominant history at the time of A's admission was diarrhoea - not abdominal pain or vomiting - which was complicated by acute kidney injury. The emergence of abdominal pain, distension and vomiting occurred later, at least 27 hours after A's documented arrival time in the ED.

Abdominal examination and assessment

31. We asked the Board whether an abdominal examination was carried out when A was admitted to hospital or when A was reviewed by a doctor after admission to the MAU; and whether an abdominal x-ray was carried out on A's admission.

32. The Board explained that the junior doctor who admitted A to the MAU at 01:55 on 12 June 2022 noted diarrhoea and no abdominal pain, and an arrow was through the abdominal diagram in A's records. The Board said an arrow through the abdominal diagram commonly represented 'no abnormality', and they would interpret this as indicating the absence of physical signs in the abdomen.

33. The consultant physician who completed A's review at 10:00 on 12 June 2022 provided a statement as part of the complaint investigation and advised their notes were brief and focussed on the positive. The abdomen was not mentioned specifically but comments were provided on physical signs of dehydration. They explained it would be their normal practice to examine the relevant organ systems when evaluating new patients, and they presumed they would have inspected and felt A's abdomen; however, they were unable to confirm this.

34. The Board said the first record of abdominal pain was to a nurse at 19:00 on 12 June 2022. The Board said this means peritonism (inflammation of the tissue in the

abdomen, which indicates acute disease that should be rapidly diagnosed and treated) at A's earlier review was unlikely.

35. The Board confirmed an abdominal x-ray was not carried out on admission, nor was one requested the following morning, because examination was documented as normal at that time. An x-ray would have been requested if there had been clinical suspicion of obstruction or perforation (a hole in the lining of the colon, which requires immediate treatment).

36. The Board said an abdominal x-ray was requested the evening of 12 June 2022, when A had vomited at around 19:00 and had a distended abdomen. The x-ray was carried out at 21:09.

Significant Adverse Event Review

37. We asked the Board about whether the Board had considered completing an adverse event review in this case.

38. In response to our enquiry, the Board completed a review of this case for a potential SAER. The Board said the review concluded that there was persisting uncertainty about whether peritonism may have been detectable before the morning of 13 June 2022, and a SAER would not resolve this uncertainty.

39. The Board said that the review was in-depth and carried out by a senior consultant in acute medicine. The Board also said that the briefing note following the review (which was supplied to my office) provided sufficient information and robust assessment, so the Board determined that further investigation with SAER was not required.

40. The Board said the review identified areas for improvement that are progressing via the Board's improvement groups. The review identified the following areas for improvement:

- multiple incidents of failing to respond to A's NEWS score in line with guidance;
- a delay in transfer to the MAU after arrival in hospital;
- delays in assessment by a consultant;
- hesitancy to arrange a CT scan in an emergency;
- lack of completed or documented medicine reconciliation; and

- missing documentation from scanned records, e.g. ambulance record, GP referral or medicine reconciliation.

41. We asked the Board about a section of the briefing note that contained assessment questions to support the decision about whether or not to carry out a SAER. This section contained nine questions with the following advice noted:

> If you have answered 'YES' to any of the assessment questions or there are a significant number of unknowns about the case, consider escalating to SAER or BNR[2].

42. In A's case, three questions were answered positively, indicating that there had been a breach of policy or procedure; something should have been done differently in this case; and there were family concerns regarding the treatment, care or outcome. The Board said that these questions were designed to prompt and support decision making regarding the need for further investigation but do not in themselves mandate one.

Relevant guidance

43. Scottish Antimicrobial Prescribing Group policy on Clostridioides difficile (C. diff) infection (CDI)[3]

44. SIGN guideline on care of deteriorating patients[4]

Medical advice

Wait for medical review upon arrival

45. The Adviser told us there was an unreasonable delay in A receiving medical review or intervention after arrival in the ED. A's NEWS score indicated intervention ideally within 20 minutes, but A waited around four hours. A's NEWS score should have been repeated within an hour. A's first NEWS score was taken around 17:00 on 11 June 2022 and not repeated again until after midnight, which was unreasonable.

46. The Adviser said the Board's position that failing to repeat the NEWS score did not affect the outcome in this case, because the score decreased, was speculative

[2] BNR - Briefing Note Review

[3] www.sapg.scot/guidance-qi-tools/infection-specific-guidance/clostridioides-difficile-cdiff-infection-cdi/

[4] www.sign.ac.uk/our-guidelines/care-of-deteriorating-patients/

and does not excuse poor practice, which the Board recognised and apologised for in response to our enquiries.

