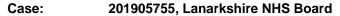
SPSO decision report



Sector: Health

Subject: Clinical treatment / diagnosis

Decision: not upheld, no recommendations

Summary

C underwent an emergency caesarean section (an operation to deliver a baby. It involves cutting the front of the abdomen and womb). Following this, the stitches holding C's wound together failed. C believed they had not been properly cared for after their surgery. They said they had experienced abnormal levels of pain and discomfort. These had been incorrectly attributed to other causes such as constipation, but C believed they were a sign their wound closure was failing. C also noted significant amounts of fluid had leaked from the wound. C felt this was excessive, but that it had not been properly considered by nursing or medical staff. C said the experience had been very traumatic for them and for their spouse.

The board had conducted an internal review into the failure of the stitches. C felt they had not been properly involved in this and that it had not recognised properly the seriousness of the incident, or the implications of its conclusion that incorrect suture material was used.

We took independent medical advice which stated the complication suffered by C was rare. C's condition was monitored appropriately postoperatively, including escalation for medical review due to the concerns about wound leakage and pain levels. Although the documentation was poor, there was no evidence of operator error, or that the specific suture material used had contributed to the failure of the wound. We found C's care and treatment had been of a reasonable standard. Therefore, we did not uphold the complaint.

The board had acknowledged there had been confusion between the complaints process and the serious adverse event review process and that this had led to delays and poor communication with C. We found that the board's handling of the complaint had been unreasonable, but they were able to demonstrate that they were taking steps to address this issue.

