SPSO decision report



Case: 201909975, Greater Glasgow and Clyde NHS Board - Acute Services Division Clyde NHS Board - Acute Clyde NHS Board - Acute

Sector: Health

Subject: Clinical treatment / diagnosis

Decision: some upheld, recommendations

Summary

C underwent a bowel operation. They were told that scarring from the surgery would affect their ability to start a family in the future. C attended the board's fertility clinic and asked for fertility preservation treatment. This was denied on the basis that this treatment was only being offered to cancer patients at that time. C complained that they were denied access to this treatment, despite it being approved for other patients who had had the same surgery.

Following their surgery, C experienced complications that ultimately led to them developing sepsis and requiring further surgery. C attended their local A&E, but was discharged home after an examination. C complained that they were discharged despite showing clear signs of postoperative complications and infection.

We found that, although C had been advised that fertility preservation treatment was only being considered for cancer patients, this was not the reason that they had been denied access to this treatment. Rather, a National Complex Case group had reviewed C's case and concluded that they would have alternative options for starting a family in the future and that fertility preservation was, therefore, unnecessary. We found that the reasons for the board's decision in this respect was reasonable and did not uphold this aspect of the complaint.

With regard to C's attendance at the A&E, we found that reasonable investigations were carried out to check for infection. There was no obvious sign of infection at that stage. However, we were critical of the board for failing to identify that C was displaying signs of postoperative complications. Staff failed to carry out an abdominal examination. We noted that C should have been urgently referred for follow-up investigations with their surgeon and the board failed to do this. We upheld this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

• Apologise to C for the failings identified in our decision. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

In relation to complaints handling, we recommended:

Share this decision with A&E staff with a view to ensuring that patients describing post-operative
complications like this (where clinical examination does not rule out there being a complication) are
discussed with, or referred to, their surgical teams.

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.