SCOTTISH PUBLIC SERVICES OMBUDSMAN

People Centred | Improvement Focused

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: Glasgow

Case ref: 202002915, Greater Glasgow and Clyde NHS Board - Acute Services Division

Sector: Health

Subject: Hospitals / Clinical treatment / diagnosis

Summary

C complained about the standard of care and treatment provided to them in relation to a hysterectomy that they underwent in January 2020, which resulted in damage to their bowel requiring additional, emergency surgery. In addition to concerns regarding the procedure itself, C also complained that the Board had failed to provide reasonable ongoing care, before, between, and after the surgeries in question.

On investigation, we sought independent clinical advice from an experienced consultant gynaecologist. The advice we received, and which we accepted, was that there were a number of unreasonable failures in the care and treatment provided. Particular key points from our findings were that:

- the damage caused to C's bowel during surgery should have been identified at the time;
- the Board failed to inform C of the complication in a timely manner; and
- the Board failed to subsequently investigate how the injury occurred and the overall conduct of the procedure in a reasonable manner, or apply their duty of candour appropriately.

As a result of these failures, we upheld both of C's complaints.

Redress and Recommendations

What we are asking the Board to do for C:

Complaint number	What we found	What the organisation should do	What we need to see
(a)	The Board failed to carry out the operation in a reasonable manner, with damage occurring which was not identified during the operation, that the operation was carried out by a trainee doctor and this was not openly referred to in the complaint response.	Apologise to C for the care provided by the Board, acknowledging the impact the bowel injury had on C.	A copy of the letter of apology which should meet the standards of the SPSO guidance accessible here: https://www.spso.org.uk/meaningful-apologies. By: 1 month of publication of report

We are asking the Board to improve the way they do things:

Complaint number	What we found	Outcome needed	What we need to see
(a)	The Board failed to carry out the operation in a reasonable manner.	A Significant Adverse Event Review (SAER) is carried out which includes review of the pre-operative investigations, the decision to undertake the procedure, the missed complication during the operation, a trainee conducting the operation, senior input during and after the operation, the aftercare, investigations postoperation and support given to the clinicians concerned in relation to the event, in particular to trainee and junior doctors.	Evidence a SAER has been completed. By: 6 months of publication of report
(a)	The Board failed to inform C of the complication in a timely manner.	Complainants should be informed candidly, openly and honestly when a complication occurs during a procedure, including explaining what happened and what action the Board have taken (or intend to take).	A review of how surgical complications are communicated with patients and consideration for a standard operation procedure for such instances. By: 3 months of publication of report

We are asking the Board to improve their complaints handling:

Complaint number	What we found	Outcome needed	What we need to see
(a)	The response to C's complaint failed to adequately investigate how the injury occurred, the overall conduct of the procedure and learning from the event.	Complaint responses are open and candid as to what happened and identify learning and what action will be taken in response.	Evidence that the findings of my investigation have been fed back to the staff involved, in a supportive manner, for reflection and learning. By: 2 months of publication of report
(a) and (b)	The Board failed to identify through their own investigation the need for a SAER. This includes why this incident was not reported/consideration given to a SAER at the time, and why duty of candour wasn't applied. The complaint investigation did not consider these omissions and prompt a robust investigation into the incident and candid explanation as to what happened.	Where an incident occurs measures are in place to consider whether further investigation is required and providing open and honest communication with a patient.	Evidence a review of the reporting processes has been undertaken and whether further action is required to reduce the likelihood of a recurrence. By: 3 months of publication of report

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 C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. The complainant (C) complained to my office about the standard of care and treatment provided to them both during and after an operation in January 2020. C underwent a sub-total hysterectomy (a surgical procedure to remove part of the uterus). During the procedure C's bowel was damaged, requiring emergency surgery. The complaint from C that I have investigated is:

(a) The Board failed to carry out C's hysterectomy procedure in a reasonable manner on 14 January 2020 (*upheld*); and

(b) The Board failed to provide reasonable care and treatment while C was on the ward at the Royal Alexandra Hospital (the Hospital) from 14 to 17 January 2020 (*upheld*).

