SPSO decision report

Case: **201809719, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the standard of medical care and treatment provided to their late parent (A) during an admission to Queen Elizabeth University Hospital (QEUH). A was admitted to QEUH with worsening symptoms of a chest infection and a leg ulcer. When A's condition deteriorated, medical staff decided to transfuse three units of blood. During the transfusion, A went into cardiac arrest and died. C complained that the decision to transfuse A with blood was unreasonable given their condition and symptoms, and that this led directly to their death.

We took independent advice from a consultant geriatrician (a specialist in medicine of the elderly). We found that A should have had a thorough clinical review prior to the transfusion being prescribed. The transfusion monitoring protocol was not followed, and the board acknowledged that this may have led to a delay in recognising A's deterioration. We also noted that when A's observations and condition indicated a serious concern, nursing staff should have contacted a senior doctor but instead contacted the most junior doctor on duty. We considered all of this unreasonable. We saw no evidence that the severity of A's condition, and likely poor prognosis, was actively considered or discussed with them or their family. This would have been good practice.

We noted that after A's death the team appropriately discussed the case with the Procurator Fiscal and the death certificate review team, who stated that they would be content for a death certificate to be issued without the need for a post mortem examination. However, when this was then discussed with A's family, they remained concerned and said they would like things investigated further. With reference to the relevant guidance, we found that the case should have been referred back to the Procurator Fiscal for further consideration. If the Procurator Fiscal had still considered there was no need to investigate, the medical team should have offered the family the option of a hospital post mortem examination. We upheld this complaint. We were satisfied that the learning already implemented by the board was appropriate and satisfactorily addressed what had gone wrong in A's care. However, we made further recommendations in relation to the reporting of a death to the Procurator Fiscal.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to advise the Procurator Fiscal of the family's ongoing concerns regarding A's death, and for failing to offer a hospital post mortem. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.
- Share this decision notice with the Procurator Fiscal for advice as to whether the board should take any further steps.

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

- Medical staff are clear about the procedures for reporting deaths to the Procurator Fiscal. In particular, in the event that nearest relatives of the deceased are concerned that medical treatment may have contributed to the death of a patient this requires discussion with the Procurator Fiscal, even if initial

reporting has already been carried out.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.