SPSO decision report

Case: **201605344, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mrs C complained to us about a sterilisation procedure she underwent and the events afterwards. Mrs C had chosen to have a procedure to make her sterile which involves putting devices (called Essure devices) in the fallopian tubes to block them. When Mrs C had the procedure, she became faint and therefore the procedure was stopped. Mrs C complained that she was told that one of the devices had not been placed and therefore she was not sterile. She said that due to how distressing she had found the procedure, she did not want to undergo it again to have the second device placed, and therefore she was told her only option was to have her fallopian tubes completely removed. Mrs C had this operation and afterwards was told that in fact both devices had been in place. Mrs C complained that the board did not investigate whether both devices had deployed, and that they did not reasonably communicate with her about the deployment of the devices.

During our investigation, we took independent gynaecological advice. We found that whilst the original mistake in thinking that one device had not deployed was not necessarily unreasonable, the consultants involved should have acknowledged that they could not be sure and should have offered Mrs C a scan before she underwent further treatment. We also found that whilst the records from the time of the original procedure were written as if the consultants were sure that one device had not deployed, the board's complaint response to Mrs C said that they had been unsure. We considered that due to the incorrect assumption at the time of the procedure that one device had not deployed, Mrs C underwent a potentially unnecessary operation to remove her fallopian tubes. We upheld this complaint.

Mrs C also complained that several months after she underwent the operation to remove her fallopian tubes, she developed a severe infection. She felt that this was due to poor post-operative care. However, we found that there was no evidence to suggest that the post-operative care she received was unreasonable or that the infection she developed was due to the operation. Therefore, we did not uphold this aspect of Mrs C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for failing to investigate whether both devices had deployed, and for failing to communicate with her reasonably regarding the deployment of the devices.

What we said should change to put things right in future:

- Consultants should be aware of the possibility of being mistaken about non-deployment of Essure devices.
- Patients who have undergone Essure device placement should be offered a scan before deciding on further treatment, and this should be documented in the medical records.

In relation to complaints handling, we recommended:

- Complaint responses should be based on the contemporaneous records.

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.