Records of vomiting

47. The Adviser said that the records from the ED Nursing Record referred to A&E attendance information documented by nurses and recorded diarrhoea and vomiting for one week.

48. However, admitting doctors documented that A denied vomiting. The Adviser said it is possible that patients can become confused when unwell or forget to mention important details. Nevertheless, the Adviser said that ED records provided very useful additional information that - had they been used - may have guided the team towards earlier investigation and management.

Assessment for C. diff

49. The Adviser explained that C. diff is a serious gastrointestinal infection that can cause megacolon (an abnormality of the colon) or colitis (inflammation of the lining of the large intestine). C. diff can be fatal and is an iatrogenic problem, meaning that it is caused by medical treatment, due to antibiotic use. The Adviser said that an abdominal x-ray is part of the severity scoring for C. diff under the Scottish Antimicrobial Prescribing Group policy, and it was unreasonable an abdominal x-ray was not carried out as part of A's C. diff assessment.

50. The adviser said A should have been managed in a side room until potentially infective diarrhoea or vomiting was excluded. The adviser said this requires more than a single negative stool sample, which was obtained in this case.

Abdominal x-ray

51. The Adviser explained that because A had diarrhoea, vomiting and a recent course of antibiotics, assessment for colitis or megacolon should have been undertaken, which involves an abdominal x-ray. The Adviser said that it was unreasonable the Board did not consider megacolon and colitis in A's case, and it was unreasonable an abdominal x-ray was not carried out when A was admitted to hospital. The Adviser said that an abdominal x-ray should have been carried out at the same time A had a chest x-ray after admission.

52. The Adviser said that had an abdominal x-ray been performed earlier in A's hospital stay, it would have likely shown bowel dilation (a condition where the bowel becomes abnormally large or widened, which indicates potential bowel obstruction) and the requirement for a CT scan, and further investigations and management could

have been instigated before A became profoundly unwell. The Adviser said no abdominal x-ray was performed until A's clinical situation was extreme. A had an abdominal x-ray approximately 24 hours after admission, when A was too unwell for intervention.

53. The Adviser said that had an abdominal x-ray been carried out in the 24-hour period before it was, there is a probability the x-ray would have shown a dilated bowel, which should prompt treatment for bowel obstruction. Therefore, there is a probability that A might have survived if bowel obstruction had been identified earlier in their hospital stay. The Adviser explained that small bowel obstruction is not a diagnosis that is fatal and can be reversible. It may have required an operation, but at the time of admission to hospital, A might have survived an operation to correct it. Some small bowel obstructions can also be managed conservatively.

Abdominal examination

54. The Adviser said the entry in the medical records by the junior doctor who admitted A to the MAU included a picture (hexagon to signify abdomen with arrow through it) meaning everything was fine. This record was not detailed; did not address bowel sounds; did not record what the junior doctor found and only showed nothing was abnormal. This was not unreasonable, but it was a concern.

55. On the consultant's ward round the following morning (12 June 2022) there was no abdominal examination documented. The Adviser said that while doctors may forget to document normal examination findings, the records suggest that A's abdomen was not examined. The Adviser said it was unreasonable not to examine the abdomen, given A's presentation, and unreasonable not to record an examination.

56. The Adviser said that in a case of bowel obstruction, abdominal examination is typically abnormal, with unusual bowel sounds and a distended and tender abdomen. A normal abdominal examination would be reassuring because it would mean that bowel obstruction happened after this time; however, it is unclear whether A's abdomen was examined or not, which means a bowel obstruction could have been present at this time. The Adviser said that an abdominal examination would not have definitely identified a bowel obstruction, because the obstruction may have occurred after the time of the examination.

57. The Adviser considered the Board's position that the patient had been examined and the examination was normal and said this was conjecture.

SAER

58. The Adviser said that the Board's records did not provide a clear explanation why a SAER was not carried out in this case. They considered this was unreasonable and represented a missed opportunity for learning from this case.

59. The Adviser said that learning and improvement is a reasonable expectation in this case, but it has not been evidenced. In response to the Board's position that correcting the problems in this case would not have changed the outcome, the Adviser said that the outcome in this case may have changed in the event of:

- an earlier diagnosis of small bowel obstruction;
- an abdominal x-ray on admission; or
- the examination of A's abdomen, which may have identified an abnormality.

