SPSO decision report

Case: **202008412, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained on behalf of their spouse (A) regarding the care and treatment A received from the board. A has serious health issues and has had multiple surgeries over a number of years.

Following a scan of A's abdomen, it was identified that they had staples attached to their bladder. A considered that these had been left behind following surgery to remove their J-pouch (a pouch made from part of the small intestine and attached to the anal canal to form a pathway for the passage of stool). C complained that A experienced recurring infections and other complications as a result of the staples being left in their abdomen. A said that these had a detrimental impact on their long-term health.

We took independent advice from a general and colorectal surgeon (specialist in conditions in the colon, rectum or anus). While it was not possible to establish exactly which operation the staples came from, we considered that the staples were a likely source of A's infections. We found that the staples were clearly visible on previous scans but that these had not been reported on by radiology and therefore the clinical team did not consider these when they were assessing A's likely source of infection and future treatment. Therefore, we upheld this aspect of C's complaint.

C also complained about the handling of their complaint. Whilst we found that there were some delays to the board's investigation, we recognised that many years had passed between the events complained about and the complaint being submitted to the board. This meant that some issues were reasonably time-barred and some parts of the investigation were delayed due to difficulties sourcing the records and staff comments. Overall, we were satisfied that communication was generally reasonable with C and A, and that the board's complaints procedure was followed appropriately. Therefore, we did not uphold 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 provide us with an update as to any procedural changes that have been made to ensure patients' individual needs are considered when handling a complaint.
- The board should share this decision with their radiologists as a reminder of the importance of fully reporting on scans to reduce the chances of important omissions.
- The board should share this decision with their surgical team with a view to ensuring that the origin of infection is included when considering treatment of chronic infection.

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.