SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: South of Scotland

Case ref: 201601541, Ayrshire and Arran NHS Board
Sector: Health
Subject: Hospitals / Clinical treatment / Diagnosis

Summary
Ms C complained on behalf of her son (Mr A) about the care and treatment he received following a road traffic accident. Ms C said Mr A had suffered a serious injury to his arm in the accident, which had required two operations. Following surgery, Mr A was transferred for a third operation to another NHS board.

Ms C said she was told following the third operation that Mr A's original surgery had not been properly performed and had had to be revised. She was told that the original surgery had damaged a nerve in Mr A's arm and that he had developed a life-threatening infection.

Following her complaint to the board, Ms C and her son met the board. Ms C said the board would not explain why Mr A's first operation had been incorrectly carried out. Ms C also believed that her son's infection had been caused by a failure to clean his wounds correctly and that the board should have identified this sooner.

We took independent medical advice from a consultant orthopaedic surgeon on the standard of care provided to Mr A. The adviser said that the board's position that Mr A's operations had been properly performed and his nerve left in the correct position was not logical. Mr A had as a consequence suffered further damage to his nerve. The adviser noted that Mr A's wounds were heavily contaminated and at high risk of infection. However, the cleaning of his wounds and provision of antibiotics to prevent infection were carried out to a reasonable standard. Overall, we found the board had failed to provide Mr A with a reasonable standard of care and treatment. We were highly critical of board's failure to acknowledge that Mr A's surgery had not been carried out correctly, resulting in damage to the nerve in his arm.

We also found that the board's handling of Ms C's complaint was inadequate as it did not properly acknowledge the failures in care, despite the board being aware of these at the time. We found that the board had failed to handle Ms C's

complaint in an open and transparent manner and failed to address the concerns of the family properly.

Redress and Recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) carry out a significant event analysis ensuring that Surgeon 1 reviews the findings of Operation 3;	28 June 2017
(ii) provide evidence that Surgeon 1 has reflected on the failings identified in this report as part of their appraisal process;	16 August 2017
(iii) review their complaints investigation in light of the comments from the Aviser and provide Ms C with a full explanation for the findings of Operation 3;	14 June 2017
(iv) review their handling of Ms C's complaint in order to identify areas for improvement and ensure compliance with the 'Can I help you' guidance; and	14 June 2017
(v) apologise unreservedly in writing to Ms C and Mr A for the failings identified in this report.	14 June 2017

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as Ms C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Ms C complained to my office about the care and treatment provided by Ayrshire and Arran NHS Board (the Board) to her son (Mr A). The complaints from Ms C I have investigated are that:

(a) the Board failed to provide Mr A with a reasonable standard of medical care and treatment (*upheld*); and

(b) the Board failed to investigate Mrs C's complaint properly and provide a response to all the issues raised.(*upheld*)

2. I note that Ms C raised a significant number of issues about the nursing care provided to Mr A. She was, however, satisfied by the Board's proposed actions in response to her complaint. This aspect of the original complaint was not, therefore, investigated further.

Investigation

3. In order to investigate Mrs C's complaint, my complaints reviewer requested further information from the Board and sought the views of an consultant orthopaedic surgeon (the Adviser). In this case, we have decided to issue a public report on Ms C's complaint due to the serious nature of the failings that the investigation has identified.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Ms C and the Board were given an opportunity to comment on a draft of this report.

Background

5. Mr A was involved in road traffic accident on 21 September 2015. He was taken by ambulance to Ayr Hospital (Hospital 1) arriving around 11:30. He had sustained significant injuries to his right arm and side. These included a broken shoulder, a broken arm, broken ribs and severe lacerations to his arm.

