SPSO decision report

Case: **201200259, Highland NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mr C, complained to us on behalf of his son (Mr A). Mr A suffered a serious leg fracture in late 2010, and underwent treatment in a hospital orthopaedic department until June 2011. At that point, he sought a second opinion and received further treatment from another health board. Mr C had a number of concerns about his son's initial treatment, including about the type of fixator (a device to fix the position of fractured bones) that was used, the pain relief provided and the timing of appointments.

Having taken independent advice from one of our medical advisers, a consultant orthopaedic surgeon, we found that the decision to use an external fixator was in itself appropriate. We noted, however, that the board had not identified that one of the pins used had been placed into one of the fractures. We also noted that Mr A was not seen by a consultant until nearly three months after surgery, although we had no concerns about the treatment provided during this period. On balance, therefore, we upheld the complaint that the initial management of his fracture was inappropriate.

We upheld the complaint that on a number of occasions during his treatment Mr A was not given adequate pain relief, but did not uphold a complaint that it was inappropriate to use a sarmiento cast (a below-knee cast that allows the knee to bend) once the external fixator was removed.

Finally, we upheld the complaint that Mr A was not given timely out-patient appointments. Mr A had review appointments in April and June 2011. He was fitted with a leg brace and advised to use his leg when walking. He was given another appointment for eight weeks later. However, we found that at that stage it was clear that the fracture was not healing and required further management, but that the board failed to recognise this. By June 2011, Mr A was suffering severe symptoms and sought treatment elsewhere. We recognised that this had been a complex injury to manage, and that the orthopaedic department might have recognised that the fracture was not healing had Mr A continued his treatment with them. However, it was clear that he had already received substandard care, given that the fact that during the April and June 2011 appointments it was not recognised that the fracture was not healing.

Recommendations

We recommended that the board:

- provide evidence to the Ombudsman that the orthopaedic department ensures timely consultant review of patients when appropriate; and
- bring our findings to the attention of the staff who treated Mr A on 1, 14 and 15 February 2011 to allow them to reflect on his pain management.