**Scottish Parliament Region: Central Scotland**

**Case 200800763: Lanarkshire NHS Board**

**Summary of Investigation**

***Category***

Health: Hospital; gynaecology and obstetrics (maternity); clinical treatment and diagnosis

***Overview***

The complainants (Mr C and his partner Ms C) were unhappy about the care provided to Ms C during her pregnancy by Lanarkshire NHS Board (the Board). Sadly, Mr and Ms C's daughter (Baby A) was stillborn on 21 October 2007. Mr and Ms C considered a number of warning signs had been missed and, in particular, a scan at 36 weeks which showed the umbilical cord near Baby A's neck should have been followed up. They also complained about the postnatal care provided and that the response to their complaint was not adequate.

***Specific complaints and conclusions***

The complaints which have been investigated are that:

(a) the care and treatment provided to Ms C during her pregnancy was inadequate (*upheld*);

(b) there were failings to ensure appropriate support was provided following the death of Baby A (*upheld*); and

(c) the response to Mr and Ms C's complaint was not adequate (*partially upheld, to the extent that full information was not provided at the time of Mr and Ms C's complaint*).

***Redress and recommendations***

The Ombudsman recommends that the Board:

(i) reassess the training provided to midwives on cardiotocographs, given the failure to recognise, record or follow up the deceleration correctly;

(ii) review the use and purpose of the Board's telephone call records, given the failure to complete any record on 18 October 2007 and the presence on file of a badly completed record;

(iii) apologise to Mr and Ms C for failing to recognise, record and respond appropriately to the deceleration;

(iv) review their standard care pathway for bereaved parents, in light of the concerns raised in this report and the best practice examples elsewhere in NHS Scotland, and ensure that parents are given timely advice about counselling;

(v) review the supervision arrangements for their ante-natal clinics taking into account the advice received in paragraph 17 and inform the Ombudsman of action taken as a result of this review;

(vi) apologise to Mr and Ms C for failing to communicate with their GP, in line with their procedures, and for the time taken to provide them with information about counselling; and

(vii) when responding to complaints, take into account the need to provide as full information as possible, particularly where interviews have been held with staff.

## Main Investigation Report

### Introduction

1. Ms C's pregnancy was confirmed by her GP on 18 February 2007. Following this, for the duration of her pregnancy, Ms C attended appointments with both midwives and medical staff employed by Lanarkshire NHS Board (the Board). Her estimated date for delivery of the baby was 22 October 2007.

2. Ms C had ultrasound scans provided by the Board on 2 April and 26 June 2007. She also attended for a cardiotocograph (CTG) on 18 September 2007 and on 28 September informed clinical staff that a private ultrasound had shown nuchal cord, ie, that the umbilical cord was close to or around the neck. Ms C said she spoke to a midwife and a doctor (Doctor 1) but they advised her this was a common finding and not of concern. Ms C contacted a midwife on 18 October 2007, saying that she was experiencing pain close to her ribs and other symptoms (see paragraph 13). She said she was informed that this was a sign of early labour. Ms C was admitted to Wishaw General Hospital (the Hospital) on 20 October 2007. A fetal heart rate was not located and sadly, Mr and Ms C's daughter (Baby A) was stillborn on 21 October 2007. Following a post-mortem, the cause of death was given as asphyxia due to compression of the umbilical cord.

3. Mr and Ms C complained to the Board about aspects of Ms C's care and undertook their own review of the care, including contacting external experts. The Board met with Mr and Ms C on 20 December 2007, 7 February and 4 April 2008. During the meeting on 7 February, the Board proposed that one of their internal seminars should look in detail at umbilical cord accidents. They later declined Mr and Ms C's requests that they or an overseas doctor with whom Mr and Ms C had been in contact (Doctor 2) should be allowed to attend.

4. Mr and Ms C remained unhappy with the Board's response to their concerns and complained to the Ombudsman. As well as raising concerns about the clinical aspects of the care received, they said they were unhappy about the support provided to them following Baby A's death. They said their GP had been unaware of Baby A's stillbirth when they attended for their first appointment with the GP following the stillbirth; counselling was not offered to them; and they felt that the response to their complaint had been inadequate.

5. The complaints from Mr and Ms C which I have investigated are that:

(a) the care and treatment provided to Ms C during her pregnancy was inadequate;
(b) there were failings to ensure appropriate support was provided following the death of Baby A; and
(c) the response to Mr and Ms C's complaint was not adequate.

