SPSO decision report

Case: **201801849, Lanarkshire NHS Board**
Sector: health
Subject: communication / staff attitude / dignity / confidentiality
Decision: upheld, recommendations

Summary

Ms C underwent gallbladder removal surgery at University Hospital Monklands. She became unstable in recovery and needed to return to theatre for open surgery to repair tears in her bowel and an artery. She required a large blood transfusion.

Ms C complained that the procedure was described to her as a simple keyhole operation, and she did not recall being told of any potential risks as serious as her bowel or anterior aortic wall being damaged. We took independent medical advice from a general and colorectal (bowel) surgeon. It was noted that steps were taken to obtain Ms C's consent the day before her surgery, and many of the risks were explained to her. However, she received no explanation of the small risk of major vascular (circulatory system) injury, or what actions may be necessary in the event of a serious complication. We, therefore, upheld this complaint.

Ms C also complained that a mistake had been made during her surgery. We considered that the major vascular injury could have been avoided if the operating surgeon had exercised reasonable skill and care. In technical delivery, decision-making and note-keeping, the surgical care provided during the operation fell seriously below the standard we would expect of a reasonably competent consultant general surgeon. Additionally, in their failure to undertake a formal investigation into the incident, the board's response also fell seriously below the standard we would expect. We upheld this complaint.

Finally, Ms C complained to us about the board's response to her complaint. She was concerned that the board had failed to provide her with a copy of any internal investigation report, and also that they had not spoken to the operating surgeon as they were on a period of extended leave and subsequently did not return to their post. In the surgeon's absence, the board received comments from another surgeon but these were submitted late, after the board had issued their complaint response. The board acknowledged that they should have sent these comments to Ms C. It was also unclear from the response whether the complaint had been upheld. We considered that the board failed to address Ms C's desired outcome. Therefore, we upheld this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms C for failing to appropriately inform her of all the risks and the likelihood of those risks prior to gallbladder removal surgery. The apology should meet the standards set out in the SPSO guidelines on apology available at: www.spso.org.uk/information-leaflets. The apology currently offered by the board in their response to SPSO enquiries does not meet these standards.
- Apologise to Ms C for failing to properly investigate what happened during her operation. The apology should meet the standards set out in the SPSO guidelines on apology available at: www.spso.org.uk/information-leaflets.
- Apologise to Ms C for failing to provide a full response to her complaint. 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 ensure that all surgical departments are reminded of the requirement to obtain informed consent, with discussion of all material risks, to the current Royal College of Surgeons standard.
- The board should develop a standardised consent process for patients undergoing gallbladder removal and ensure staff are fully trained in it. This should include an operation-specific patient information leaflet that outlines all material risks of the gallbladder removal procedure.
- The board should initiate a root cause analysis and disseminate any learning from it to all surgeons undertaking gallbladder removal surgery. That analysis should include the decision-making and subsequent responses to the event.
- The board should contact the General Medical Council to make them aware of concerns about the main operating surgeon in this case. If the surgeon is practising in a country outside the UK, if known, the board should contact the relevant healthcare regulator in that country and advise them about the concerns raised.
- The board should remind surgical staff that operation notes should be as accurate and complete as possible.
- The board should remind clinical staff of the need to respond to requests for information relating to a complaint within the appropriate timescale.

In relation to complaints handling, we recommended:

- The board should ensure that their complaint responses: address complainants' desired outcomes, and make clear whether or not they have upheld a complaint and what action they will take as a result of it. This may involve a reminder to staff, further staff training, and/or a change to their template letter to ensure these issues are not omitted.

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.