SPSO decision report

Case: **202001327, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the care and treatment their spouse (A) received over a number of years by the board.

C submitted a complaint to the board expressing A's concern that they did not take reasonable care when carrying out two surgeries. C and A were dissatisfied with the board's investigation and response to their complaint.

A underwent surgery in their abdomen in an attempt to resolve recurring infections and said they suffered significant pain afterwards. We took independent advice from a general and colorectal surgeon (a surgeon who specialises in conditions in the colon, rectum or anus). We were satisfied that this surgery did not cause the pain that A had linked to the procedure. However, we were critical of the board for failing to recognise that scans taken prior to the surgery had shown evidence of staples in A's abdomen from previous surgeries. We found that the staples were a likely source of A's infections and that this should have been identified prior to the surgery taking place. Had it been identified, A's management plan may have been different. Therefore, we upheld this aspect of C's complaint.

A also underwent a procedure on their reproductive organs. C complained that the procedure that was carried out, as described in the record of the operation, was not the one to which A had consented. We found that it had not been possible to complete the planned procedure due to an issue in the affected area, which had not been apparent until the procedure began. Whilst we were critical of the way that the procedure was described in the records, we found that the procedure itself was reasonable and appropriate in the circumstances. Therefore, we did not uphold this aspect of C's complaint.

C and A complained that despite the board's complaints procedure stating that complaints could be submitted in writing, in person, or over the telephone, the board insisted that A's complaint was submitted in writing. A explained that they found it difficult to put their complaint in writing and had specifically requested a meeting with the board to discuss their concerns. This request was denied. We found that although there were reasonable reasons for asking A to submit the complaint in writing, these were not explained clearly by the board, and A was given no explanation as to why their request for a meeting was refused. We were critical of the board's communication with C and A regarding the complaint, and of delays in the early stages of the board's investigation. Therefore, we upheld this aspect of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the issues highlighted in this decision. 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:

- The board should share this decision with the clinical staff involved in A’s treatment with a view to identifying ways of avoiding similar issues in the future.

In relation to complaints handling, we recommended:

- The board should provide us with an update as to any procedural changes that have been made to ensure patients’ individual needs are considered when they make a complaint.

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.