SPSO decision report

Case: **202002493, Lanarkshire NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the care and treatment that their parent (A) received from the board. Following surgery to remove bladder lesions, A experienced severe pain and urinary problems. It was established that they had a bladder perforation. C complained that, whilst A's consultant initially accepted and apologised for the fact that A's bladder was likely perforated during surgery, the board subsequently backtracked and suggested that there could have been a number of causes. C did not consider that their family had been given a clear explanation as to how A's bladder had been perforated.

A subsequent review of A's case established that they had cancer invading their bladder muscle. The cancer could not be treated with chemotherapy or radiotherapy and staff had discussions with A regarding the difficulties associated with attempting surgery in light of their other existing medical conditions. A was readmitted to hospital via A&E the following month, due to bladder spasms and catheter (a flexible tube used to empty the bladder and collect urine in a drainage bag) pain. A CT scan was carried out and A was admitted to a ward for ongoing monitoring and treatment. A's pain worsened and further scans showed that the cancer had spread to their lungs. Surgery was no longer an option and A died shortly afterward.

C complained that the communication from the urology staff (specialists in the male and female urinary tract, and the male reproductive organs) during A's hospital admissions was poor and that there was an unreasonable delay to A and other family members being told the extent of A's condition.

We took independent advice from a consultant urologist. We considered that, when responding to C's complaint, the board sought to provide a detailed description of events and a clearly set out explanation as to the potential causes of A's bladder perforation. That said, we found that information provided by C was not taken into account and, had it been, a clearer explanation could have been provided by the board. Therefore we upheld this aspect of C's complaint.

We found that A did not require routine input from urology. Their day-to-day care in hospital was managed reasonably by gastroenterology (specialists in the diagnosis and treatment of disorders of the stomach and intestines), with input from urology as required. We were satisfied that A's urology investigations took place in good time and a reasonable management plan was put in place for their ongoing urology input. Overall, we found that the communication from the urology staff to be reasonable. We did not uphold this aspect of C's complaint.

A had a rare and aggressive form of cancer. We accepted evidence from the board that earlier scans showed evidence of changes that were visible, but not identified. We concluded that, whilst the treatment options available to A may not have been any different, had the changes been identified earlier, they may have been given details of their cancer and prognosis sooner and this may have given A more time to prepare and make arrangements. Therefore, we upheld this aspect of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C and their family for the failings identified 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.

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.