SPSO decision report

Case: **201608505, Highland NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Ms C, who works for an advocacy and support agency, complained on behalf of her client (Mr A). Ms C complained that Mr A did not receive a reasonable standard of surgical care and treatment when he was admitted to Raigmore Hospital for an operation. During the operation, Mr A suffered an ureteric injury (an injury or cut to the ureter - a tube that carries urine from the kidneys to the urinary bladder). Ms C said that Mr A was not warned of the risk of ureteric injury when he consented to the procedure and that the injury itself was an unreasonable surgical error. Ms C also said that the injury was not identified and treated within a reasonable time. As a result of the failings, Mr A has endured poor health and the quality of his life has significantly deteriorated. It was also likely that Mr A would require further surgical procedures.

We took independent advice from a colorectal surgeon. We found no evidence that the specific risk of ureteric injury was discussed with Mr A during the consent process, which was unreasonable and contrary to the relevant guidance. We also found that the ureteric injury was a surgical error which had an adverse outcome and that it was, to an extent, avoidable. We also found that there was an unreasonable lack of detail in the operation note which may have helped clinicians to be more alert to post-operative complications, although we found that the standard of post-operative care and treatment provided was reasonable. We upheld Ms C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr A for failing to follow the relevant guidance on consent and ensure sufficient care was taken during the procedure and in completing the operation note. The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/leaflets-and-guidance.

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

- The consent process and related documentation should be reviewed so that clinicians properly obtain and document consent for procedures. The surgeon involved should reflect on this case in their annual appraisal.

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.