SPSO decision report

Case: **201909224, Fife NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the care and treatment that they received from the board after they were diagnosed as having a tumour in their bowel.

C underwent surgery to remove their tumour. Following the procedure, they experienced a number of complications that led to extended hospital treatment and the need to be fitted with a stoma (a surgically made pouch on the outside of the body). It was ultimately established that their surgery failed to heal properly, possibly due to a fault with an item of equipment used to staple their bowel. C complained that the issues resulting from their surgery had life-changing consequences.

C raised a number of concerns regarding the care and treatment that they received from the board at the time of their surgery and once they had been discharged. They also did not consider that the board adequately took responsibility for the issues that affected them.

We took independent advice from a general and colorectal surgeon (a surgeon who specialises in conditions in the colon, rectum or anus). It was evident from C's complaint that they went into surgery expecting a straightforward procedure. The procedure was complicated by C's high body mass index (BMI, a measure for estimating human body fat) and took several hours longer than they had anticipated. Whilst we were critical of the board for not explaining to C that their BMI was a potentially complicating factor, overall we were satisfied that the surgery was carried out reasonably. During the procedure, the surgeon made reasonable adaptations when issues arose and there was no indication at the time of the issues that would later affect C. We were also satisfied that there was no indication at that time that there was a fault with the equipment being used during the procedure. Therefore, we did not uphold this aspect of C's complaint.

Following their surgery, C experienced a significant amount of pain. We were largely satisfied that the board's staff took this seriously and took appropriate action when it became apparent that the pain was not resolving as expected. C was ultimately found to have a leak from the site of their bowel surgery. We found that this was treated appropriately with further surgery once it was identified. That said, we found that C's symptoms should have led staff to suspect a potential leak sooner than they did. Whilst we found nothing to suggest that the outcome would have been any different for C, had staff considered a leak earlier, an earlier diagnosis could have been made and C's pain may have been relieved sooner. We upheld this aspect of C's complaint.

We found that, four months after C's surgery, the board proactively identified and investigated a cluster of patients (including C) that had experienced bowel leaks following surgery. The board concluded that there was no common factor linking these cases. Two months later, the board were advised by a medical equipment manufacturer that an item of equipment that was used during C's surgery was faulty and should be withdrawn from use. We found that there was no clear link between the faulty device and the leak that C subsequently experienced. However, we were critical of the board for not going back and reviewing the cluster of cases in the presence of the new information regarding the faulty medical device. We also found that the board could have

done more to address C's questions about the situation. Therefore, we upheld this aspect of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the delay in diagnosing the leak. 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:

- The board should share this decision with the staff involved in C's care with a view to identifying any aspects of their care and treatment that could have been improved.
- The clinical team should review C's case with a view to ensuring their protocols for considering and diagnosing anastomotic leaks take account of all relevant risk factors.

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.