SPSO decision report

Case: **201910063, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the board after suffering wound care complications following a caesarean section (an operation to deliver a baby. It involves cutting the front of the abdomen and womb) during the birth of their child. They considered that a number of factors meant that the board had failed to provide reasonable treatment in relation to the birth of their child.

We took independent advice from a consultant obstetrician (specialist of pregnancy, childbirth etc) and gynaecologist (specialist of the female genital tract and its disorders). We found that the board had failed to provide reasonable treatment. In particular, we found that the board failed to follow up on a phone call to ensure C's safety when a full triage could not be completed; that they had failed to ensure a timely review by a senior doctor when complications occurred; that they failed to keep reasonable records of C's care; that they failed to identify that a Significant Adverse Event Review (SAER) should have been carried out, meaning that the staff in question were unable to clearly recollect events by the time the complaints investigation was completed and additionally, that the board made insufficient attempts to establish a cause for the complication, which may possibly have been operator error or the result of faulty sutures, either of which would have required further action to ensure wider patient safety and avoid a repeat. For these reasons, we upheld C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to provide reasonable treatment relating to the birth of their child. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

What we said should change to put things right in future:

- All relevant staff should know when to suspect complications in post-caesarean wound care and escalate for review by a senior doctor as soon as possible, if indicated.
- If a triage is unable to be completed for any reason, the board should have robust procedures to ensure the safety of the patient in question.
- Sufficiently detailed records should be made of all operations carried out.
- When a wound has ruptured following surgery, the board should ensure reasonable steps are taken to invsetigate the cause of this.
- When a relevant adverse event occurs, the board should promptly carry out an SAER to investigate the cause and identify any potential learning.

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.