Adviser's conclusions

60. In conclusion, the Adviser reiterated that the Board failed to:

- take appropriate action in response to A's high NEWS score on admission, which the Board acknowledged and has taken appropriate action to improve;
- carry out an abdominal x-ray when A was admitted to A&E, based on A's presentation of diarrhoea and vomiting, and recent course of antibiotics, in order to assess colitis, megacolon and C. diff;
- appropriately document an abdominal examination by the consultant on the morning of 12 June 2022; and
- reasonably explain why a SAER was not carried out in this case.

Board's comments on draft report

61. In line with our normal practice, a draft report of this decision was shared with both parties for their comments. The Board provided the following comments.

62. They considered the emphasis put on a comment written early in the ED records in relation to vomiting was incorrect. They advised that, regrettably, the member of nursing staff who added this note failed to include their name, grade, or

time of the assessment. The comment '1/52 n+v'[5] appeared to have been written by a triage nurse in the absence of a clinical assessment.

63. While they accepted failings in record keeping and documentation, there were multiple comments documented in the admission records by clinicians caring for A which did not support a history of vomiting, but diarrhoea was noted, including:

- The Scottish Ambulance Service noted the patient as 'dehydrated, loose stools, malaise, recent antibiotics, poor mobility'.
- Nursing documentation noted that the patient was 'made comfortable, personal care carried out, offered tea and sandwich'.
- The junior doctor noted diarrhoea and specifically stated 'no vomiting nor abdo pain'.
- Nursing notes on transfer to the MAU stated 'Poor oral intake, continent of urine, incontinent of faeces'.
- The consultant review did not mention vomiting.

64. The Board said the first record confirming vomiting following A's admission was at 19:00, following which they considered there was a rapid and clinically appropriate response with timely medical review, investigation, and management.

Abdominal x-ray

65. The Board said A did not have confirmed C. diff infection, but this was suspected by the admitting clinical team based on A's history and presenting features.

66. They confirmed that they use the Scottish Antimicrobial Prescribing Group guidance[6] to support their management of C. diff infection, including antimicrobial decision making and assessment of clinical severity using a standardised clinical severity score. The Board had discussed this guidance with their Infectious Diseases team. They commented that the assessment of severity is a clinical assessment, and the need for radiological imaging remains based on the clinical assessment features, specifically abdominal pain, distension or peritonism, which would raise clinical concern regarding colitis or megacolon. These features were documented not to be

[5] The record reads 'D+V 1/52' and appears on the Emergency Department Nursing Record dated 11 June 2022.

[6] www.sapg.scot/guidance-qi-tools/infection-specific-guidance/clostridioides-difficile-cdiff-infection-cdi/

present on examination on admission, and therefore it was incorrect that an abdominal x-ray was indicated at that time. The Board said that had these features been present on examination, then an abdominal x-ray, or preferably urgent abdominal CT scanning, would be indicated. The Board considered their approach was not inconsistent with the Scottish Antimicrobial Prescribing Group guidance.

67. They noted the adviser had acknowledged that the admitting doctor documented their abdominal examination in the clinical notes using a hexagon with an arrow through it. The adviser acknowledged that this meant everything was fine and it was not unreasonable.

SAER

68. The Board disagreed with the findings and recommendations of the draft report in relation to the SAER and considered it was contrary to the Board's policies and national guidelines[7]. The Board advised their process, which they understood to be best practice, is to review and risk assess stage 2 complaints[8] when they are received, to help determine what further action or investigation may be necessary.

69. The complaint regarding A was reviewed and risk assessed by the Chief of Medical Services and was not felt to require any incident investigation, such as a SAER. Following receipt of an enquiry from the SPSO in January 2024, a briefing note review (BNR) was carried out. In line with the national approach, this helps to guide decision making with regards to the need for a SAER. The Board said the information from the BNR provided a very detailed clinical review of the case and a rationale for a SAER not being required. The Board also said that while the briefing note found areas for improvement, the Board remain content that a SAER was not required. The Board said it is at the discretion of the site commissioner if they choose to convert a complaint to a SAER, and they did not consider any breach of their procedures had occurred.

70. The Board acknowledged that the briefing note failed to identify actions for the issues identified, and an action plan had since been developed. The Board provided a copy of an action log describing work they have undertaken to address the issues identified in the BNR.

