SPSO decision report

Case: **201607186, Grampian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mr C complained about the care his wife (Mrs A) received at Aberdeen Maternity Hospital after she became unwell following delivery of their child by caesarean section. Three days after the procedure, Mrs A required emergency surgery for a perforated bowel, resulting in a temporary ileostomy (where an opening is made in the abdomen to allow waste to pass out of the body) and further surgery to reverse this, which caused her a difficult and protracted recovery period. Mr C raised concern that they had been told by a doctor that the complications had arisen because the bowel had been accidently stitched to the caesarean section wound.

We took independent advice from a consultant obstetrician and a consultant general surgeon. We found that the consent form Mrs A signed, with the assistance of a doctor, agreeing to the caesarean section was not fully completed and did not warn her of the rare but recognised risk of bowel injury, which we were critical of. We also considered that it was likely that the bowel had been caught at the time of stitching, which meant that it was unlikely an adequate check of the wound was carried out by a second doctor at the time of the procedure. We upheld the complaint and made a number of recommendations to address these failings.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs A for the failings identified in relation to the consent process and her caesarean section. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

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

- Patients undergoing an elective caesarean section should be fully informed of the possible complication and risk of bowel injury and give clear, informed consent.
- All relevant sections on the consent form should be fully completed.
- The doctor who performed the surgery should reflect on the clinical incident at their appraisal to identify any training needs to ensure the matter does not recur.

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.