6. Mr A was assessed by a surgeon (Surgeon 1) and underwent surgery (Operation 1) on the evening of 21 September 2015. His wound was washed out, as it was substantially contaminated with dirt and debris from the accident. His radial nerve was trapped between bone fragments at the site of the fracture in his upper arm and the nerve itself had been damaged. The Board stated that Mr A's wound was debrided (the removal of unhealthy tissue from a wound to promote healing) and the fracture to his upper arm was fixed with a large fragment plate to hold the pieces of bone together. The radial nerve, which had

been moved to protect it during surgery, was returned to the correct position. Mr A's wound was washed out again and underwent further debridement on 23 September 2015 (Operation 2). He was also treated with antibiotics to guard against infection. Mr A was transferred to Glasgow Royal Infirmary (Hospital 2) on 24 September 2015.

7. At Hospital 2 Mr A underwent further operation (Operation 3) under a different surgeon (Surgeon 2). He was found to have reduced median, ulnar and axillary nerve function in his right arm and no radial nerve function at all. Mr A also had a severe soft tissue infection, with developing necrotising fasciitis (a serious bacterial infection affecting tissue beneath the skin). Mr A's radial nerve was found to be on the wrong side of the bone in his upper arm, causing the nerve to bend ninety degrees and resulting in a compression injury to the nerve. Surgeon 2 was obliged to remove the fracture plate and revise the surgery carried out in Operation 1, rescuing the radial nerve before carrying out further wound debridement.

(a) The Board failed to provide Mr A with a reasonable standard of medical care and treatment

Concerns raised by Ms C

8. Ms C complained to the Board on 9 November 2015. She said Mr A had noticed a deterioration in the level of sensation in his fingers between 23 September and 24 September. Ms C said that she had significant concerns about Mr A's care and treatment whilst at Hospital 1 due to the information they had been given whilst at Hospital 2.

9. Ms C said the family had been told that Mr A had developed a potentially life threatening infection whilst at Hospital 1. Ms C said she understood this infection was due to the amount of debris within Mr A's wounds and suggested this meant they had not been properly cleaned out. Ms C added she did not understand why this infection was not identified sooner.

10. Ms C said she had also been told the radial nerve had been left in the wrong position and that the fragment plate repairing Mr A's fracture had to be removed during Operation 2 in order to reposition the nerve. Ms C was told that it would take time before it could be ascertained if the nerve was permanently damaged, but there was no response from it at that point. Ms C said although she asked if the misplacing of the nerve during Operation 1 had damaged or

killed it, Surgeon 2 had told her they could not be certain, but had acknowledged this could be the outcome.

The Board's response

11. The Board responded on 9 February 2016. They said they were sorry to hear about Mrs C's concerns. They set out a chronology of Mr A's treatment. They said Mr A had been treated by Surgeon 1, who had found his wounds very heavily contaminated with mud, glass and plant debris. The radial nerve had been trapped between bone fragments and although the nerve was freed it was damaged due to trauma from the fracture. The nerve had been protected and the wound thoroughly washed out with six litres of saline solution. The fracture had been repaired, although it had been noted the nerve was likely to catch on bone fragments, and this had been addressed.

12. Surgeon 1 had discussed Mr A's care with him on the morning of 22 September 2015. His treatment, including the need for further surgery was explained. Surgeon 1 had noted the loss of sensation from the radial nerve. Mr A was returned to theatre for Operation 2 on 23 September and as planned, his case was discussed with Hospital 2 and arrangements were made to transfer Mr A there for plastic surgery assessment.

13. The Board said they were sorry to hear Mr A had developed an infection. He had been provided with the appropriate antibiotic treatment before and after surgery. The Board said they were satisfied his wound had been appropriately and extensively washed out in order to remove as much debris as possible. The Board said the infection had occurred despite this, and was not as a result of the surgery or any failings in Mr A's care.

14. The Board then set out their understanding of what happened during Operation 3. Their view was that Mr A's radial nerve was badly damaged at the time of the accident and not by any subsequent surgical intervention. The Board said they had discussed Mr A's case widely with all the medical staff involved and were satisfied he had received the correct care.