[7] The national framework is available as a PDF document at this link https://www.healthcareimprovementscotland.scot/wp-content/uploads/2024/03/20191216-AE-framework-4th-Edition.pdf

[8] The NHS model complaints handling procedure involves a two-stage process including early resolution (stage 1) and investigation (stage 2).

Further advice from the Adviser

71. In response to the Board's comments on the draft report of this decision, I obtained further advice.

Vomiting

72. The Adviser said the Emergency Department Nursing Record contained a record of vomiting. The fact that this was noted means that at some point A was vomiting. While the Board are correct that they did not record any vomiting while A was in the ED, the Adviser remained of the view that an opportunity was missed by the Board to recognise that vomiting was part of A's presenting symptoms.

Abdominal x-ray

73. The Adviser reiterated their position that under the Scottish Antimicrobial Prescribing Group guidance an abdominal x-ray should be performed in cases of *suspected* C. diff infection as part of the severity scoring[9], not just in cases of confirmed C. diff infection. The Adviser also said that more than one doctor had documented that C. diff was suspected. Given this, and based on A's presentation, they should have undergone a full assessment for severity. They noted that the guidance states "review and document severity of disease daily". They advised that daily x-rays should be carried out until clinicians know which way the patient is going. The Board did not do this.

SAER

74. The Adviser said that while it appeared that the actions the Board had taken were part of on-going improvement work rather than directly in response to this case, it represented good work that will make patient care safer. The Adviser also considered the Board had provided evidence of learning in that they had recognised there was a problem, taken steps to improve patient care and provided an appropriate response.

75. The Adviser recognised that the Board did not consider this was a significant adverse event. They commented that the way an adverse event is rated (under the national guidance) can be subjective. Nevertheless, they remained of the view that a SAER should have been carried out at the time of this event, because if A's care and treatment had been handled appropriately from the time A arrived at the ED, there would have been opportunities to try and save A's life, and A may not have died.

[9] The Scottish Antimicrobial Prescribing Group decision tool for C. diff infection is available as a PDF document at this link https://www.sapg.scot/media/6829/20220418-cdi-decision-tool-sapg.pdf

They considered the Board had now provided evidence of adequate learning that addresses many of the failings the Board identified.

Decision

76. 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.

77. In investigating this complaint, I have obtained professional advice from the Adviser (as outlined above). I have carefully considered this advice, which I accept in full, along with the other information and evidence I hold.

78. I welcome the Board's recognition, during my investigation, of the delays A experienced after arrival at hospital in terms of having a NEWS score taken, being transferred to the MAU, and receiving a medical review. I am satisfied that the actions identified by the Board as part of the BNR; and as set out in the action log the Board provided address these failings and will lead to improvements in patient care. I have asked for evidence of the actions the Board have taken when making my recommendations, which are set out at the end of this report.

79. Notwithstanding this, it is disappointing that these failings were only recognised after I decided to investigate, when the Board carried out the BNR of A's care. I am critical that these failings were not picked up and addressed when C first raised their complaint with the Board; and that the other serious failings identified by my investigation were not identified during the Board's complaint investigation and subsequent BNR. I address these points in more detail at paragraphs 88-93 below, and under complaint handling.

80. C was initially concerned that the Board's complaint response did not refer to vomiting. My investigation has found that A's records from the Emergency Department referred to both diarrhoea and vomiting. The Board have maintained that A's dominant history at the time of admission was diarrhoea.

81. I recognise the Board's strongly held views on this point, and do not dispute that there is a clear history of diarrhoea recorded. I also note that it is recorded A denied vomiting. Nevertheless, I accept the advice I have received that more cognisance should have been taken of the Emergency Department nursing record which recorded a history of vomiting (as well as diarrhoea). Overall, while it was not unreasonable for Board clinicians to consider diarrhoea as a presenting symptom given the clear history recorded, I consider it is unsatisfactory that A's history of

vomiting was also not fully considered and acted on at the time of A's admission. I have therefore provided feedback to the Board in relation to this.

82. While noting the Board's comments, I am satisfied that my investigation has established that an abdominal x-ray should have been carried out when A was admitted to hospital in the early hours of 12 June 2022. This is on the basis of A's presentation, and also as part of an assessment for C. diff as set out under relevant national prescribing guidelines. These guidelines indicate that the treatment for suspected or confirmed C. diff should include daily x-ray. It is clear from the records that clinicians suspected C. diff, and I consider the failure to carry out an x-ray in A's case was unreasonable.

