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PUBLIC SERVICES OMBUDSMAN FOR WALES
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The investigation of a complaint by Mrs B against Cwm Taf Local Health Board

A report by the
Public Services Ombudsman for Wales
Case: 201200624

Contents

Introduction

This report is issued under section 16 of the Public Services Ombudsman (Wales) Act 2005.

In accordance with the provisions of the Act, the report has been anonymised so that, as far as possible, any details which might cause individuals to be identified have been amended or omitted. The report therefore refers to the complainant as Mrs B.

Summary

Mrs B complained about Cwm Taf Health Board ("the Health Board") in relation to treatment she received at Prince Charles Hospital in July 2011. Mrs B explained that she fell into a pond and sustained a broken ankle. She said that the Hospital should have transferred her urgently to a specialist centre due to the circumstances and severity of the fracture. She added that the treatment she received at the Hospital was inappropriate and led to her having to have an amputation of her lower leg after she was belatedly transferred.

The Ombudsman concluded that an immediate transfer was not necessary. However, he found that due to the possibility of marine type infection, the Hospital should have taken urgent microbiological advice. He found that once the wound was infected, an urgent transfer to a specialist centre should have occurred. The Ombudsman also had concerns about the supervision of the junior surgeons who operated on Mrs B's ankle.

The Ombudsman recommended that the Health Board pay Mrs B £3000 as an acknowledgement of the injustice she suffered because of the Health Board's failings. He also made a variety of systemic recommendations including de-briefing activities, record keeping and supervision of junior surgeons. The Health Board accepted his recommendations.

The complaint

1. Mrs B complained about Cwm Taf Health Board ("the Health Board"). Her complaint related to treatment she received at Prince Charles Hospital ("the Hospital") after she fell into her fish pond and fractured her right ankle. She explained that she broke her ankle on a rock, which was on the pond floor. She said that she was totally submerged in the water for a short time. Mrs B added that her ankle remained under water for about ten minutes. She then managed to return to her house and seek help after dragging herself out of the pond and crawling over a gravel path.

2. Mrs B said that she was taken to the Hospital by ambulance and admitted on 16 July 2011, soon after her accident. She maintained that the Hospital responded poorly to her injury and then seriously mishandled her care. Her central point was that the Hospital should have referred her urgently to Morriston Hospital ("MH"), a specialist centre.[1] Mrs B said that her injury was a "compound bimaleolar fracture dislocation".[2] She added that it involved marine contamination. Mrs B therefore, asserted that her injury necessitated a referral to a specialist centre and the failure was ongoing. She claimed that authoritative sources supported her view. Mrs B added that in October 2012, she was invited to take part in a "study" by the Wales Lower Limb Trauma Recovery Scale Group. The group includes leading experts in this area of clinical practice. The invitation said that Mrs B was asked to partake "because of the injury you have received". The "purpose" of the study relates to evaluating improvements in treatment of "complex fractures". It said that the Surgeon at MH had agreed that Mrs B was an appropriate patient to be involved.

3. Mrs B stated that the Hospital did not refer her to MH until 27 July. In the meantime, it had failed to:

- obtain adequate details of the accident
- appreciate the severity of the injury

[1] MH is part of Abertawe Bro Morgannwg University Health Board. MH has confirmed that it has the plastic surgery and orthopaedic facilities to fulfil the role of a specialist centre in the treatment of complex open wounds. It receives referrals from hospitals in South Wales.
[2] A compound fracture is where the fractured bone is exposed. A bimaleolar fracture means that two of the three parts or "malleoli" (the rounded protuberances on each side) of the ankle are broken.

- carry out effective debridement[3]
- close the wound
- implement a rigorous and appropriate infection control regime, which related to the marine type nature of the injury.

4. Mrs B said that despite a response from the Health Board to her written complaint about these matters, she remained dissatisfied. She maintained that the Health Board failed to acknowledge its errors.

5. Mrs B explained that at MH, staff amputated her right leg below the knee. She considered that an early referral to MH and proper treatment would have prevented this. She added that the consequent suffering and changes have greatly reduced the quality of her life. Mrs B said that she should be "financially compensated" for her suffering.

Investigation

6. The investigation started on 31 May 2012. My investigator obtained comments and copies of relevant documents from the Health Board. I have considered those in conjunction with the evidence provided by Mrs B. I have taken advice from one of my professional advisers ("my Adviser"). He is an experienced Consultant Orthopaedic Surgeon. He has over 15 years experience of managing trauma in a teaching hospital. My Adviser has held posts such as Divisional Medical Director for Surgery and Anaesthetics in an English health authority. His name is Bruce H Pennie. I have not included every detail investigated in this report. However, I am satisfied that nothing of significance has been overlooked.

7. Both Mrs B and the Health Board were given the opportunity to see and comment on a draft of this report before the final version was issued.