Investigation

2. In order to investigate C's complaint, my complaints reviewer requested further information from the Board and took independent advice from an experienced consultant gynaecologist (the Adviser). In this case, I have decided to issue a public report on C's complaint because of the criticisms of C's care and who performed the surgery made in the advice I received and accepted from the Adviser.

3. This report includes the information that is required for me to explain the reasons for my decision on this case. Please note, I have not included every detail of the information considered. My complaints reviewer and I have reviewed all of the information provided during the course of the investigation. C and the Board were given an opportunity to comment on a draft of this report.

(a) Complaint: The Board failed to carry out C's hysterectomy procedure in a reasonable manner on 14 January 2020

Concerns raised by C

4. During the surgery C suffered damage to their bowel, resulting in the need for an emergency operation to rectify this. C considered it was unreasonable that their bowel was damaged during the hysterectomy procedure.

Background

5. C attended the Board in relation to experiencing heavy menstrual bleeding. It was determined a sub-total hysterectomy would be carried out in response. On 14 January 2020 C underwent the sub-total hysterectomy and removal of both ovaries at the Hospital. Initially the procedure was noted to be uneventful. After C woke up

from the surgery they reported they were in significant discomfort which increased over the coming days.

6. On 17 January 2020 it was identified that C had suffered a bowel injury during the procedure and required emergency remedial surgery.

The Board's response

7. The contents of the Board's complaint response to C are known to all parties so I will not repeat them in detail. I have summarised the key points of their response to C:

i. The Board did not consider it was possible to provide a definitive cause for C's bowel injury or whether it was avoidable. Bowel injury was a recognised but rare complication of open hysterectomy surgery and more common in patients who have had previous surgery, as C had. The Board apologised that this risk was not discussed with C at the time they consented to surgery as it should have been.

ii. The Board considered C's clinical care was appropriate and the standard of documentation in the records was reasonable apart from the operating note from the operating consultant. The Board considered there should have been more extensive case note entries from the operating consultant.

iii. The Board acknowledged that communication with C was not at the level and standard it should have been. The Board apologised that the heightened risk regarding previous surgeries was not discussed with C as part of the consenting process.

8. The Board did not provide further comment in response to my enquiries.

Relevant policies and procedures

9. Royal College of Obstetricians and Gynaecologists (RCOG) issued consent advice for 'Abdominal hysterectomy for benign conditions' (RCOG guidance).

10. NICE (National Institute for Health and Care Excellence) issued a guideline for 'Heavy Menstrual Bleeding' Quick reference guide (1.34) (NICE guidance).

Advice

11. The Adviser provided the following comments on C's surgery:

i. Having four lower segment caesarean sections (LSCS) in the past[1] put C at some increased risk in relation to the operation. However, this increased risk was predominantly of damage to the bladder which might be densely adherent to the uterine cervix. The Board said that was why a sub-total hysterectomy was decided upon as it avoided dissecting an adherent bladder from the cervix.

ii. There would also be an increased risk of the bowel being adherent to the underside of the scar and increased risk of wound complications from an incision used four times previously. Using Pfananesteil incision[2] for a fifth time would give much less access and reduced visibility due to fibrosis of the abdominal wall. There would not be an increased risk of bowel damage occurring during the hysterectomy itself if there were no adhesions in the pelvis (none were described in the operation note).

iii. The Board failed to communicate the risks of the surgery to C reasonably. Even prior to the Montgomery case (2014) which determined that consent and counselling should include all issues the patient (not the doctor) would think important to know, the counselling and consent was inadequate. The consent form simply said 'Risks of bleeding, infection, organ damage'. The consent as written fell well short of the guidance referenced above.

iv. In relation to the operation, the notes taken were not ideal but not sufficiently poor to be unreasonable. If no complication had occurred they would have given sufficient information for any future medical problems. The findings were described, though not in detail, as was what was done. No mention was made of whether access was adequate, C's obesity, whether the bowel was adherent to the abdominal wall at entry or if the swab and instrument count were correct.

v. The record of the operation did not indicate a complication occurred but, with the degree of bowel injury which would have (and did) cause considerable leakage of the small bowel contents, I would have expected this to have been seen and therefore described.

