SPSO decision report

Case: **201500190, Tayside NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mrs C was referred to Perth Royal Infirmary due to a missing intrauterine system (IUS - a contraceptive device). A scan showed the IUS could be in her abdomen, but she was then found to be pregnant, so no x-ray could be done to confirm the exact location. The pregnancy was not viable and a medical miscarriage was performed. Mrs C was discharged after this without an x-ray to locate the missing IUS. Her GP arranged an x-ray, which showed the IUS was in her abdomen, and she was referred to gynaecology for surgery to locate and remove it. Mrs C raised concerns about the failure to x-ray her after the medical miscarriage, and about her surgery (which was more complex than expected). Mrs C said she was told an x-ray would be taken before the surgery to confirm the exact location of the IUS, and she queried why this did not happen. Mrs C also complained about delays in her gynaecology appointment and in the board's response to her complaint.

The board agreed Mrs C should have been x-rayed after her medical miscarriage and they apologised for this. They said the delay in gynaecology appointments was due to increased demand, and they were taking action to improve this. However, they considered the surgery was carried out appropriately.

After taking independent medical advice, we upheld Mrs C's complaints. We agreed the board should have x-rayed Mrs C earlier, and we found unreasonable delays in arranging the gynaecology appointment. However, we found that the surgery was carried out reasonably. The adviser explained that x-rays are not normally used to confirm the location of an IUS before surgery, as an x-ray cannot show the exact location (in three dimensions) and the position of the IUS can also change during the surgery as the patient is moved. We found the delay in responding to Mrs C's complaint was unreasonable, as the bulk of the delay (over five weeks) was caused by a delay in the draft response being signed off, rather than the investigation itself.

Recommendations

We recommended that the board:

- demonstrate to us the steps being taken to ensure the national standards for waiting times for gynaecology can be met;
- apologise to Mrs C for the failings we found; and
- review their processes for clearing draft complaint letters, to ensure this does not cause undue delay.