SPSO decision report

Case: **201805569, Grampian NHS Board**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mr C complained about the care and treatment he received from Aberdeen Royal Infirmary. Mr C had a nerve sheath tumour (a type of tumour of the nervous system) in his neck in an area known as the brachial plexus (a group of nerves that come from the spinal cord in the neck and travel down the arm. These nerves control the muscles of the shoulder, elbow, wrist and hand, as well as provide feeling in the arm). Mr C had surgery to remove the tumour. During the operation three nerves were found to be running through the tumour. All three nerves were stimulated electrically. One nerve made the deltoid muscle twitch and this nerve was preserved. The other two nerves produced no apparent muscle movement and were cut and removed with the tumour. This resulted in Mr C losing the use of large muscles in his arm.

We took advice from an otolaryngology (the study of diseases of the ear and throat) and head and neck surgeon and from a consultant neurosurgeon (a surgeon specialising in surgery of the brain and nervous system). We found that:

advice should have been sought from the Scottish Brachial Plexus Team prior to Mr C's operation

intraoperative neurophysiological nerve monitoring (IONM – where fine needles are placed in the target muscles and spontaneous muscle fibre electrical activity is continuously displayed on a screen as waves) should have been used during Mr C's operation

Mr C's nerves should not have been cut during the operation

Mr C was not referred to the Scottish Brachial Plexus Team within a reasonable amount of time following his surgery

the board failed to consider at an earlier stage whether an Adverse Event Review should have been carried out.

We upheld Mr C's complaint that the board did not provide him with reasonable care and treatment.

Mr C also complained that the board did not inform him of the risks of the surgery. We found that the board did communicate reasonably with Mr C about the risks of the surgery and therefore we did not uphold this aspect of Mr C's complaint.

Finally, Mr C complained that the board failed to handle his complaint reasonably. We found that:

the board's own complaint investigation did not identify the serious failings in the care provided to Mr C

there was a delay in responding to Mr C's complaint and he was not kept updated on the progress of his complaint or provided with a revised timescale for the response

the board's complaint response said that Mr C's reparative surgery took place on an incorrect date.

Therefore, we upheld this aspect of Mr C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C for the failure to seek advice from the Scottish Brachial Plexus Team prior to his operation; the failure to use IONM; cutting his nerves during the operation; the length of time taken to refer him to the Scottish Brachial Plexus Team after the operation; the delay in responding to his complaint and that he was not kept updated and; that the complaint response did not accurately state the date his reparative surgery took place. The apology should meet the standards set out in the SPSO guidelines on apology available at HYPERLINK "http://www.spso.org.uk/leaflets-and-guidance" www.spso.org.uk/leaflets-and-guidance .

What we said should change to put things right in future:

- The board should consider carrying out an Adverse Event Review where an event has occurred that could have resulted in harm (a near miss) or did result in harm to a patient.

In relation to complaints handling, we recommended:

- Complaint responses should contain accurate information.
- Complaints should be handled in line with the model complaints handling procedure. The model complaints handling procedure and guidance can be found here HYPERLINK "http://www.spso.org.uk/the-model-complaints-handling-procedures" www.spso.org.uk/the-model-complaints-handling-procedures .
- The board's complaints handling system should ensure that failings (and good practice) are identified, and that it is using the learning from complaints to inform service development and improvement (where appropriate).

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.