[1] The most commonly used type of Caesarean section; to deliver the baby a low transverse incision (Pfananesteil incision) is made in the lower uterine segment above the attachment of the urinary bladder to the uterus.
[2] A pubic incision which is a type of abdominal surgical incision that allows access to the abdomen, used for gynaecological and orthopaedic surgeries.

12. In their comments to a draft version of this report, the Board questioned the advice detailed in point 11v above. They did not consider it was correct to say that the injury to C's bowel should have been seen at the time of surgery, because:

i. Current literature suggests a 50% chance of intra-operative bowel injury.

ii. As no abnormality was seen on a computerised tomography (CT) scan performed the following day, it should be concluded that the injury either took time to develop or was very small and took days to become visible.

iii. It is well known that not all bowel injuries are apparent at the time of surgery.

13. The advice I have accepted from the Adviser in response to this comment was that:

i. The Board were correct that, especially after laparoscopic surgery only 50% of bowel injury is recognised as these are usually small, thermal injuries.

ii. Such thermal injuries usually do not present for 5-7 days post op.

iii. C's injury was a large defect in the bowel wall suggesting direct damage, such as that from a scalpel or scissors.

iv. There were symptoms and signs within 30 hours in keeping with such a direct injury.

v. The CT scan was not normal 30 hours after the operation, again in keeping with an immediate, significant leak.

vi. During the subsequent surgery, there was extensive leaking of the abdominal cavity, not in keeping with a recent leak.

14. The Adviser provided the following comments on the Board's learning taken from the event:

i. Superficially yes, the Board have taken learning from what happened but I am not convinced that adequate counselling and listening to patients have really been improved. Even though the operating consultant has left the Board I can see no sign from the lead clinician's reply to the complaint that any real investigation into how the bowel injury happened or the overall conduct of the procedure. I can see no lessons to prevent this occurring again. There appears to be a lack of duty of candour in the response from the lead clinician to the complainant including disclosure as to who the operating surgeon was.

15. Following sight of a Significant Adverse Event Review (SAER) carried out by the Board during the course of my investigation, the Adviser added:

i. That they considered the action plan completed as a result of the SAER was reasonable in addressing the failures in the communication and documentation.

ii. However, there was no critical evaluation of the decision to operate or of the possible cause of C's injury.

16. The Adviser provided a summary of their view regarding the procedure:

i. Overall the Board did not carry out the procedure in a reasonable manner. There are a number of concerning features about the procedure. There was the potential for problems due to C's previous surgery and obesity. Regarding the operating consultant's decision to operate; the uterus was thought to be the size of a 14-16 week pregnancy. At operation the uterus was found to be normal size. Prior to the operation the size of the uterus was not measured with any form of scanning. The histology report showed the body of the uterus to be 60x50x43mm in size, confirming it was entirely normal sized.

ii. If the uterus really was as large as thought, a sub-total hysterectomy was a reasonable option, though access via a Pfanensteil incision used four times before in an obese patient was likely to be poor and a vertical incision should have been considered. As the uterus was normal sized an endometrial ablation (a procedure to remove a thin layer of tissue (endometrium) that lines the uterus) should have been considered, though the thickness of the LSCS scar would have required to be measured by an ultrasound scan (a procedure that uses high-frequency sound waves to create an image of part of the inside of the body).

iii. C should have had a biopsy of the lining of the uterus done (unless recently done at a prior consultation) before having a sub-total hysterectomy. The Board were asked to provide results of previous endometrial biopsies. None were received so presumably none have been done. As C was significantly overweight, in their late forties and with heavy menstrual bleeding there was a small chance they had endometrial cancer or pre-cancer. A sub-total hysterectomy would have been contraindicated with either of those two findings and to have left the cervix in situ would have put C at serious risk as a further procedure to remove the cervix would have been required.

