SPSO decision report

Case: **201804582, Grampian NHS Board**
Sector: Health
Subject: Communication / staff attitude / dignity / confidentiality
Decision: some upheld, recommendations

Summary

C, a patient adviser, complained on behalf of their client (A) in relation to the care and treatment provided to A's child (B) by the board. B was diagnosed with a type of slow growing brain tumour and subsequently underwent a surgical procedure to treat build-up of fluid in the brain. B experienced a neurological deficit following the procedure and the surgeons identified that the burr hole (a small hole drilled into the skull) was not placed at the intended site. Over the following months, the neurological deficit improved but B continued to experience severe headaches following the procedure. Follow-up care was provided by paediatric oncology (specialists in treating children with cancer) and paediatric neurology (specialists in treating children with disorders of the nervous system) as well as other specialties over the following years.

We took independent advice from a consultant paediatric neurosurgeon and a consultant paediatric neurologist.

Firstly, C raised concern that the board did not obtain informed consent for the surgery and that the surgery was not performed to a reasonable standard. We found that there was limited reference to complications within the consent form and the written notes, whilst a number of known serious complications were not included in the consent form. We also found that the incorrect placement of the burr hole was unreasonable and that this likely caused the neurological deficit that B experienced. We upheld these aspects of C's complaint.

C also complained that the board did not manage B's pain reasonably following the surgery. We found that this aspect of B's care had been reasonable, with close involvement from both a consultant paediatric oncologist and a consultant paediatric neurologist over a number of years. We did not uphold this aspect of C's complaint.

Finally, C raised concern about the communication between the board and the family about B's care. We found that the documentation of discussion with B's parents about the surgical complication was poor. We found that the communication in relation to B's headaches was, on balance, reasonable. However, we noted that there should have been better communication from the paediatric oncology team. Therefore, we upheld this aspect of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to B and B's parents for the failings identified in the consent process, in the surgical procedure and in communication with the family. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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

- Adequate systems should be in place to ensure that technical errors are minimised.
- In accordance with the professional duty of candour, health professionals must tell the patient (or, where

appropriate, the patient's advocate, carer or family) when something has gone wrong and apologise for what happened. This should be clearly documented.
- Informed consent should be obtained in accordance with the General Medical Council's guidance on this matter.

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.