SPSO decision report

Case: **201507919, Grampian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mr C, who suffers from chronic back pain, raised a number of concerns about surgery performed on his spine at Aberdeen Royal Infirmary. Mr C complained that he suffered significant blood loss during the operation and that the surgeon failed to record on the operation note that he required blood transfusion. Mr C also complained that the surgeon operated on him using old scan images and that the operation caused nerve damage.

We took independent advice from a consultant neurosurgeon (a surgeon specialising in surgery of the brain and nervous system). They did not find evidence that the surgeon unreasonably failed to record a blood transfusion on the operation note and noted that it was only after the conclusion of the operation that the requirement for transfusion became apparent. The adviser was satisfied that it was reasonable for the surgeon to operate on Mr C using an old scan, and considered that there was no evidence that the operation caused nerve damage. Although we did not uphold this complaint, the adviser was critical about the level of detail in the medical records and we made a recommendation to address this.

Mr C also underwent operations to replace his hips. He complained that the board unreasonably failed to diagnose his hip condition for five years. The adviser noted the extended process involved in diagnosing the cause of Mr C's pain but found that it was reasonable of the board to have focused their investigations on his back given that he had a known back condition. The adviser did not consider that successive consultant neurosurgeons failed to diagnose Mr C's hip condition and said that it was the responsibility of a patient's GP to first investigate the potential of a hip pathology. We did not uphold this complaint.

Mr C also complained about the way the board communicated with him during their investigation into his chronic pain. Mr C felt that a consultant neurophysiologist (a doctor specialising in disorders of the central and peripheral nervous systems) failed to inform him that he had nerve damage following a consultation. The adviser reviewed the findings of the neurophysiologist and concluded that the clinical significance of the findings was questionable and did not necessarily indicate nerve damage. The adviser was therefore satisfied that it was not unreasonable that the neurophysiologist failed to discuss the abnormality in the findings with Mr C. We did not find evidence that the board's communication was unreasonable and we did not uphold this complaint.

Mr C also raised concerns about the way the board handled his complaint. We found that the board had commissioned an independent clinical review into Mr C's concerns about his treatment but we noted that this investigation was not undertaken in accordance with the complaints procedure. We found evidence of a number of instances where the board did not treat Mr C's concerns as complaints, and we considered that this unnecessarily prolonged the board's handling of Mr C's concerns. We found evidence that only one of Mr C's concerns had been handled through the board's complaints handling procedure, although the board noted that there was a delay in responding to Mr C. The board confirmed to us that the Feedback Team (the department that handles complaints) has since introduced a process to prevent such delays. We upheld this complaint and made a number of recommendations.

Recommendations

We recommended that the board:

- feed back the adviser's comments about the level of recording in the clinical notes in this case to clinical staff in the neurosurgery department;
- issue Mr C with a written apology for the complaints handling failures identified in this investigation;
- ensure that the clinical staff involved in this case receive appropriate support and training in handling complaints in line with the board's complaints handling procedure; and
- provide us with details of the Feedback Team's change in process.