SPSO decision report

Case: **202000786, Grampian NHS Board**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C's sibling (A) received care and treatment from the board in response to symptoms of pain and urinary issues. A was later diagnosed with bladder cancer and died. C complained that the treatment provided to A prior to their diagnosis was unreasonable. Dissatisfied with the board's response to their complaint, C brought their complaint to our office.

We took independent advice from a consultant urological surgeon (a doctor who specialises in the male and female urinary tract, and the male reproductive organs). We found that the board failed to carry out a general anaesthetic cystoscopy (passing a thin viewing tube called a cystoscope along the urethra (the tube that carries urine out of the body) and into the bladder) in a reasonable timescale. This was accepted in the board's own complaint investigation. However, we considered that there were opportunities to pick up and correct the delay which were missed. As such, we upheld the complaint.

In relation to a complaint about pain management, we found that while there were elements which could have been improved, overall the board reasonably managed A's pain. We considered that the board could have enquired about pain with A and did not do so, however, there was also no record that A had reported pain which had not been responded to. As such, we did not uphold this complaint.

We considered that the board had failed to diagnose A in a reasonable timescale. We found, which the board had previously acknowledged, that due to the delay in carrying out the general anaesthetic cystoscopy there was an unreasonable delay in diagnosing A with cancer. We also considered that the lack of follow-up for one of A's symptoms following a botox injection was a failing. As such, we upheld this complaint.

Finally, C complained that the board had failed to reasonably respond to their complaint. We found that, overall, the board's responses to C's complaint were accurate and the board took action to discuss C's concerns at a meeting and provide explanations as to what happened during A's care. While there were delays in responding to C's contact, the board reasonably responded to the complaint. As such, we did not uphold the complaint.

Recommendations

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

- Patients with a potential malignancy should be kept moving through the pathway, even where staffing and capacity issues exist.
- Procedure-specific patient information leaflets should be provided.

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.