The background events

8. On 16 July **2011**, Mrs B slipped and fell into a fish pond in her garden as explained above. An A & E doctor diagnosed the injury as a compound fracture of the right ankle. The records referred to a fall into the fish pond

[3] Debridement is the process of removing dead tissue from a wound.

and that Mrs B "took some time to come out". Staff treated her with painkillers and antibiotics. They cleaned the wound. Cultures were taken and sent for testing. Mrs B was referred to the orthopaedic team.

9. A member of the Orthopaedic medical team estimated that the wound was about 10cm long and there was 7.5-10cm of periosteal stripping. The injury was described as "Gustilo 2/3".

10. A junior surgeon took Mrs B to theatre later that evening. He washed the wound with saline. He then operated to stabilise both sides of the ankle and closed the wound with sutures. He recorded the wound as 8cm.

11. On 17 July, the Consultant in charge of Mrs B's treatment reviewed her. He included in the medical notes that she required "aggressive" antibiotic treatment due to the "marine" element of the injury.

12. On 19 July, staff inspected Mrs B's wound and found it infected. Staff removed the wound sutures. Further surgery was deemed necessary but delayed.

13. In the early hours of 20 July, Mrs B underwent surgery by a junior surgeon (not the same surgeon as operated on 16 July). This surgeon washed the wound and carried out further debridement. He identified that pus was oozing on one side. The wound was left open on one side of Mrs B's ankle and closed on the other.

14. On 22 July, the Consultant conducted further surgery. The wound was washed out and debrided again. Again, pus was discharging from the wound. The operation note included a "management" plan. This involved antibiotics, liaison with microbiological colleagues, considering closing the wounds after a further examination on 25 July and discussing the case with "plastics".[4]

15. On 23 July, the medical notes said that Mrs B might be transferred to MH after liaison with the plastic team there.

[4] This is a reference to MH.

16. On 25 July, the Consultant led a ward round. He examined Mrs B. Further debridement was planned.

17. On 26 July, the Consultant wrote a note after receiving information from microbiological staff. The note said that Mrs B had "finally grown an interesting bug in her right ankle", which is associated with stagnant water. It stated that the Consultant received news of this on 25 July. It referred to advice from microbiological staff about the antibiotic regime. The note said that he was "aiming for closure" after a further examination today.

18. The operation note for the surgery of 26 July stated that the wound was washed and sutures removed but "unable to completely close the wound".

19. On 27 July, Mrs B was sent to MH for further care, where she had an amputation below the knee due to the level of infection.

20. On 26 October, Mrs B complained to the Health Board about her treatment at the Hospital. Before the Health Board responded, Mrs B clarified and added some points in further correspondence. Her letters said:

- the Hospital "ignored" the Standards and should have referred her to MH immediately due to the "complex" nature of her injury
- the "unacceptable" 11 day delay in sending her to MH cost her the opportunity of having surgery at a specialist centre offering orthopaedic and plastic surgery skills
- debridement is vital and for complex injuries, orthopaedic and plastic surgeons should be involved
- antibiotic material should have been used in the wound dressings
- the wound was a type 3B and not fixed properly
- the wound was left open for far too long
- the failure to inform her that the Hospital breached the Standards invalidates her consent to procedures
- her treatment was "negligent".

21. On 21 February **2012**, the Health Board responded to the complaint. The response included the following:

- the nature of the injury did not warrant referral to a specialist centre "other that the contamination by the fish pond"
- the infection led to the failure of the fixation and healing
- the Standards are adhered to in the Hospital but Mrs B's injury was not "complex" and only rarely requires plastic surgical input
- what made the injury "atypical" was contamination and that is why it was deemed necessary to clean the wound promptly and "proceed with fixation"
- at surgery on 16 July, an 8cm wound was identified but "no periosteal stripping" was evident
- after an infection was noticed on 19 July, surgery was planned but delayed due to "a large number of clinically urgent theatre cases"
- the wound was a type 2 not 3B
- the wounds were closed after surgery but this could not be done after the 26 July procedure, hence the referral to MH
- the 26 July surgery should have occurred on 25 July but was delayed due to "pressure and priorities"
- the infection that was identified on 25 July via microbiological input was a marine type and was likely to have been "colonised" during the initial injury
- microbiological advice was taken "throughout" the admission
- the identification of the marine infection, Aeromonas Sobria, led to a change in the antibiotic regime.

22. The Ombudsman's office received Mrs B's complaint on 10 May.

The Health Board's evidence

23. The Health Board's response was compiled by the Consultant. The Consultant explained that although the Health Board does comply with the Standards, Mrs B's injury was not of the type that required immediate referral to a specialist centre. He stated that he considered the wound to be 8cm long. This was confirmed in the operation note of 16 July. It did not involve "extensive soft tissue loss" and was able to be closed with simple sutures

"without tension". The Consultant added that injuries such as Mrs B's are "commonly encountered outside specialist centres and frequently, despite their risks, managed successfully".

