SPSO decision report

Case: **201404357, Grampian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mr and Mrs C attended the Aberdeen Fertility Centre and were diagnosed with unexplained infertility. They underwent two in vitro fertilisation (IVF) cycles but neither cycle resulted in pregnancy. The board decided not to offer a further IVF cycle, saying that egg donation could be considered. Mr and Mrs C underwent assisted conception treatment privately. This found that Mrs C's ovarian reserve (the capacity of a woman's ovaries to produce healthy eggs) was higher than expected, and that Mr C's sperm had a significant number of antibodies which caused the sperm to stick together. Mrs C raised concerns about aspects of the assisted conception care and treatment provided by the Aberdeen Fertility Centre as well as the nursing care provided. She also raised concerns about the way the board handled their complaint.

We found that the board's actions were reasonable in relation to the provision of assisted conception. However, in light of the new information about the nature of the couple's infertility and Mrs C's ovarian reserve, we recommended that the board consider whether the couple met the board's eligibility criteria (as outlined in their policy) for a third round of IVF treatment. We also found communication and record-keeping failures by nursing staff, particularly around pain assessment and relief. In relation to the board's complaints handling, we found that the board should have told Mrs C about the delays in responding to her complaint, the reasons for the delays, and of her right to approach us in such circumstances.

Recommendations

We recommended that the board:

- consider whether Mr and Mrs C meet the eligibility criteria in the board's policy for a third cycle of assisted conception treatment in light of the new information about the nature of their infertility and Mrs C's ovarian reserve;
- bring the record-keeping and communication failures to the attention of relevant staff and review the process to ensure there is no recurrence;
- apologise for the failures identified in complaints handling and bring them to the attention of relevant staff; and
- apologise for the failures identified.