SPSO decision report

Case: **202101210, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C, who suffered with hip problems, was diagnosed with a labrum tear (a condition which occurs due to damage of the soft cartilage that rims the socket portion of the hip joint) and underwent surgery.

C's symptoms failed to resolve following surgery and they were informed during a follow-up consultation that a metal artefact was visible on x-rays of their hip. C complained to the board about the advice to proceed with surgery and the treatment that they received.

C also complained about their concerns regarding their assessment and suitability for surgery to address their symptoms, and that the surgery had been carried out unreasonably.

We took independent advice from an orthopaedic (conditions involving the musculoskeletal system) adviser. With respect to C's complaint about diagnosis and treatment which resulted in the hip surgery being undertaken, we found that C underwent appropriate assessment. We found that the surgery, including relevant complications, was discussed and C had consented to the procedure. On this basis we did not uphold this aspect of the complaint.

With respect to the complaint that the board failed to provide appropriate care and treatment during, and following, the hip surgery, we found that whilst the surgery was performed to a reasonable standard, and subsequent problems investigated reasonably by clinicians, the board failed to comply with the duty of candour when they failed to inform C after the operation about the failure of a metal anchor used in the hip repair. We also identified that the board, in their complaints investigation and response to C, failed to adequately address the issue of the metal artefact in their hip following the operation. We therefore upheld this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to meet its duty of candour. 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:

- Discussion by the Orthopaedic Department Clinical Governance meeting of the requirements around Duty of Candour, including reflection on C's case.

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.