SPSO decision report

Case: **201602059, Lothian NHS Board - Acute Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mrs C underwent a pubovaginal sling procedure (a surgical procedure used to manage urinary incontinence) and a cystoscopy (a bladder examination using a narrow tube-like telescopic camera) to address her stress incontinence. She was reviewed a few months later, and she reported a loss of sensation and significant distress about the appearance of her scars. She was referred to plastic surgery to see if anything could be done about the scarring.

Mrs C complained to the board about her treatment, and one month later she was advised that her complaint had been forwarded for investigation. Five months later Mrs C wrote to the board to raise concerns about the long wait for a response to her complaint. Upon receiving Mrs C's letter, the board discovered that her complaint had inadvertently been closed five months previously. Some weeks later, the board phoned Mrs C to explain that the complaint had been inadvertently closed and to discuss Mrs C's concerns about the delay in responding and her concerns about her treatment. The board then referred Mrs C to a different consultant urologist, and agreed that they would look into why the complaint had been closed. They also suggested that they would arrange an external review of the case, and they said that they would update Mrs C when they had further information. Despite phoning several times over a period of a further four months, Mrs C heard nothing from the board about her complaint. When she did manage to speak to the board again Mrs C asked to be sent a letter with the findings of the board's investigations. Mrs C did not receive a letter, and she then brought her complaints to us.

Mrs C complained to us about the medical treatment she received and the board's handling of her complaint. We took independent advice from a urologist. We found that the treatment that had been carried out was reasonable, and that it had achieved the outcome of restoring continence, even though there were some problems with loss of sensation. We found that Mrs C's scarring was considered to lie within the bounds of what can be seen following the types of surgery she had underwent. We did not uphold Mrs C's complaint about her treatment.

We were highly critical of the board's complaints handling. We found that there were delays, and that some of the board's communication with Mrs C about her complaint was misleading. We found that the board failed to investigate her complaint as agreed. We upheld this aspect of Mrs C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise for closing Mrs C's complaint in error, for including misleading information in their communication with Mrs C and for failing to investigate her complaint as agreed. This apology should comply with SPSO guidelines on apology, available at www.spso.org.uk/leaflets-and-guidance.

In relation to complaints handling, we recommended:

- Complaints handling staff should ensure that complaints are not closed unless there is clear evidence that

this is the correct course of action.
- Key staff should receive refresher training in complaints handling, in particular in relation to managing the expectations of complainants.

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.