Scottish Parliament Region: Mid Scotland and Fife

Case 200500831: Fife NHS Board

Summary

Category: Health, Hospital, Maternity

Subject and conclusions:

(a) time taken to give diagnosis *(upheld)*
(b) delay in admission to hospital *(upheld)*
(c) inadequate care after admission (*partly upheld)*
(d) failure to interpret tracings and failure to send for medical assistance appropriately *(upheld)*
(e) delay in giving antibiotics *(upheld)*
(f) delay in performing Caesarean section *(upheld)*
(g) lack of information and action following complaint *(upheld)*

Recommendations:

The Ombudsman recommends that the Board provide further information, ensure special instructions are prominently displayed, strengthen midwifery management and adopt a more robust and structured approach to adverse incidents and the staff involved. The Board have accepted the recommendations and will act on them accordingly.

Overview: The complainant raised a number of issues regarding her treatment and care following the stillbirth of her son.

Introduction

1. On 1 July 2005 the Ombudsman received a complaint about the care and treatment provided to the complainant from (Mrs C) by Fife NHS Board (the Board) both prior to and following the stillbirth of her son (L) on 15 September 2002.

2. Mrs C complained that she received unsatisfactory care from the Board and that the night midwife made major mistakes. Mrs C applied for Independent

Review of her complaint. The Convener originally allowed her request but changed his mind after he sought independent advice. Mrs C then complained to the Ombudsman.

3. The complaints from Mrs C which I have investigated are:

(a) time taken to give Mrs C the diagnosis of Group B Streptococcus (GBS) *(upheld, see paragraphs 12 to 13)*;

(b) delay in admitting Mrs C to hospital *(upheld, see paragraphs 19 to 20);*

(c) the night midwife's care and attention to Mrs C after admission was inadequate *(partly upheld, see paragraphs 25 to 31)* ;

(d) the night midwife failed to interpret tracings accurately and failed to send for medical assistance appropriately *(upheld, see paragraphs 37 to 41)*;

(e) delay in giving Mrs C antibiotics *(upheld, see paragraphs 47 to 49)*;

(f) delay in performing Caesarean section *(upheld, see paragraphs 54 to 56)*;

(g) lack of information and action following Mrs C's complaint *(upheld, see paragraphs 60 to 63)*.

4. The Ombudsman makes the following specific recommendations; that the Board should:

i. provide more information to Mrs C about what happened and what action the Board have taken to prevent it happening again;

ii. ensure that special instructions on labour ward notes are more prominently displayed and that further training is considered;

iii. ensure that the Board strengthen midwifery management and adopt a more robust and structured approach to adverse incidents and the staff involved.

5. The Board have accepted the recommendations.

Investigation and findings of fact

6. In writing this report I have had access to:

- the complaint and documents provided by Mrs C;
- Mrs C's clinical records covering the period of the complaint;
- the complaints correspondence from the Board;

Relevant documents used in the preparation of this report were:

- NHS Scotland A *Framework for Maternity Services in Scotland*;
- The Nursing and Midwifery Council *Midwifery Rules and Standards.*

7. I have obtained and accepted advice from Independent Professional Advisers on both the midwifery and obstetric aspects of this complaint.

8. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Board have been given the opportunity to comment on the draft of the Report.

(a) Time taken to give Mrs C the diagnosis of Group B Streptococcus (GBS)

9. Mrs C complained to the Board that, on 18 August 2002, she had been diagnosed with a heavy growth of GBS but that she was not notified of this or treated until 4 September 2002 when she received a course of penicillin. Mrs C asked why it had taken so long for her to be informed.

10. This complaint was not dealt with in the initial response from the Board, as it was not raised as a complaint until 25 March 2003. The Acting Chief Executive

subsequently wrote to Mrs C. He confirmed that Mrs C had attended the hospital on 18 August 2002 with possible spontaneous rupture of membranes. The examination had shown no evidence to support this but a high vaginal swab had been taken which showed a heavy growth of GBS. He said that GBS infections are not normally treated during pregnancy, unless causing symptoms, as the evidence suggests this does little good. Instead, mothers are normally given intravenous antibiotics during labour, as it is normally after delivery that the baby can get into difficulty if the organism is not known about.

11. In Mrs C's case, however, the Consultant Obstetrician had felt it wiser to treat the infection with a course of antibiotics and he dictated a letter to Mrs C on 20 August 2002 to ask her to contact her GP for a prescription. Unfortunately, that letter was not typed until 29 August 2002. The Acting Chief Executive said he had commissioned a review of how information is communicated to GPs to prevent delays occurring.

