SPSO decision report

Case: **202204291, Lanarkshire NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained that surgery performed to remove material from their leg was not carried out to a reasonable standard. C broke their leg and underwent an operation to insert pins, plates, and a device known as a 'TightRope' (a device where string is passed through a channel in the bone and secured with 'buttons' at each side) to stabilise their leg. C developed an infection in their leg and subsequently underwent a further procedure to remove the 'TightRope'. The procedure was not successful, some material was retained in C's leg and the infection persisted. C then underwent further procedures to have the material removed completely, however, the infection proved to be too advanced and C had a below knee amputation. C complained that the board did not appropriately remove the 'TightRope' material during the initial procedure when they should have done.

The board said that although there was an intention to remove all of the 'TightRope', the material is not always visible. Cutting through the 'TightRope' in order to pull it through, staff expected all of the material to come out. Staff assumed that they had removed all of the suture, however, some of the material had stayed behind. The only way to have fully confirmed this would have been to make a larger hole through the bone, which could have allowed further spread of the infection.

We took independent advice from a consultant orthopaedic surgeon (a specialist in the treatment of diseases and injuries of the musculoskeletal system). We found that the surgeon who carried out the initial procedure to remove the 'TightRope' should have been familiar with the device, including the volume of material, and should therefore have been able to assess whether removal was complete. The surgeon should have curetted (cleaned/scraped) the channel in the bone to ensure that all material was removed. We noted that an experienced surgeon would likely have undertaken a more complete removal of the material and suggested that the board could consider reviewing their arrangements for supervision of surgeons who are not experienced in a specific procedure. We considered that the initial surgery performed to remove the 'TightRope' material was not carried out to a reasonable standard. Therefore, we upheld this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failure to carry out the procedure to an acceptable standard resulting in some material being retained in the TightRope channel and for the impact this had on C. 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:

- Operations should be carried out to a high standard.

In relation to complaints handling, we recommended:

- Complaint investigations should be carried out in line with the NHS Complaints Handling Procedure. Particular notice should be given to the responsibility to ensure that staff learn from complaints, especially when mistakes have been identified. Good practice should be followed when compiling the complaint response.

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.