SPSO decision report

Case: **201708155, An NHS Board**
Sector: health
Subject: admission / discharge / transfer procedures
Decision: upheld, recommendations

Summary

Mr and Mrs C complained that the board unreasonably failed to maintain the air system at the neonatal unit at a hospital in their area. They said that the air system failed and their baby, who was born prematurely and was dependent on air/oxygen, had to be moved to a hospital in a second board's area and died there instead of the hospital in the board's area. Mr and Mrs C raised various concerns, including questioning the board's account that there had been no similar failures with the air system previously.

The hospital's air system includes two dryers (dryer 1 and dryer 2) which remove contaminants and moisture from the compressed air. When one dryer is in use, the other is set as a back-up dryer. The treated air is sent to the medical and surgical terminals within the hospital.

We found that at the time of events in question, services within the hospital began experiencing intermittent drops in air pressure. The problems were caused by the failure of dryer 2. The hospital activated contingency plans and began using air cylinders. The fault with dryer 2 was repaired five hours later, but recurred after seven hours and neonatal services took the decision to transfer babies to other hospitals. The fault was subsequently repaired.

We found that there was an incident 14 months before the events in Mr and Mrs C's case, in which dryer 1 failed, but there was nothing to suggest this previous fault itself was connected with the issues with dryer 2. However, it was clear that the board were not able to carry out all of the works needed to dryer 1, which meant that the air system was less resilient at the time the fault in dryer 2 occurred (and had been so for approximately 14 months).

The board offered an explanation for the time period taken to finalise the repairs to dryer 1, and the steps that they took to stock additional air cylinders during this time (increasing their supply fivefold) to mitigate the risk of a fault. However, given that the air system supplied air to the whole of the hospital, including the neonatal unit, we were concerned that it took such an extensive period of time to repair the fault to dryer 1; and that the board did not undertake any formal written risk assessment for having a dryer with an intermittent fault as the backup dryer, after the decision was made to operate the system this way.

Therefore, we upheld the complaint. In addition, we considered that in their response to Mr and Mrs C's complaint, the board did not fully address Mr and Mrs C's concerns and that they should have provided more information on the events in this case and the action that the board was taking in response to these.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr and Mrs C for failing to undertake a formal written risk assessment for their air system and for failing to respond to the complaint appropriately. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

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

- Any potential threats to a hospital wide operational system such as the hospital's air system should be formally risk assessed and documented. There should also be a clear process for reporting and signing off the risk assessment.

In relation to complaints handling, we recommended:

- Complaint responses should fully address the concerns raised and provide the complainant with all the relevant information held on the matters complained about.