(a) Time taken to give Mrs C the diagnosis of Group B Streptococcus (GBS): Conclusion

12. The adviser considered that the delay made no clinical difference to the outcome, as ante-natal prophylaxis with oral penicillin does not reduce the likelihood of GBS colonisation at the time of delivery. He agreed, however, that there was an unacceptable delay between dictating and typing the letter. I therefore uphold this complaint.

13. I note that the Acting Chief Executive said he had commissioned a review of how information is communicated to GPs to prevent delays occurring but there is no evidence that he told Mrs C the results of the review or what has been done to ensure that this situation does not recur. The Ombudsman recommends that the Chief Executive does so and asks that a copy of that letter is sent to her. The Board have accepted this recommendation.

(b) Delay in admitting Mrs C to hospital

14. On 14 September 2002 Mrs C was admitted to the hospital, following referral by her GP for high blood pressure and oedema. She was later allowed to return home on condition that she returned immediately if she felt unwell in any way. Her contractions started in the early hours of the following day and her waters broke at

about 03:20 hours. Mrs C telephoned the labour ward and explained her history and symptoms but she was told to have a bath and call back later. Mrs C says that when she did this she was told 'that was a very quick bath' and that the ambulance would be with her within the hour. Mrs C asked why she was not considered to be an emergency.

15. Two telephone calls are noted in the records. The first is at 04:10 hours. Under advice given it says 'Come to Forth Park. Has no transport. Will have a bath and phone back when ready to come'. The second, at 04:35 hours, says 'staining from the vagina now watery, to come in 04:38 ambulance ordered'.

16. The ambulance was ordered for 'within one hour'. Mrs C was admitted at 05:30 hours.

17. In her response to Mrs C on 18 March 2003, the Director of Nursing said that, given Mrs C's history and the stage of her pregnancy, the midwife who dealt with her call should have arranged for Mrs C to come immediately to the hospital. She apologised for the delay and for the distress caused to Mrs C as a result. The Board had reviewed the telephone advice documentation and it had been amended to include women with suspected premature labour, as this had not previously been included in the documentation.

18. Mrs C asked for evidence that this change had been implemented. The Acting Chief Executive sent her a copy of the new telephone advice documentation, which now stated that women under 37 weeks in premature labour should make their way straight to the Obstetric Unit.

(b) Delay in admitting Mrs C to hospital: Conclusion

19. There is a discrepancy between the recollections of Mrs C and the person who took the calls. In the absence of further evidence, it is not possible to resolve this. The Board have accepted, however, that in view of Mrs C's history she should have been told to come into hospital when she first called. This advice should have been clearly documented, regardless of whose idea it was that Mrs C should have a bath first. That did not happen. When Mrs C first called she should have been discouraged from taking a bath and arrangements should have been made for the ambulance at that time. I uphold this complaint.

20. The Board have reviewed the telephone advice documentation and it has been amended to include women with suspected premature labour. I am, therefore, satisfied that the Board have taken appropriate action to prevent this situation arising again and the Ombudsman makes no recommendation on this complaint.

(c) The night midwife's care and attention to Mrs C after admission was inadequate

21. Mrs C said that her treatment on admission had been degrading and traumatic. She complained that the night midwife had not stayed with her. Mrs C also complained that she was left uncovered for an unacceptable length of time after the monitor was attached and was asked to give a urine sample in a container that was not sterile or appropriate.

22. The Director of Nursing said that the night midwife had been unable to stay in the room with Mrs C all the time because she had other duties to deal with. The night midwife believed that she had been attentive to Mrs C's needs but wished to apologise for the distress felt by Mrs C.

23. In her response to the complaint, the night midwife said that she still had notes from a previous delivery to complete and so had found it impossible to remain constantly with Mrs C.

24. The Manager of Clinical Midwifery and Nursing Services agreed, in her letter of 18 March 2003, that it was unacceptable for Mrs C to have been left uncovered unnecessarily and that this should not have happened. She apologised unreservedly for the embarrassment caused to Mrs C. She also explained that it would be standard practice to use the type of container in which Mrs C was asked to provide a urine sample. The Acting Chief Executive explained that the Board now provide a different type of container which they hope patients will find more appropriate.

(c) The night midwife's care and attention to Mrs C after admission was inadequate: Conclusion

25. The adviser said that Mrs C was admitted in premature labour with premature

rupture of membranes, a history of GBS and temporarily raised blood pressure and was, therefore, at risk. The night midwife's professional responsibility was to Mrs C and notes should not have taken precedence over that responsibility.

