SPSO decision report

Case: **201807339, Lothian NHS Board - Acute Division**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Miss C complained about the care and treatment she received following elective abdominal surgery. When Miss C awoke following the surgery, she had considerable pain in her leg. She was given pain medication but her leg became significantly worse the next day. Compartment syndrome (when pressure rises in a compartment bordered by a facial covering because of a reduction in the blood flow to the muscle) was suspected and later diagnosed. Miss C underwent surgery but suffered outer muscle loss on her left leg. Miss C complained that there had been a delay in diagnosing compartment syndrome in light of her symptoms. She also complained that the board failed to provide proper treatment because of this delay. Finally, Miss C complained about how the board handled her complaint.

We took independent advice from a surgeon. We found that there had been an unreasonable delay in diagnosing compartment syndrome. Specifically, the signs and symptoms Miss C experienced should have led to an earlier orthopaedic consultant (specialist in the treatment of diseases and injuries of the musculoskeletal system) review and diagnosis of compartment syndrome. In light of this, we upheld this aspect of the complaint.

In respect of Miss C's second complaint, we considered that her symptoms were well-monitored and recorded. We considered the failing to be in the interpretation of the clinical observations. Outside of this failure, we considered Miss C's management to be good and as expected following significant surgery. Once compartment syndrome was diagnosed, we found the care and treatment to be reasonable. We concluded that the failing had been the unreasonable delay in diagnosing compartment syndrome and not in the treatment provided. Therefore, we did not uphold this aspect of the complaint.

Finally, we concluded that it took an unreasonable length of time for the board to carry out their stage 2 complaint investigation and that Miss C was not appropriately updated about this delay. Furthermore, we did not consider the board's response to clearly reflect the findings of an Adverse Event Review that was carried out. Finally, the board's internal records indicated that Miss C's complaint was upheld but this was not apparent in their stage 2 response. As a result of this, we upheld this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Miss C for failing to diagnose compartment syndrome promptly and for failing to keep her adequately informed about delays in the investigation of her complaint and the progress and outcome of the Adverse Event Review. The apology should meet the standards set out in the SPSO guidelines on apology available at HYPERLINK "http://www.spso.org.uk/information-leaflets" www.spso.org.uk/information-leaflets .

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.