Meeting on 27 April 2016

15. The family met with the Board on 27 April 2016. The Board did not take any formal note of the meeting and could not provide a record of the discussion with the family. They wrote to Ms C on 5 May 2016 to confirm the actions that

would be progressed as a result. With regard to the outcome of Operation 1 they said:

> 'I am sorry we have been unable to reach any closure in relation to the comment made by [Surgeon 2] regarding the radial nerve found to be lying on the wrong side of the humerus, as explained by [Surgeon 1] at the meeting this was not the case when [Mr A] left [Hospital 1]'

16. The Board said they would update Ms C on the progress of the agreed actions. These related to communication with patients and their family members as well as the staffing levels for nurses on the ward.

Response by the Board to this office

17. The Board were asked to provide an explanation for the apparently contradictory statements about the position of Mr A's radial nerve. The Board said the incident had been investigated fully. They said the radial nerve was found to have been abraded, secondary to it being stuck between the fracture fragments. It was, however, intact and protected throughout the remainder of Operation 1. After the fracture had been stabilised the nerve was released from its protective sloops and Surgeon 1 was satisfied that it was in the correct position.

Medical advice

18. The Adviser said it was not possible for Mr A's radial nerve to have been in the correct position following Operation 1 and then to have changed position between this point and his transfer to Hospital 2. The Adviser said during Operation 1 the radial nerve was recorded as being trapped in the fracture ends. It would have needed to be moved from its normal position in order to allow the fracture ends to be fixed. Given the findings at Hospital 2, however, it had to be the case that the nerve had not been returned to the correct position at the conclusion of Operation 1.

19. The Adviser said the Board had failed to provide an adequate explanation for this. Surgeon 2's account of their findings was clear the nerve was in the incorrect position. The Adviser emphasised that there would have been no reason to remove the fracture plate during Operation 3, unless the nerve had been in the wrong place. Given the nerve could only be relocated through the removal of the fracture plate, it was impossible for it to have been in the correct position at the conclusion of Operation 1. The Adviser said the Board's position

that the outcome of Operation 1 had left the nerve in the correct position was not, in any sense, logical.

20. In the Adviser's opinion Mr A's infection, however, was not something the Board should have identified prior to transfer. Mr A's wound was significantly and severely contaminated and was always at risk of infection. The Board's explanation of their approach to infection control was reasonable, including their use of antibiotics. There was nothing to suggest that Mr A's infection could have been avoided, rather it was a recognised complication in cases where a wound had been very heavily contaminated.

21. The Adviser said Mr A had suffered a significant injury to his right arm. They said it was important to be clear about the extent and timing of the damage to the radial nerve. The Adviser said the Board were correct to state Mr A's nerve had been damaged in the original accident. There was, however, further damage to the nerve due to its incorrect positioning during Operation 1, although it was not possible to determine the extent of this damage at this stage.

(a) Decision

22. Ms C was concerned that Mr A did not receive adequate care and treatment during his stay at Hospital 1. There are two principle areas of concern, the first is the positioning of Mr A's radial nerve following Operation 1 and the second is the infection that Mr A developed.

23. The Board's position is that Mr A received an appropriate level of care and treatment. They maintain that Operation 1 was conducted correctly and that the radial nerve was in the appropriate position when it was completed. Although they were invited during this investigation to provide a detailed response explaining the disparity between the findings of Surgeon 2 and their statements, they did not do so.

24. The advice received is clear that Mr A's radial nerve could not have been correctly positioned following the completion of Operation 1. Operation 3 included the removal of his fracture plate and repositioning of his radial nerve, which would not have been necessary had Operation 1 positioned the radial nerve correctly. The advice stated it would not have been possible for the radial nerve to have migrated within the arm following Operation 1. The advice considered the Board's position incompatible with the available evidence.

25. Given the clarity of the advice I am highly critical of the Board for failing to recognise or address this significant failing. It must have been apparent following receipt of the findings of Surgeon 2 that an error had been made during Mr A's surgery. Of particular concern, given the unequivocal nature of the advice I have received is the Board's claim that the medical staff involved in Mr A's care have reviewed this information and are satisfied with the care and treatment that was provided to him, alongside the Board's statement that Surgeon 1 is satisfied the radial nerve was in the correct position at the end of Operation 1. These statements are concerning, given the advice I have received that this was a physical impossibility based on what was found in Operation 3.

