SPSO decision report

Case: **201406038, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Ms C complained on behalf of Ms A, who was diabetic, that after she had a stent (a mesh tube) inserted into her kidney in April 2013, staff at the Southern General Hospital failed to monitor or remove it. As a result, Ms C said that Ms A was caused extreme pain, which led to her having an emergency operation early in 2014 to remove her kidney. Ms C believed that early intervention with regard to the stent could have avoided this.

We took independent medical advice from a consultant urologist (a doctor who treats disorders of the urinary tract). We found that after the insertion of the stent, it was planned to remove it in July 2013. However, at her anaesthetic pre-assessment for the removal of the stent, Ms A was found to have poor diabetic control, which meant that her operation could not go ahead. Her GP was asked to inform the hospital when Ms A's condition improved so that her operation could be rescheduled. However, the hospital was never updated. The investigation also showed that Ms A's name continued on the waiting list for stent removal and this should have provided an adequate safety net, but it did not. In the meantime, Ms A's stent was removed in England. In these circumstances, we upheld the complaint about the monitoring of the stent. However, in reaching our decision we did not conclude that the failure to monitor the stent ultimately led to Ms A losing her kidney, as there was no evidence that this had been the case.

Recommendations

We recommended that the board:

- make a formal apology in recognition of the failures identified; and
- advise us of the processes that have since been put in place as a consequence of the complaint made.