83. It is of significant concern that there is no record of an abdominal examination by a consultant on the morning of 12 June 2022, given an abdominal examination should have been carried out (and documented) based on A's presentation. I consider this was unreasonable. I note the consultant's statement that their normal practice is to carry out an examination of the relevant organs and they presumed they would have inspected and felt A's abdomen. I accept that doctors may sometimes forget to document normal examination findings; however, I consider that forgetting to document an important medical examination in a case like this is, of itself, unreasonable.

84. My investigation is based on available evidence in the form of medical records. In this case, there is no record that an abdominal examination took place on 12 June 2022. This would suggest that one was not carried out. While noting the consultant's statement, given the lack of documentation of examination by them I am unable to conclude with any certainty that an abdominal examination was carried out at this time as it should have been. This is unreasonable.

85. The record of the earlier abdominal examination, while not wholly unreasonable, was also lacking in detail. Given the context of this case, this is a further concern. I have provided some feedback for the Board in relation to this point and in relation to the advice I have accepted that A should have been nursed in a side room until potentially infective diarrhoea or vomiting was excluded.

86. The Board's failure to carry out an abdominal x-ray on admission and the lack of evidence that an abdominal examination was carried out by the consultant on the morning of 12 June 2022 means that the opportunity to detect signs of bowel obstruction was missed at an earlier stage when A was stable enough to undergo life-saving treatment. The advice I have received and accept is had an abdominal x-ray been carried out in the 24-hour period following admission (before one was carried out), there is a possibility it would have shown a dilated bowel, which should

have prompted treatment for bowel obstruction at a point when A was stable enough to undergo surgery. Therefore, there is a prospect that A might have survived. I understand that this will make very difficult reading for C and A's family, and they have my heartfelt sympathy.

87. Taking account of the advice I have received (and accepted), and in view of the failings identified, **I uphold this head of complaint**.

88. The Board have explained that, in line with their processes they carried out a risk assessment when C's complaint was received and it was not considered to require any incident investigation, such as a SAER. I agree with the Board that it is good practice to carry out such an assessment and that such an assessment was carried out from the evidence I have seen. Despite this, as noted above, it is clear from my investigation that there were significant failings in A's care that were not identified and addressed when the complaint was received and risk assessed (I consider this under complaint handling).

89. As noted above, I welcome the Board's engagement in reviewing this case after contact from my office by carrying out a BNR and the actions they have taken in response to the failings they identified. I recognise that the Board remain of the view that, having carried out a BNR, a SAER was not required, and I accept that ultimately this is a matter for the Board to determine taking into account the relevant national guidance. Nevertheless, given this related to an unexpected death and given the Board's BNR identified three specific points where consideration should be given to escalating to a SAER, my view is that more consideration should have been given to carrying one out. This is also supported by the advice I received that a SAER should have been held. I therefore remain critical that a SAER was not held.

90. In addition, the BNR did not identify all the significant failings that occurred, including that this case involved a potentially preventable death.

91. It is essential that SAERs are undertaken at the appropriate time and as soon as possible after the event(s). It is also essential that adverse event reviews identify all the failings that have occurred and that there is appropriate learning, which is acted upon and leads to improvement from the remedial action taken. I have, therefore, made a recommendation for the Board in light of this case.

92. My recommendations for the Board are set out at the end of this report.

Further comment

93. While I have specific concerns about the timeliness and quality of the BNR that was carried out in this instance, I have also made similar findings in a significant

number of other recent public reports I have published (case refs 202100979; 202209575; 202100560; 202101928; 202105840; 202200588). This has led me to conclude that there is a lack of consistency in the commissioning and completion of SAERs across Scotland. In doing so, I also note the advice I have received in this case that the way an adverse event is rated can be subjective. I, therefore, intend to write to the Scottish Government and Health Improvement Scotland (who are responsible for the learning from the adverse events national framework[10]) to draw their attention to the findings and recommendations I have made in relation to adverse event reviews/ SAERs in recent cases, including this one.

(b) The Board failed to provide reasonable communication with A's family in the period from their attendance at hospital on 11 June 2022 and death on 13 June 2022

Concerns raised by C

94. C questioned why their family did not receive an update about A's condition in the period between 19:30 and 22:00 on 12 June 2022, when A became gravely ill.