24. The Consultant said that he considered that an adequate history was recorded. He noted that this included the nature of the injury and the "marine type contamination". The Consultant stated that although the injury did not merit a referral to MH initially, he considered that contamination with stagnant water was the "major concern". That is the reason he initiated an aggressive antibiotic regime for Mrs B at the outset of her treatment.

25. The Consultant explained that the Junior Surgeon who operated on Mrs B on 16 July was "a highly competent and experienced surgeon". He has subsequently become a Consultant. He said that he could not locate any documentation to demonstrate that this clinician discussed the case with him prior to surgery. However, he said that he "would have" done so. He commented that his advice to the Junior Surgeon:

> "…would have been for thorough washout and debridement and to proceed as appropriate whether that be internal fixation versus external fixation."

26. The Consultant stated that the other Junior Surgeon, who operated on Mrs B in the night of 19/20 July, was a middle grade doctor. He was not as experienced as the first Junior Surgeon. However, the Consultant regarded him as "sensible and reliable".

27. The Consultant said that microbiological advice "would have" been taken throughout Mrs B's admission. In addition, swabs of the wound were taken regularly and sent for analysis. However, the first documented advice from a microbiologist was on 25 July after Mrs B's marine type infection became evident. The Consultant believed that there was an earlier contact but cannot locate the notes.

28. The Consultant commented that "with the benefit of hindsight", it might have been prudent to refer Mrs B to MH around the 19 July, once it was

apparent that she had an infection in the wound. He added that the referral decision was taken once it became clear that the infection was "unrelenting" despite "aggressive" debridement and antibiotic therapy.

Professional advice

29. My Adviser discussed the classification of the injury that Mrs B sustained. He said that there is only a two in three chance that two clinicians would agree on a classification for a particular injury. In Mrs B's case, he explained that the reference in the medical records to Gustilo 2/3 "only indicates that it is not Gustilo 1". He did not consider that Mrs B's injury necessitated immediate referral to a specialist centre such as MH according to his interpretation of the Standards. He said that "Gustilo 1and 2 injuries such as that suffered by Mrs B were "quite common". He did not agree with Mrs B that her injury was a grade 3B under the Gustilo system. He explained:

> "The injury produced a crush fracture on the lateral side of the ankle and an avulsion[5] fracture on the medial side (where the wound was). The stresses applied to the periosteum medially were in tension and tending to compress the periosteum onto the underlying bone. The mechanism would not allow for the periosteum to be stripped up off the bone and extensive periosteal stripping is therefore most unlikely on the bass of the injury pattern."

30. In that context, my Adviser said that there was no further reference to periosteal stripping after 16 July 2011. He explained that the reference on that date was by the most junior member of the team. In addition, he stated that it is difficult to determine the extent of periosteal stripping prior to surgery.

31. My Adviser did not agree with Mrs B about the history that Hospital staff recorded about her accident. He considered it "sufficiently comprehensive".

32. My Adviser maintained that staff did not fail to recognise the severity of the injury from the mechanical standpoint. However, he was critical of what he described as, "a failure to recognise, or at least act upon, the unusual

[5] Where a part of the bone tears away.

nature of the likely contamination". He explained that the initial choice of antibiotics was "not unreasonable for typical compound fractures". He added:

> "This however was an untypical situation with the wound likely to be contaminated with aquatic organisms and I would expect specialist advice to be sought from a microbiologist."

33. My Adviser stated that the Consultant recognised that there was the possibility of marine contamination and that an aggressive antibiotic regime was appropriate. However, he said that this did not lead to a change in the initial prescription or the acquisition of microbiological advice. He stated that there was no record of early microbiological advice or indication that it had been provided. My Adviser said that this advice should have been in place on 16 or "at the latest" 17 July.

34. My Adviser said that once the Hospital identified the nature of the infection on 25 July, Mrs B should have been referred to a specialist centre.

35. My Adviser was also critical of aspects of the Hospital's approach to planning surgery in Mrs B's case. He said that:

> "It is generally recognised that the single most important factor in the treatment of a compound fracture is the thoroughness of the removal of all the contamination at the time of the primary surgery. This, in turn, is highly dependent on the seniority and experience of the surgeon. It is clear from subsequent events that not all contamination was removed. Even the best and most experienced surgeon will only be able to reduce the risk of infection and the development of an infection is not therefore definitive evidence of inadequate surgery. The delegation of such surgery to unsupervised juniors should only happen when the responsible consultant is completely happy that the junior can offer the same standard of surgery as a consultant (i.e. when the junior is ready, with regard to that aspect of their training to take up a consultant post)."