26. Principle 10 of *Framework for Maternity Services in Scotland* states:

> 'One to one midwifery care should be given to women during labour and childbirth in order to make sure they have individualised attention and support preferably with continuity of care'.

27. In response to the draft report, the Board acknowledged that *Framework for Maternity Services in Scotland* sets out principles and practice for a modern, responsive and effective service. Following publication of this document, the Board set up an Expert Working Group on Acute Maternity Services to examine how the Board should apply these principles to their maternity services during childbirth. The Group produced a report in December 2002 and the Board are working towards the implementation of the principles.

28. The Board had not implemented the principles in *Framework for Maternity Services in Scotland* at the time of Mrs C's confinement. The clinical advice which I have received is, however, clear. The midwife should have recognised in terms of her professional responsibility that her duty was to Mrs C. I uphold this complaint.

29. I note that clinical care is part of the refresher training provided to the midwife who is the subject of this complaint. Communication training is also to be provided to all staff on an annual basis. I am satisfied that the Board have taken appropriate action in regard to this complaint and the Ombudsman has no further recommendations.

30. Although Mrs C felt that she was left uncovered for too long, there is no evidence to indicate for how long she was uncovered. In the absence of such evidence it is not possible to resolve this. I do not uphold this complaint. However, I am pleased to note that the Manager of Clinical Midwifery and Nursing Services apologised for the embarrassment caused to Mrs C. I also note that the Board

have undertaken work with the night midwife to improve her patient care skills. I am satisfied that this has addressed any shortcomings.

31. Mrs C complained that the container she was given was not sterile but the night midwife said that she gave Mrs C a sterile container. There is some confusion here, as the container did not in fact need to be sterile for the purpose for which it was required. I note that Mrs C felt that the type of container was inappropriate but it was clearly what was in normal use at the time. I do not uphold this complaint. I note, however, that the Board now use containers which they hope patients will find more acceptable.

(d) The night midwife failed to interpret tracings accurately and failed to send for medical assistance appropriately

32. Mrs C said that the monitor was not attached correctly and the discs flipped up repeatedly. She said that the night midwife failed to interpret the tracings accurately and failed to send for medical assistance appropriately.

33. The night midwife started cardiotocograph (CTG) monitoring at 05:55 hours on 15 September 2002. The night midwife said that there were some difficulties in keeping the discs in place. A Senior House Officer (SHO) was called at 07:00 hours to administer antibiotics but was not asked to look at the CTG trace.

34. At 07:20 hours, Mrs C's care transferred to the day shift. At 07:40 hours, the day midwife who was now monitoring the CTG trace was concerned at the readings and contacted the duty Obstetric Registrar. The Obstetric Registrar was sufficiently concerned to contact the Consultant. It was agreed to proceed to an emergency Caesarean section but sadly baby L was delivered stillborn at 08:42 hours.

35. The Consultant said that the CTG tracings should have alerted staff earlier to the level of foetal distress. The night midwife has acknowledged that she missed the abnormality of the trace but could not explain why.

36. The Consultant Obstetrician who advised the Independent Panel Convener said in his report:

> ‘The trace began at 05.56. From that time onwards there was very little beat to beat variability giving the 'flat' trace associated with a 'stressed' baby.’

(d) The night midwife failed to interpret tracings accurately and failed to send for medical assistance appropriately: Conclusion

37. The adviser noted the comments about the difficulty of keeping the equipment in place but said that the tracings on the file are of an adequate technical quality throughout. This problem would not, therefore, have affected a member of staff’s ability to interpret the tracings.

38. The adviser said that the trace was very abnormal from the start. The night midwife should, therefore, have recognised this at the outset and should have called an obstetrician to review it. The adviser said that earlier delivery, which was clinically indicated, would have given L some chance; delay gave him no chance. The night midwife commenced the trace and it was her responsibility to read it and recognise the abnormality. In not doing so, she failed in her duty of care to Mrs C and her baby. I uphold this complaint.

39. I have considered carefully what, if any, recommendation the Ombudsman should make in the light of that conclusion. I have done so bearing in mind that there is a clear statutory framework for the regulation of midwifery. The Nursing and Midwifery Council (NMC) are required to establish and maintain a register of qualified nurses and midwives and, from time to time, establish standards of proficiency to be met by applicants to different parts of the register. The NMC also set rules and standards for midwifery and for the Local Supervising Authorities (which in Scotland are Health Boards) responsible for the function of statutory supervision of midwives.