The Board's complaint response

95. The Board apologised that C's family did not feel fully informed throughout A's admission.

96. The Board said A's adult child was updated by nursing staff at 12:20 on 12 June 2022. At this point, A was unwell but stable and appeared to be responding to treatment.

97. A's family was updated during the course of A's deterioration on the night of 12-13 June 2022, and A's two adult children were in attendance by 02:20 on 13 June 2022, prior to A's death at 02:30. Staff explained to A's children that A was unlikely to survive this illness.

The Board's response to our enquiries

98. The Board apologised that A's family were not contacted and updated at an earlier opportunity.

[10] The national framework is available as a PDF document at this link https://www.healthcareimprovementscotland.scot/wp-content/uploads/2024/03/20191216-AE-framework-4th-Edition.pdf

Medical advice

99. The Adviser said that A's family should have been communicated with in a timely manner. The Adviser said that in reality - particularly out of hours and given the level of emergency in this case, prior to A's death - all staff are involved in trying to save a patient's life, and sometimes that means communication with a patient's family takes a lower priority.

100. The Adviser also said that this scenario occurs in many other hospitals across the country, and to take time to fully explain the situation to the family would have taken one of the team away from their attempts to resuscitate the patient, which would have been unreasonable.

101. The Adviser said that ideally, A's family should have been communicated with in a timely manner, but their view was is not unreasonable that did not happen overnight and in an emergency situation.

Decision

102. I have carefully considered the advice I have received from the Adviser on this complaint. I accept this advice. I recognise that to A's family this will be of scant comfort given the shortness of the time period they arrived prior to A's death, but sincerely hope they can appreciate that in the moment, the focus has to be on the patient.

103. My investigation found that A's family member was updated the afternoon after A's admission and a family member was present on the ward that evening. After that time, A's condition deteriorated, and staff were engaged in attempting to stabilise A in an emergency situation.

104. This will have been a very difficult time for the family and also for the staff caring for A. Ideally, A's family should have been communicated with in a more timely manner. Equally, this was an emergency situation that happened overnight, and staff were fully focused on caring for A. Taking these factors into account and the advice I have received I have concluded that the Board's communication at this time was not unreasonable. On balance, **I do not uphold** this head of complaint.

Complaint handling

105. Section 16G of The Scottish Public Services Ombudsman Act 2002 requires me to monitor and promote best practice in relation to complaints handling. This means I can make recommendations on complaints handling issues without a specific complaint having been made by the complainant.

106. In terms of the NHS Model Complaints Handling Procedure, the Board's investigation of a complaint should address fully all the issues raised and demonstrate that each element has been fully and fairly investigated. It should also include an apology where things have gone wrong.

107. Complaints are not only about addressing the concerns people raise, but they are also a source of learning and improvement; they are fundamental to building confidence in services and promoting constructive relationships between service users and the organisations providing those services.

108. In response to my enquiries, the Board identified that the final response was not provided within the statutory timescale of 20 working days, nor was an update provided with a revised timescale for the response.[11]

109. I acknowledge that when responding, the Board apologised to the family for their not feeling fully informed throughout A's admission. However, the Board's complaint response failed to recognise the serious failings in care and areas for improvement that were later identified by the Board's own review. The Board's complaint response also did not identify or address the other significant aspects of care and treatment that my investigation has identified, including the failure to carry out an x-ray when A was admitted to hospital and that this was a potentially preventable death. Nor did it refer to the nursing record in the Emergency Department of A vomiting.

110. Overall, I consider there was a failure to appropriately update about delays to the final complaint response and to provide a full and informed response to the complaint about A's care and treatment. Given this, I consider the Board's complaint handling was unreasonable.

111. In view of this, I have made a recommendation about complaint handling.

[11] The complaint was made to the Board by an adviser from the Patient Advice and Support Service. The adviser was the main contact for the complaint whilst it was handled by the Board. A's family member has been the main contact for the complaint whilst it has been handled by the SPSO and is referred to as 'C' throughout this report.

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 the Board to do for C

Rec number	What we found	What the organisation should do	What we need to see
1	Under complaint point a) I found the Board's care and treatment fell below a reasonable standard. In particular I found the Board should have: vi. carried out an abdominal x-ray when A was admitted to hospital in relation to A's presentation and as part of screening for C. diff. vii. carried out an abdominal examination on the consultant ward round the	Apologise to C for the failings identified in this investigation. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/meaningful-apologies	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
	morning after A's hospital admission and appropriately documented the results of the examination. There is no evidence that this happened which is unreasonable. viii. the Board's own review, which was only carried out after I decided to investigate, did not identify all of the significant failings in care and areas for improvement including that this was a potentially preventable death. This was unreasonable. ix. the Board did not appropriately consider carrying out a SAER. x. In relation to complaint handling, I found that the Board's complaint investigation was unreasonable. In particular the Board failed to update about delays to the final response and to provide a full		

Rec number	What we found	What the organisation should do	What we need to see
	and informed response to the complaint about A's care and treatment.		