36. My Adviser added that there is no record in the medical notes to demonstrate that the Consultant discussed management before the operation

with his junior colleague. He explained that bearing in mind the chosen method of fixing the wound was the "highest risk option" (fixing both sides of the ankle without using an external fixator), the Consultant should have ensured that liaison with his junior colleague was recorded. However, he did not conclude, bearing in mind the apparent experience of the junior surgeon, that the Consultant should have necessarily been present at the procedure.

37. My Adviser noted that it was also a junior surgeon who carried out surgery on 20 July. Although my Adviser accepted that Mrs B's operation was at the end of the list of patients due to a risk of infection to subsequent patients, he questioned the approach. He stated:

> "…this was likely to be a difficult procedure and the decision to delegate it to a junior doctor…in the middle of the night is potentially unsound (depending on the level of skill and experience of the junior surgeon)."

Despite this, he stated that it was not obviously remiss to delegate this procedure to that junior surgeon as he also had substantial experience.

38. My Adviser said that he did not agree with Mrs B about the alleged failure to close the wound. He said that the wound was closed at the initial procedure.

39. My Adviser summarised his analysis:

> "Although I do not agree that [Mrs B] should have been immediately transferred to MH, her initial treatment fell short with regard to antibiotic treatment…Once the infection had been recognised, it would have been wiser to seek an early transfer to [MH]. The outcome for compound fractures is always uncertain and one can never be sure what would have happened with optimal treatment – especially in the presence of contamination with an atypical bacterium. On balance, I would have expected the wounds to have healed and the fracture united."

Analysis and conclusions

40. Mrs B suffered a horrific injury and a traumatic period of recovery, ending in a damaging life changing procedure. Based on the analysis from my Adviser, I do not agree with all of Mrs B's criticisms of the Hospital. Nevertheless, although Mrs B's injury presented challenges to the Hospital, I find that the care provided fell short of an acceptable standard. Furthermore, the failings might have contributed to the sad outcome. I will explain these findings below, which have been largely based on the submission of my Adviser.

41. I consider that there were three important aspects of Mrs B's treatment that fell short of reasonable care. First, the Hospital should have sought microbiological advice by the second day of her admission at the latest. There might have been unrecorded conversations and there were swabs taken. However, there should have been pro-active action taken to minimise the chances that marine based contaminants could cause serious infection. In the event, although normally adequate antibiotics were used, these were not specific and did not relate to the nature of the injury.

42. My second misgiving, concerns junior surgeons carrying out vital procedures, without direct support or evidence of significant input from the Consultant. I am prepared to accept that the Junior Surgeon, who operated on 16 July, was sufficiently experienced to perform that role. However, there still should have been evidence of discussion with the Consultant prior to surgery. With regard to the procedure in the early hours of 20 July, the Junior Surgeon was less experienced. I accept my Adviser's comments that the situation might have been unsatisfactory.

43. My Adviser did not consider that immediate referral to MH was necessary at the time of Mrs B's admission. However, he said that it would have been appropriate around 19 July when an infection was in evidence.

44. This was eight days before the Hospital made that referral. It seems that the Consultant accepts this.

45. Whilst I have not agreed with all the points made by Mrs B, the criticisms I have made are crucial. They undermine the antibiotic regime,

create doubts about the vital debridement and early fixation process and throw into question the merits of her treatment from 19-27 July, when she should have been at MH.

46. I cannot say whether any of these areas of concern led to Mrs B losing part of her leg. However, the combination of factors leads me to conclude, as informed by my Adviser, that it is likely that failures in care contributed to it. Mrs B will have to live with her disability for the rest of her life. Moreover, she will have to cope with the uncertainty about whether it could have been prevented. That is a major injustice. I **uphold** the complaint.

Recommendations

47. I recommend that within one month of the date of this report or later where specified, the Health Board:

A. sends Mrs B an apology from the Chief Executive for the injustice I have outlined above

B. pays Mrs B £3000 as an acknowledgement of the uncertainty that surrounds the outcome of her injury

C. pays Mrs B £250 for her time and trouble in pursuing this complaint

D. within two months, ensures that medical staff within the relevant team liaise and record the interaction with microbiological staff to learn lessons that may help to minimise the chances of an equally unfavourable outcome in future similar cases

E. invites a senior and appropriate colleague in MH to liaise with relevant staff in the Hospital to ensure that they are clear about when to refer patients to the specialist centre

F. reminds the Consultant about the need for records to be kept that fully reflect events

G. reminds its Consultant Surgeons that when delegating to junior colleagues procedures to be performed without direct supervision, there needs to be clarity about the level of competency of the junior surgeon and the advice provided.

48. I am pleased to note that in commenting on the draft of this report the Health Board has agreed to implement these recommendations.

Peter Tyndall
Ombudsman

6 December 2012

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