iv. In terms of the operation, according to the operation note the procedure was performed by a trainee (operating trainee) assisted by the operating consultant. It is not possible to tell from the operation notes whether the consultant performed any part(s) of the procedure.

v. From the RCOG register I believe the trainee passed the MRCOG (membership of the RCOG exam) in 2019 meaning that they were probably at least three years from completing their training. Hysterectomy is no longer a procedure that all trainees in obstetrics and gynaecology are trained to do. Hysterectomy is now part of the Advanced Training and Skills Module (ATSM) in benign gynaecological surgery which is not done by all trainees. If taken, it is done at the end of training. For all the reasons above this was a procedure with a higher than usual degree of difficulty. This was not a suitable case for a trainee except for one very close to becoming a consultant and already trained in hysterectomy and doing it under supervision and certainly not for a trainee unless doing the ATSM.

vi. The operation note says the abdominal wall was scarred (with no mention of adherent bowel) but there were no adhesions in the abdominal or pelvic cavity. The bowel would have been damaged at one of two times in the procedure; on opening the abdominal wall or during the hysterectomy itself. If the bowel was adherent to the abdominal wall, damage may have been unavoidable. However, with a defect measuring one third of the bowel circumference, bowel damage should have been recognised and dealt with during the operation. As there was no mention of the bowel being adherent to the abdominal wall either in the hysterectomy operation note or in the comprehensive operation note from the laparotomy by the general surgeon (the resulting emergency operation) this seems less likely.

vii. There is no reason to explain why or how the small bowel could have been damaged at the hysterectomy. The small bowel should have been packed out of the pelvis and therefore, not at risk. However, C's obesity and reduced access through the incision may have allowed the small bowel to enter the operative field and been damaged, particularly when amputating the cervix. Again a leak of this size should have been recognised as the bowel contents would leak freely from this part of the intestine. The reply from the Board shows little willingness to identify a cause for the complication and learn from it with little duty of candour being displayed.

viii. Finally the general anaesthetic lasted from 10:40 hrs until 11:50 hrs (1 hour and 10 minutes), of which not all would have been operating time, which is quite a short time for a less than straight forward hysterectomy.

Additional evidence

17. In their comments responding to this report the Board informed us that, since the time of our investigation, they have developed procedure specific consent forms which detail consistent information regarding risks of surgery.

(a) Decision

18. The Board failed to carry out the procedure in a reasonable manner. In making this decision I have relied on the clinical advice which I received and have accepted. In particular I have taken cognisance of the following points:

i. The Adviser considered that appropriate investigations were not carried out prior to the surgery and, as such, the decision to undergo the procedure was unreasonable.

ii. The Adviser considered that prior to the operation taking place the Board failed to communicate the risks of the surgery to C reasonably. Notably this was acknowledged in the Board's own response to the complaint, as well as in their SAER.

iii. The Adviser did not consider the operation was suitable for a trainee doctor to undertake, given the particular risks associated with the case and the point they were at in their training. Therefore, it was unreasonable to have expected a trainee to perform this procedure.

iv. The records from the operation did not indicate a complication occurred, however, the Adviser's view was that it should have been recognised during the operation given the nature of the damage and consequently dealt with at that time. It was unreasonable that the complication during the surgery wasn't recognised, recorded or responded to.

v. The Adviser considered that the Board did not take all appropriate learning from the complaint, with particular regard to a lack of any real investigation into how the bowel injury happened or the overall conduct of the procedure.

vi. In relation to the response to this element of C's complaint, the Board failed to be transparent as to who conducted the procedure.

19. It is clear from the advice I have received and accepted that C's care and treatment both before and during the operation fell below a reasonable standard.

20. It is also of considerable concern to me that there appears to be no acknowledgement by the Board of the role of the trainee doctor; in terms of why they

considered it an appropriate procedure for them to perform; what safeguards they have in place to ensure that trainees are appropriately supervised and supported during a procedure; or what support the trainee (and other clinicians) were given in relation to what was likely to have been a traumatic experience, particularly early in their career.