40. I have seen that the Board recognised that the night midwife’s failure to interpret and take action on the CTG was a serious error. Her managers properly sought advice from the human resources department about what action should be taken. The decision reached was that the appropriate way forward was to provide counselling and professional development. Such action means that an experienced midwife can continue to practice (with support) until such time as her management team’s confidence in her abilities is restored and confirmed. By contrast, a midwife who is suspended would remain free to practice elsewhere.

Similarly, giving a formal written warning to a midwife would not, in itself, contribute to improvements in practice.

41. The adviser said that a period of supervised practice was appropriate in this case; commented favourably on the quality of the training package purchased and implemented; and noted that information provided by the Board suggested that it had been effective. Taking account of that advice, while recognising the seriousness of the night midwife's failure, the Ombudsman has no recommendations to make with regard to this complaint.

(e) Delay in giving Mrs C antibiotics

42. Mrs C said that it clearly stated on her notes that she had GBS which required antibiotics during labour. However the night midwife failed to ensure that Mrs C received these at the appropriate time.

43. In the initial response to the complaint, the Consultant accepted that, because Mrs C was a known carrier of GBS, antibiotics should have been administered on admission because her membranes had ruptured.

44. In a further response, the Acting Chief Executive sought the opinion of a Consultant Paediatrician and Neonatologist, who reviewed the circumstances surrounding L's birth. His clinical opinion was that L was already severely infected when Mrs C was admitted to hospital. He said it was unlikely that a delay of two to three hours in giving the antibiotics would have affected the outcome.

45. The SHO covering night duty that night said that she was called at 07:00 hours to put in a venflon and give antibiotics, as suggested in the protocol for known GBS carriers.

46. The Director of Nursing said that the delay in the prescription of intravenous antibiotics had not been adequately explained. This was confirmed in the report on the investigation of the complaint.

(e) Delay in giving Mrs C antibiotics: Conclusion

47. The adviser said that the antibiotics were given too late. They should ideally have been given two hours before delivery. It was the night midwife's responsibility

to arrange that as a matter of priority on admission. The adviser pointed out that even if antibiotics had been given earlier it is unlikely that this would have affected the outcome as it was immediate delivery of the baby that was required. Whether the delay in administering antibiotics would have made any difference to the outcome, however, does not alter the night midwife's failure of duty of care. I uphold this complaint.

48. The Board reviewed their protocol on GBS in May 2005 and sent me a copy. The adviser and I have read this and I am satisfied that the Board have taken appropriate action in this regard.

49. In the draft report, I adopted the adviser's suggestion that the hospital's labour ward notes should have a box for special instructions, such as antibiotics, and recommended that such information be recorded as a strong distinguishing feature on the front of the file. The Board explained that there is a designated area on the file for special problems and a sticky label is now in use to highlight these. They provided a sample of highly visible bright yellow *alert* labels. I note, however, that the space for the labels appears to be on the second page rather than on the front of the record where they would be more easily seen on picking them up. The Ombudsman recommends that the Board consider putting the labels on the front page and asks that they inform her of the result of this consideration.

(f) Delay in performing Caesarean section

50. Mrs C complained that, after the decision was taken to deliver the baby by Caesarean section, time was wasted in trying to give her a spinal anaesthetic.

51. Mrs C raised this issue in her letter of 25 March 2003. In his letter of 11 September 2003, the Acting Chief Executive explained that a spinal anaesthetic is much safer for the mother than a general anaesthetic. He said that it is standard practice in Britain to attempt a spinal anaesthetic first for an emergency Caesarean section, only resorting to a general anaesthetic if there is difficulty or delay in achieving a satisfactory anaesthetic block. He had asked a Consultant Anaesthetist for comments and he said that there were a number of increased possible risks to the mother from general anaesthetic. It would, therefore, be regarded as standard practice for the anaesthetist to attempt a spinal anaesthetic in the first instance.

52. The Clinical Event Investigation Report identified that the Registrar had failed to answer his bleep at 07:25 hours and had attended Mrs C at 07:45 hours. The Registrar was subsequently counselled about the need for urgency.

53. The 'decision to incision' time was 51 minutes. This is outwith the 30 minutes recommended in a Report published in 2001 by the Royal College of Obstetricians and Gynaecologists (*Why Mothers Die - Report on Confidential Enquiries into Maternal Deaths in the United Kingdom 1997-1999*). That Report is accepted by the Expert Group on Acute Maternity Services as an audit standard for response to emergencies within maternity services. (*Expert Group on Acute Maternity Services Reference Report* 2002: Scottish Executive Health Department).

