

## SPSO decision report

**Case:** 202408417, Ayrshire and Arran NHS Board  
**Sector:** Health  
**Subject:** Clinical treatment / diagnosis  
**Decision:** upheld, recommendations

### Summary

C complained on behalf of their adult child (A), who underwent septorhinoplasty surgery (to improve the function and appearance of the nose) after a rugby accident. C complained about the care and treatment provided to A following the procedure. C had all skin sutures and brace, seven days after surgery, as per the clinic letters. A developed a post-operative infection and was reviewed again 12 days after surgery, when a further suture was removed. More than a year later, A noted black suture material extruding from the scar line on their nose. They were commenced on antibiotics and further review arranged. C complained that the medical records did not support the board's position that a suture was intentionally left in place and that the board had failed in their duty of candour.

We took independent advice from a consultant otorhinolaryngologist (specialist in ear, nose, and throat medicine). We found the standard of care and treatment when A attended 12 days after surgery unreasonable. We also found that A was wrongly told that all remaining suture material had been removed at that time.

With regard to the suture material which extruded from the scar line more than a year later, we found that the board's explanation that this suture was intended to remain in place permanently was not supported by the records. Had it been intended to remain in place permanently, it should have been clearly recorded. We found the board had failed in their duty of candour and that it was unreasonable for the board not to have offered A a second opinion, even if that required referral outwith the board area. We therefore upheld the complaint.

### Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified. The apology should meet the standards set out in the SPSO guidelines on apology available at [www.spsso.org.uk/meaningful-apologies](http://www.spsso.org.uk/meaningful-apologies).

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

- Practitioners document the number and type of skin sutures placed in a wound.
- Where a second opinion is requested this should be appropriately considered in line with relevant guidance.

In relation to complaints handling, we recommended:

- Complaint decisions should be evidence-based. Complaint responses should be quality assured to ensure decision-making is based on the available evidence. We offer SPSO accredited Complaints Handling training. Details and registration forms for our online self-guided Good Complaints Handling course (Stage 1) and our online trainer-led Complaints Investigation Skills course (Stage 2) are available at [HYPERLINK "https://www.spsso.org.uk/training-courses"](https://www.spsso.org.uk/training-courses) <https://www.spsso.org.uk/training-courses> .

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.