26. Furthermore, the advice I have received is that the failure to perform Operation 1 correctly has resulted in further injury to Mr A's radial nerve, although the extent of this is not yet clear. This damage has not been addressed or acknowledged by the Board, although it was identified by Surgeon 2 in their correspondence to the Board about his findings.

27. The care and treatment provided to Mr A was not of an acceptable standard. I uphold this complaint.

(a) Recommendations

28. I recommend that the Board:

		Completion date
(i)	carry out a significant event analysis ensuring that Surgeon 1 reviews the findings of Operation 3; and	28 June 2017
(ii)	provide evidence that Surgeon 1 has reflected on the failings identified in this report as part of their appraisal process.	16 August 2017

(b) The Board failed to investigate Mrs C's complaint properly and provide a response to all the issues raised

Concerns raised by Ms C

29. Ms C said although she had been satisfied with some parts of the Board's response and she had been reassured following the meeting with them that these concerns were being taken seriously, she could not accept the Board's overall position. Ms C noted the discrepancy between what she believed she had been told following Operation 3 and the position maintained by the Board.

30. Ms C said she felt it was unacceptable for a complaint to be closed on the basis that the Board felt unable to 'reach closure' between to mutually exclusive statements from the surgeons involved in Mr A's care. Ms C said the Board's investigation should have provided a proper explanation for what appeared to be poor care on their behalf. Although the Board had acknowledged failings in Mr A's nursing care, Ms C felt they had not addressed the most serious part of her complaint.

31. Ms C was particularly unhappy that this was the case after what she felt was a protracted complaints process. Ms C said she thought the Board had taken too long to investigate the complaint and that there had been limited value to meeting with them, given their inability to explain what had happened to Mr A whilst in their care.

The Board's response

32. The Board's responses to the original complaint have already been set out in detail. I note the Board's complaint file does not contain any statements from the staff members involved, although it does contain the comments received from Surgeon 2, which were sought by the Board. As previously noted the Board did not keep any records of the meeting with Ms C and Mr A.

(b) Decision

33. The Board's investigation of the complaint did take a long time, and exceeded the twenty working day target for a response. Some of this delay, however, was due to the need to obtain the comments from Surgeon 2. As they did not work for the Board, and the complaints correspondence provided shows their availability was limited at the time, I do not consider the Board can be held responsible for all of the delays.

34. It is not, however, clear from the complaint file whether this was properly explained to Ms C. The Board did need to obtain consent from Mr A to allow them to respond to Ms C, but their internal deadline for response once this had been done was 14 December 2015. I am concerned that although the letter was ready by 23 December 2015, it was not approved for issue, because the Board had a requirement that contact be made with the complainant first. This had not been done and it is unclear why the staff handling the complaint were unaware of this.

35. I am, also highly critical of the findings of the Board's complaint investigation. The response letter to Ms C crucially does not reflect the information that was available to the Board regarding the position of the radial nerve following Operation 1. Whilst the letter accurately describes the surgery that was performed during Operation 3 it avoids any comment on the implications of Surgeon 2's findings for the Board. As set out previously, the advice I have received it that it is not possible for the radial nerve to have positioned correctly following Operation 1.

36. It has not been possible to assess the views of the Board's medical staff. There are no statements or comments from them in the complaint file provided. The internal file states that the complaint response was seen by medical staff and that they are content with it. It is not clear what discussions were had to explore the different findings of Surgeon 1 and Surgeon 2, or why the Board have concluded there is no need to provide a definitive explanation.

37. The Board had multiple opportunities to address this through their complaints process, but did not do so. Their final response letter does not set out clearly the implications of the findings of Surgeon 2. Although the letter does state the nerve was in the wrong position and that he sustained an injury due to the compression of the nerve, the Board make no comment on the relevance of these findings in relation to the care they provided to Mr A.