21. I uphold this complaint.

(b) Complaint: The Board failed to provide reasonable care and treatment while C was on the ward at the Royal Alexandra Hospital from 14 to 17 January 2020

Concerns raised by C

22. C considered that their concerns after the procedure were dismissed prior to the evening of 16 January 2020. They said that there was an unreasonable delay in identifying the bowel injury and nurses took repeat observations in an unreasonable manner, asking C to change positions until observations were at an acceptable level. C considered there was an unreasonable delay in the second CT scan being carried out and the clinicians on the ward failed to notify C of the seriousness of their condition prior to their transfer to another hospital.

Background

23. C attended the Board in relation to heavy menstrual bleeding. On 14 January 2020 C underwent a sub-total hysterectomy and removal of both ovaries at the Hospital. Initially the procedure was noted to be uneventful. After C woke up from the surgery they reported they were in significant discomfort which increased over the coming days.

24. On 17 January 2020 it was identified that C had suffered a bowel injury during the procedure and required emergency remedial surgery. Given the symptoms C was reporting they considered there was an unreasonable delay in identifying the complication.

The Board's response

25. The key points of the Board's response were:

i. The Board apologised that C had not felt listened to and found any of the nursing staff to be anything other than professional, respectful, kind and compassionate.

ii. No evidence was found that C's observations were manipulated by nursing staff. The Board apologised that the behaviour of nursing staff led to C feeling their care was not appropriate.

iii. Symptoms for a surgical injury such as what C sustained can take time to manifest. The case note review identified C's postoperative care was appropriate and there were no missed opportunities to identify the bowel injury sooner than it was.

iv. C's observations postoperatively were performed within the acceptable timeframes and until early on 17 January 2020 were within reasonable parameters. The Board considered C's abdominal pain was appropriately assessed and showed no initial signs of cause for concern.

v. There was a delay of four hours between C showing signs of clinical deterioration and being assessed by a doctor due to the doctor being unavoidably detained in another ward.

vi. C's initial CT scan did not indicate any cause for concern and there was no suspicion of bowel injury from the first scan. This was a factor in influencing the initial reluctance for a second CT scan to be performed in a short space of time given the finite resources of the radiology department. The Board considered that the initial reluctance to perform a second CT scan was not an error.

vii. The Board said it would not have been appropriate for the staff on the ward at the Hospital to comment or speculate about the care and treatment to be provided by another specialty nor would they have been fully aware of C's treatment plan once they had been transferred.

Advice

26. The Adviser provided the following comments on C's care after surgery:

i. After the operation C was seen at 16:30 hrs on 14 January 2020. The notes stated 'Debriefed the procedure' however, it was unclear who wrote this. There was no other medical note on 14 January 2020 but the nursing notes did not show any major problem. The entry in the notes on 15 January 2020 at 09:30 hrs stated 'Informed by [the operating consultant]. For FBC [full blood count] if significant drop in Hb [haemoglobin] for imaging ?CT.'

ii. From the observation charts C's pulse was 90/minute and blood pressure (BP) was 105/60 which were not greatly abnormal. At 11:30 hrs the records stated

'seen by [the operating consultant]. See above for CT today. Stomach tender and tense to palpate. For Hb check and review.'

iii. Based on a blood gas analysis report from 10:54 hrs on 15 January 2020 C's Hb was 133. There was no white blood cells (WBC) count reported. This seems to be from a blood gas analysis machine in the maternity hospital. There was no evidence that a formal laboratory FBC was sent. No formal lab samples were provided by the Board prior to those taken on 17 January 2020.

iv. On 15 January 2020 at 16:30 hrs C was seen by a FY2 (a foundation year doctor qualified for 18 months who was not a gynaecology trainee). They wrote 'PT NAD (patient no abnormality detected). Patient encouraged to mobilise. Hb 130.' There is no mention of the WBC. At 18:16 hrs the CT is described as 'nad'. I can't see any other medical note until 21:00 hrs on 16 January 2020 when the nurses asked a FY2 to see C as they were tachycardic (with a heart rate over 100 beats per minute) and hypotensive (with abnormally low blood pressure). The abdomen was distended. C was not seen by either a registrar (a doctor who is receiving advanced training in a specialist field of medicine in order to become a consultant or General Practitioner) or a consultant.

