SPSO decision report

Case: **201603128, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mrs C, who works for an advocacy and support agency, complained on behalf of her client (Mrs A). Mrs A fractured her ankle in a fall and was admitted to Victoria Hospital, where she had surgery to insert a plate and pins. Mrs A returned to hospital a few weeks later with signs of infection. Her wound was washed out, but staff decided not to remove the plate and pins at that time. Mrs A's health deteriorated and she spent some time in intensive care. Mrs A also suffered a heart attack while in hospital, and she remained in hospital for about six weeks. Following her discharge, Mrs A had a further fall and the fracture in her ankle was displaced again. Staff considered it was no longer possible to reconstruct the ankle, and Mrs A's leg was amputated.

Shortly after this, Mrs A returned to hospital feeling unwell, and with pain in her other foot. Surgery was planned to bypass an artery in her leg (to improve blood flow to her foot). This was not possible in view of Mrs A's underlying vascular disease, and her other leg was also amputated.

The board sent a written response to Mrs A's initial complaint, and also met with Mrs A and Mrs C. They considered the care and treatment were appropriate. At the meeting, Mrs A raised some additional concerns that were not in her original complaint and the board agreed to investigate these. Mrs C contacted the board numerous times to follow this up, and was told a response was being prepared. However, the investigation was not begun until four months after the meeting. By the time a response was prepared, managers decided not to send this, as so much time had elapsed and they did not realise that Mrs C had been following up a response.

After taking independent medical advice, we did not uphold Mrs C's complaints about care and treatment. We found the surgery and treatment for Mrs A's infection were reasonable, and the clinical records indicated the wound was healing well before Mrs A's second fall. We also found the problems with Mrs A's fractured leg did not contribute to the amputation of her second leg, which was due to her underlying vascular disease.

We upheld Mrs C's complaint about the board's complaint handling. We were critical of the significant delays and the failure to respond to the additional points, as well as the poor communication between staff and with Mrs C.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C and Mrs A for their poor communication and failing to respond to the additional points of the complaint. This apology should comply with SPSO guidelines on making an apology, available at www.spso.org.uk/leaflets-and-guidance
- Finalise and send the written response to the additional points of complaint.

In relation to complaints handling, we recommended:

- Where a complaint response takes more than 20 working days, the board should explain the reasons for

the delay and agree a new timeframe.

- The board should meet any commitments they make about responding to complaints, unless otherwise agreed with the complainant.
- There should be effective communication between the staff handling a complaint and the managers making decisions about it.

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.