38. Instead the letter moves onto the issue of wound debridement, before concluding that the various medical staff involved had no concerns about Mr A's care. The implication from the Board's complaint response is that although his radial nerve was in the wrong position and that this has caused an injury to the nerve, this is not related to the care Mr A received from the Board.

39. The Board had a subsequent opportunity when they met with the family to either an acknowledge the error, or provide an explanation for the difference between Surgeon 1's statement and the findings recorded by Surgeon 2.

40. The Board did not keep any record of this meeting. We have, therefore, only a statement in the follow up letter expressing regret that it had not been possible to 'reach closure' on the positioning of the radial nerve. I consider the Board's characterisation of the disagreement as a matter of opinion rather than fact misleading. It does not appear that the family were provided with an accurate account of Mr A's care and treatment at the meeting.

41. As noted in the advice I received, when assessing Mr A's care, it is not a question of reconciling competing, but possible alternatives. The Board's position that the radial nerve was in the correct position following Operation 1 is untenable, unless they wish to suggest that Surgeon 2 was mistaken, which they have not done.

42. A complaints process must investigate concerns expressed by the public openly, transparently and effectively. In this case I find the Board's response was unreasonably delayed through a failure by staff to follow internal procedure and make contact with the family and offer to meet with them prior to issuing a complaint response. Moreover, the Board's complaint investigation failed to address an issue they were aware was of great concern to the family. Given the conclusions reached by the Adviser, I consider this a significant failing.

43. I am particularly critical of the Board's approach, since the family of Mr A did not have access to the written remarks to the Board from Surgeon 2. There is no record of an open and frank discussion with Ms C and Mr A exploring the implications of the findings of Surgeon 2. As noted in the advice, the Board's position is not, in light of Surgeon 2's comments logical, and I consider it unreasonable for the Board to have closed the complaint investigation without having resolved this issue.

44. I uphold this complaint and make the following recommendations.

(b) Recommendations

45. I recommend that the Board:	*Completion date*
(i) review their complaints investigation in light of the comments from the Adviser and provide Ms C with a full explanation for the findings of Operation 3; and	14 June 2017
(ii) review their handling of Ms C's complaint in order to identify areas for improvement and ensure compliance with the 'Can I help you' guidance.	14 June 2017

General Recommendation

46. I recommend that the Board:	*Completion date*
(i) apologise unreservedly in writing to Ms C and Mr A	14 June 2017

for the failings identified in this report.

47. The Board have accepted the recommendations and will act on them accordingly. We will follow-up on these recommendations. The Board are asked to inform us of the steps that have been taken to implement these recommendations by the date specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Ms C	the complainant
the Board	Ayrshire and Arran NHS Board
Mr A	the complainant's son
the Adviser	A Consultant Orthopaedic Surgeon who assessed Mr A's care and treatment
Hospital 1	Ayr Hospital
Surgeon 1	the surgeon who operated on Mr A at Ayr Hospital
Operation 1	surgery performed on Mr A on 21 September 2015
Operation 2	surgery performed on Mr A on 23 September 2015
Hospital 2	Glasgow Royal Infirmary
Operation 3	surgery performed on Mr A on 24 September 2015
Surgeon 2	the surgeon who operated on Mr A at Glasgow Royal Infirmary

Annex 2

Glossary of terms

axillary nerve	nerve running from the armpit to the hand
debridement	removal of unhealthy tissue from a wound to promote healing
fragment plate	metal plate designed to hold fragments of broken bone together
median nerve	nerve in the upper arm
necrotising fasciitis	a serious bacterial infection affecting the tissue beneath the skin
orthopaedic surgeon	surgeon specialising in injuries and diseases of the musculoskeletal system
radial nerve	nerve in the arm
saline solution	sterile solution containing sodium chloride
ulnar nerve	nerve running through the elbow