SPSO decision report

Case: **201500675, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: not upheld, no recommendations

Summary

Mrs C, who works for an advice agency, complained on behalf of the family of Mr A. She said they believed Mr A's nasogastric tube had been incorrectly inserted, which had caused a collapsed lung by puncturing the inside of his lung. They said that, following this, he had deteriorated and this had contributed to his death. Mr A's family believed that Mr A had been being prepared for discharge at the time of the insertion.

The board said that they did not believe it was possible that the nasogastric tube had led to Mr A's death. The tube had been inserted by an experienced nurse, and checked by x-ray. When it was found to be in the wrong place, it had been immediately removed. The board said that there had been no discharge plan in place for Mr A.

We received independent medical and nursing advice. The medical advice stated it was not medically possible for a nasogastric tube to puncture a lung. Mr A had suffered from serious lung disease and it was more likely that this had caused his collapsed lung. The nursing advice said the insertion of a nasogastric tube was routine, but that even if inserted correctly, it could subsequently move within a patient. It was appropriate for the board to have confirmed the position by x-ray and this was an example of good practice.

We found there was no evidence that Mr A had not received an appropriate level of care and treatment and did not uphold the complaint.