SPSO decision report

Case: **201204486, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: complaints handling
Outcome: upheld, recommendations

Summary

Mrs C, who is an advice worker, complained on behalf of her client (Mrs A), whose late brother died during an investigative procedure in Glasgow Royal Infirmary. The complaint was about the way the board investigated Mrs A's complaint about her brother's care and treatment.

Mrs A complained to the board in July 2012 and two weeks later she and a friend met with members of the clinical, nursing and complaints team staff to discuss her concerns. Mrs A expected to receive a copy of the meeting notes shortly afterwards, but this did not happen. She chased this up over the next few weeks but did not receive the notes until October that year.

When Mrs A reviewed them, she found several inaccuracies and omissions according to her recollection of the meeting and sent the board a list of these in early November. She asked them for a final written response, so that she could escalate her complaint to us if necessary. This did not happen, although she had several more contacts from the board. Mrs C eventually complained to us in October 2013. The board eventually, and only after our intervention, provided an amended copy of the notes. Mrs A still thought that there were inaccuracies and omissions, and was confused by conflicting information about the board's process for investigating significant clinical incidents and how they are reported on the NHS system (known as Datix).

In response to our enquiries, the board said that the complaint file was closed in error after the meeting, so no automatic reminders were sent to the complaints team or the clinical staff involved in the complaint about the outstanding meeting notes.

Our investigation found that the board had not complied with the timescales in their own complaints handling procedure. We were concerned at the time taken, firstly to produce the meeting notes, and then to correct them. We were particularly concerned that we had to intervene before the amended notes were issued. It was also of concern to us that when Mrs A contacted senior members of staff because she had not received any response from the complaints team, they did nothing to progress this or assist Mrs A. We noted that the members of the clinical team that Mrs A contacted did not respond to her because they assumed the complaints team would do so.

Recommendations

We recommended that the Board:

- issue a written apology for failing to notify Mrs A of her right to complain to this office and the inconsistent explanations she received about the significant clinical incidents policy;
- take steps to review their procedures for preparing and issuing notes of complaints meetings to ensure they are issued to complainants as soon as possible after the meeting and that they address any concerns about accuracy appropriately at the time; and
- review the current Datix form and consider how best to reflect the outcomes for incidents which, following

initial review, do not escalate to full investigation.