v. C was seen on 17 January 2020 at 06:30 hrs by a different FY2 as requested by the nurses due to a persistent high pulse rate. They noted no significant abnormality was seen on the CT. They took bloods and arranged a chest x-ray. At 09:30 hrs C's renal function was significantly abnormal showing something certainly going wrong. The FBC was not noted. At 10:10 hrs C was seen by an unknown doctor. They found C's pulse was 100 and blood pressure was 110/50 with a distended abdomen, tense, difficult to feel possible haematoma. They decided to repeat the CT and discuss the results with clinicians. It was noted C could start hormone replacement therapy after the CT and medical review.

vi. At 15:30 hrs a FY2 found C's C-reactive protein (CRP; a marker of inflammation or infection) was greatly raised at 645 (a normal reading is less than 10, but it would be raised after surgery to a variable degree but certainly not to this level). The WBC was very low at 3.8 (the normal range is 4-11 with it being raised in a bacterial infection). As it was low this suggests an overwhelming infection. The FY2 looked at the chest x-ray and found gas under the diaphragm which meant there was a high chance of a bowel perforation. They expedited the repeat CT and phoned the operating consultant who asked to be informed of the CT result. The FY2 acted very appropriately in starting antibiotics and fluid management.

vii. The repeat CT report was seen by a FY2. It showed increased intra-abdominal gas and fluid, likely a bowel perforation. They arranged a surgical review and explained and apologised to C. I am not able to say what the operating consultant said to C. The operating consultant was obviously worried on 15 January 2020 as they ordered a CT. There was a long gap from then with no apparent senior input which was not acceptable.

viii. I am concerned about the report of the initial CT which does show 'pockets of free fluid and air within the abdomen predominantly within the pelvis, within the perirectal fascia and along the right para-colic gutter. Appearances likely to represent post-operative change given that the surgery was only yesterday'. I am sure that this CT was incorrectly reported and gave much false reassurance to the FY2s. If this written report had been seen by the operating consultant (as opposed to being told it was normal) they should have been concerned especially in conjunction with the clinical situation. Either a surgical opinion or a discussion with the radiologist should have happened. Overall the FY2s acted appropriately for their competence but neither the operating trainee or the operating consultant sufficiently monitored C. If they had done it should have been very obvious that there was a significant intra-abdominal abnormality.

27. The Adviser provided their comments in relation to C's complaint that their observations were manipulated or inappropriately repeated in order to obtain suitable readings:

i. There is no evidence that I can see from reading the case records that any manipulation or alteration took place. I am unable to comment about what might have happened at the time.

28. The Adviser provided their comments in relation to whether C's concerns about their health were reasonably responded to:

i. Whilst there are differences between patients, the majority of patients after abdominal hysterectomy make a fairly rapid recovery. Normally every day is better than the day before. C's symptoms, especially of pain and difficulty moving, particularly when taking their observations into account should have raised alarm bells. The CT scan being reported as 'post op changes' might have meant that less note was made of these symptoms or them being taken as seriously.

29. The adviser commented on the timeframe for the second CT being carried out:

i. The first CT gave a false reassurance that there was nothing serious going on. As C was deteriorating a further CT was called for (or reviewing the first CT with the radiologist) but I can understand why there was a 48 hour gap between the CTs.

30. The Adviser gave their view on the communication with C about the severity of the bowel injury and impact on C's health:

i. There was no evidence in the notes that there was an adequate explanation of what was happening from the consultant gynaecologist either before or after the laparotomy. C was told that there was a bowel perforation and was apologised to by a FY2 (a doctor qualified for less than 2 years) who I think performed well under the circumstances. Even if the consultant gynaecologist was not available to see C at that point, they certainly should have been by the gynaecologist at some time post laparotomy.