We are asking the Board 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 the Board's care and treatment fell below a reasonable standard. In particular I found the Board should have: iii. carried out an abdominal x-ray when A was admitted to hospital in relation to A's presentation and as part of screening for C. diff. iv. carried out an abdominal examination the morning after A's hospital admission and appropriately documented the results of	Patients presenting with diarrhoea and vomiting should have their symptoms fully assessed and be appropriately examined in a timely manner in line with relevant guidance.	Evidence the findings of my investigation has been shared with relevant staff in a supportive manner for reflection and learning. By: 16 April 2025 Evidence that the Board have reviewed their guidance for the screening of C. diff to ensure it is in line with national guidance in relation to the carrying out of an x-ray with details provided of

Rec number	What we found	Outcome needed	What we need to see
	the examination. There is no evidence that this happened which is unreasonable.		any changes and how this will be disseminated to staff. Evidence that the Board have reviewed their guidance for clinical staff in the medical assessment unit in relation to the carrying out of abdominal examinations and x-rays and the recording of findings with details provided of any changes and how this will be disseminated to staff. By: 16 May 2025
3	The Board's review into A's case following notification of my investigation did not identify all of the significant failings in care and areas for improvement, including that this was a potentially preventable death. The Board did not appropriately consider carrying out a SAER.	Reviews into patient care should be undertaken at the right time, identify failings and good practice, and findings and recommendations are followed up, to demonstrate learning.	Evidence the findings of my investigation has been shared with relevant staff in a supportive manner for reflection and learning. By: 16 April 2025

Rec number	What we found	Outcome needed	What we need to see
		Where adverse event(s) occur a significant adverse event review should be held in line with the Board's protocols and national guidance to ensure there is appropriate learning and service improvements that enhance patient safety.	Evidence that the Board's systems for carrying out significant adverse event reviews have been reviewed to ensure they are carried out in line with the Board's protocols and national guidance. By: 16 May 2025

We are asking the Board to improve their complaints handling

Rec number	What we found	Outcome needed	What we need to see
4	The Board's complaint handling was unreasonable. In particular I found the Board should have: iv. updated about delays to the final 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	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

Rec number	What we found	Outcome needed	What we need to see
	v. identified the failings that occurred and areas for improvement during the complaint investigation, prior to contact from my office. vi. provided a full and informed response to their complaint about A's care and treatment.	key issues raised, identify and action appropriate learning.	meeting with staff; or feedback given at one-to-one sessions). By: 16 April 2025

Evidence of action already taken

The Board told me they had already taken action to address the issues and provided me with an action log which I am satisfied are reasonable. I will ask them to confirm that all actions are now complete and for an explanation about how they will assess their effectiveness going forward. (By 16 April 2025)

Feedback

Points to note

In the advice I took (and accepted), the Adviser said that:

4. the Emergency Department Nursing Record (which recorded a history of diarrhoea and vomiting) provided very useful additional information that - had it been used - may have guided the team towards earlier investigation and management;

5. the record made by a junior doctor who admitted A to the MAU included a picture of a hexagon to signify the abdomen, with an arrow through it, to indicate everything was fine. The Adviser said this record is not detailed, does not address bowel sounds and does not record what the doctor found, only showing that nothing was abnormal. The Adviser said that, while not unreasonable, this is a concern; and

6. A should have been nursed in a side room until potentially infective diarrhoea or vomiting was excluded.

I am drawing these points to the Board's attention and encourage them to consider and reflect on them, and whether there is scope for further learning from them.

Terms used in the report **Annex 1**

A	Aggrieved, C's late relative
BNR	Briefing Note Review
C	Complainant
C. diff	Clostridium difficile, an infectious disease
ED	Emergency Department
ITU	Intensive Treatment Unit
MAU	Medical Assessment Unit
NEWS	National Early Warning Score, a tool used to detect clinical deterioration in adults
SAER	Significant Adverse Event Review