(f) Delay in performing Caesarean section: Conclusion

54. The adviser said that by the time the Caesarean section was actually carried out it was too late to affect the outcome, no matter how quickly it was done after the decision to operate was made. It might have given baby L a chance if done soon after admission when he was very ill but still alive. Whether or not this would have affected the outcome, however, the time that elapsed between the decision to operate and the first incision clearly exceeded the 30 minutes recommended. I uphold this complaint.

55. The Board can provide no explanation for the target time being exceeded in this case. I recommended that the Board undertake an audit of performance against the service standard of 30 minutes and that the results and any intended action following the audit are sent to the Ombudsman.

56. The Board accepted the recommendation.

(g) Lack of information and action following Mrs C's complaint

57. Mrs C complained that she had been given contradictory explanations when she complained and, although she had been told that the night midwife had been dealt with, she had received no adequate explanation of what this meant. In her letter of 24 September 2003 Mrs C said:

> 'We are not unreasonable people. We want to know why we did not receive

> the care and medical attention that [L] and I so desperately needed. To say that the [night] midwife has been dealt with means nothing to us. Did she get a telling off? What does re-training involve? While she is re-training is she still allowed to deliver babies? What does 'dealt with' mean?'

58. Throughout the investigation, Mrs C said that she felt that she was being treated as either stupid or a liar, when she believed that in fact her complaint was entirely justified and she was entitled to a proper explanation of the steps that had been taken.

59. I have reviewed the relevant correspondence. I found that Mrs C received no details of any action taken.

(g) Lack of information and action following Mrs C's complaint: Conclusion

60. The adviser said that the night midwife's failures were recognised and acknowledged. There is evidence to show that attempts were made to improve staff training.

61. Explaining action taken to prevent a problem happening again is an important part of responding to a complaint. There is no evidence that the Board made an adequate attempt to explain to Mrs C the actions they had taken. Mrs C hoped and planned to have more children and would be returning to that hospital for care. the Board should have recognised that she would, therefore, find it particularly important to understand what had changed as a result of her complaint. They failed to do so. I uphold this complaint.

62. The Board have explained to me what they have done to prevent recurrence of failures identified in this report. In particular, they explained the action they have taken to supervise and support the night midwife who failed to interpret the CTG tracings. The adviser is satisfied with what they have done. The Ombudsman recommends that the Board explain this as fully as possible to Mrs C and send a copy of the explanation to the Ombudsman.

63. I also recommended that the Board formally apologise to Mrs C for the significant medical errors that I identified in the report.

Further action

64. As noted in paragraph 5, the Board have accepted the Ombudsman's recommendations and will act on them accordingly. The Ombudsman asks the Board to notify her when and how the recommendations are implemented.

Further issues

65. In the draft report, I identified a clear need for a Scotland-wide Unified Maternity Record, such as the initiative launched by the Scottish Executive and NHS Quality Improvement Scotland. This is referred to as the Scottish Woman Held Maternity Record (SWHMR). Principle 27 of the 'Framework for Maternity Services in Scotland' states:

> 'There should be a national unified and standardised woman-held maternity record that is available and accessible to both women and professionals.'

66. The Board anticipate adopting the National Unified Woman-held Maternity Record in November 2006. I am, therefore, satisfied that the Board intend to take appropriate action in this regard and the Ombudsman asks the Board to inform her when this has been done.

67. Mrs C also complained to the Ombudsman that the Funeral Directors contracted by the Board initially refused to take baby L to Edinburgh for post mortem. This caused Mrs C and her husband a huge amount of distress.

68. This complaint was not made directly to the Board when Mrs C first complained to them. It was raised in her letter requesting Independent Review of her complaint to the Board. I have not, therefore, investigated this complaint. the Board have, however, told me that they will clarify their position in respect of arrangements for dealing with bereavement and offer an apology to Mr and Mrs C for the additional concern caused to them. I commend the Board for this.

27 June 2006

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
L	The complainant's baby son
GBS	Group B Streptococcus
CTG	Cardiotocograph
SHO	The Senior House Officer who was called at 07:00 hours on 15 September 2002
LSA	Local Supervising Authority
SWHMR	Scottish Woman Held Maternity Record

Annex 2

Glossary of medical terms

Group B Streptococcus (GBS)	An infection that causes neonatal sepsis.
Prophylaxis	Preventive treatment
Colonisation	The multiplication of a microorganism after it has attached to host tissues
Oedema	The presence of abnormally large amounts of fluid in the body
Cardiotocograph (CTG)	Monitoring of foetal heart frequency before birth