31. The Adviser said that the Board did not provide reasonable care and treatment while C was on the ward at the Hospital from 14 to 17 January 2020.

(b) Decision

32. I have already concluded, as part of the investigation of complaint (a) that the complication during surgery could and should have been identified during the surgery itself.

33. After C returned to the ward the Adviser said that after ordering the CT on 15 January 2020 there was a period where there was no senior input into C's care.

34. The Adviser said that the CT report gave a false reassurance to junior doctors regarding C's symptoms and the CT scan was not directly seen by the consultant. The Adviser said monitoring by a senior clinician would have highlighted that there was a significant intra-abdominal abnormality.

35. The Adviser said that C's symptoms after the operation should have alerted clinicians to a problem.

36. It is clear from the advice I have received and accepted that C's care and treatment after the operation on the ward fell below a reasonable standard.

37. I uphold this complaint.

Recommendations

Learning from complaints

The Ombudsman expects all organisations to learn from complaints and the findings from this report should be shared throughout the organisation. The learning should be shared with those responsible for the operational delivery of the service as well as the relevant internal and external decision-makers who make up the governance arrangements for the organisation, for example elected members, audit or quality assurance committee or clinical governance team.

What we are asking the Board to do for C:

Complaint number	What we found	What the organisation should do	What we need to see
(a)	The Board failed to carry out the operation in a reasonable manner, with damage occurring which was not identified during the operation, that the operation was carried out by a trainee doctor and this was not openly referred to in the complaint response.	Apologise to C for the care provided by the Board, acknowledging the impact the bowel injury had on C.	A copy of the letter of apology which should meet the standards of the SPSO guidance accessible here: https://www.spso.org.uk/meaningful-apologies. By: 1 month of publication of report

We are asking the Board to improve the way they do things:

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(a)	The Board failed to inform C of the complication in a timely manner.	Complainants should be informed candidly, openly and honestly when a complication occurs during a procedure, including explaining what happened and what action the Board have taken (or intend to take).	A review of how surgical complications are communicated with patients and consideration for a standard operation procedure for such instances. By: 3 months of publication of report

We are asking the Board to improve their complaints handling:

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(a) and (b)	The Board failed to identify through their own investigation the need for a SAER. This includes why this incident was not reported/consideration given to an SAER at the time, and why duty of candour wasn't applied. The complaint investigation did not consider these omissions and prompt a robust investigation into the incident and candid explanation as to what happened.	Where an incident occurs measures are in place to consider whether further investigation is required and providing open and honest communication with a patient.	Evidence a review of the reporting processes has been undertaken and whether further action is required to reduce the likelihood of a recurrence. By: 3 months of publication of report

Terms used in the report **Annex 1**

the Adviser	a consultant gynaecologist
ATSM	Advanced Training and Skills Module
the Board	Greater Glasgow and Clyde NHS Board - Acute Services Division
C	the complainant
CT scan	computerised tomography scan; a scan that combines a series of X-ray images taken from different angles around your body and uses computer processing to create cross-sectional images (slices) of the bones, blood vessels and soft tissues inside the body
the Hospital	Royal Alexandra Hospital
laparotomy	surgical incision of the abdominal wall
low transverse incision (Pfananesteil)	a pubic incision which is a type of abdominal surgical incision that allows access to the abdomen, used for gynaecological and orthopaedic surgeries
lower segment caesarean sections (LSCS)	the most commonly used type of Caesarean section; to deliver the baby a transverse incision is made in the lower uterine segment above the attachment of the urinary bladder to the uterus
RCOG	Royal College of Obstetricians and Gynaecologists
Sub-total hysterectomy	a surgical procedure to remove part of the uterus

Royal College of Obstetricians and Gynaecologists (RCOG) issued consent advice for ‘Abdominal hysterectomy for benign conditions’ (RCOG guidance).

NICE (National Institute for Health and Care Excellence) issued a guideline for ‘Heavy Menstrual Bleeding’ Quick reference guide (1.34) (NICE guidance).