**Investigation**

6. The investigation of this complaint involved obtaining all the background documentation relating to the complaint and Ms C's medical records. Advice was also obtained from medical and midwifery advisers (Adviser 1 and Adviser 2, respectively) to the Ombudsman. As a result of the advice, further enquiries were made of the Board. The abbreviations used in the report are explained in Annex 1 and the medical terms used in the report are explained in Annex 2.

7. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mr and Ms C and the Board were given an opportunity to comment on a draft of this report.

**(a) The care and treatment provided to Ms C during her pregnancy was inadequate**

8. Ms C had a positive diagnosis of pregnancy confirmed on 18 February 2007. Her first contact with a midwife at the Hospital was on 20 March 2007. At this appointment she was weighed and a number of other tests were taken.

9. An ultrasound scan was performed at the Hospital on 2 April 2007 and a second scan on 26 June 2007, at which time Ms C was 23 weeks pregnant. Second scans are not routine in the Board area and Ms C said she had been referred for this because there was a history of heart problems in Mr C's family. No abnormalities were noted but the consultant recorded her concerns that this scan had been requested as, in her view, it had not been required. Mr and Ms C said they later had these scans reviewed and nuchal cord was present at the 23-week scan.

10. In August 2007 Ms C reported symptoms of breathlessness and was admitted to the Hospital. Ms C was reassured there was no need for concern.

11. On 18 September 2007, Ms C presented with a history of reduced fetal movements and a CTG was taken. The midwife noted that she had seen no deceleration of the fetal heart rate. (Deceleration refers to a temporary slowing of the fetal heart rate, which can indicate cord compression.)

12. Ms C had a private scan on 28 September 2007, by which time she was 36 weeks pregnant. This showed a cord close to the baby's neck.[1] She was concerned and she said she was advised by a member of staff at the private clinic to discuss this when she attended the NHS clinic that day. When Ms C attended at the clinic she spoke to a midwife and Doctor 1. She said she was assured this was a common finding and further action was not required.

13. Ms C said she then spoke to a different midwife by telephone on 18 October 2007 reporting symptoms of pain close to her ribs, diarrhoea and a slight fever. She said she was told she had the signs of early labour. She was not advised to go in to hospital at that stage. This telephone call was not noted in the clinical records. Following discussion of a draft of this report, the Board supplied notes from an interview with the midwife who took this call. The interview had been held in response to the original complaint made to the Board in November 2007 but was unsigned and undated[2]. The notes of the midwife advised that she only remembered Braxton Hicks[3] being discussed and no reference is made in the note to fever or diarrhoea. She had not had access to Ms C's notes during the call. The midwife considered that Ms C's condition did not require a home visit or for her to attend hospital at that time. Ms C was subsequently admitted to the Hospital on 20 October 2007. A fetal heart rate was not located and Baby A was stillborn on 21 October 2007. Following a post-mortem, the cause of death was given as asphyxia due to compression of the umbilical cord.

14. Mr and Ms C complained to the Board. In the course of the complaint, they examined Ms C's notes and undertook research into stillbirth. In their

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[1] This is the information that was provided by the private clinic to the Board in a letter following Mr and Ms C's complaint to them. The clinical records of the discussion with NHS staff note that Ms C reported a cord had been seen around the neck. The scan results were not viewed by staff.

[2] The Board said that, in July 2009, they had shown the note to the midwife and she had confirmed that this had been taken close to the events described.

[3] Contractions which occur during pregnancy but which are not part of labour – they are sometimes called false labour pains.

complaint to the Ombudsman, they said that they felt warning signs had been missed during the pregnancy: that there was a specific risk of nuchal cord; this included reports of frequent fetal hiccups, visual evidence of nuchal cord in the 23 and 36 week scans and a deceleration of the fetal heart rate. They were concerned that they had not been told the status of Doctor 1 who had reassured Ms C there was no concern and had only found out later that she was of a training grade.

15. They also had a number of concerns about the general standard of care and communication throughout Ms C's pregnancy. They said there had been a failure to monitor Ms C's condition throughout: for example, they noted that Ms C's weight was only recorded twice. They said that critical information was not passed on between staff; advice throughout was inadequate and they also felt that the notes did not fully record all conversations and that the notes may have been altered. For example, they were sure the midwife who recorded the notes of the conversation of 28 September 2007 was not the midwife they had seen that day (see paragraph 12) and they had been certain that Ms C's reports of frequent fetal hiccups had been recorded but these appeared to be present no longer.

16. The clinical notes, complaints correspondence and concerns noted by Mr and Ms C were reviewed in detail by Adviser 1 and Adviser 2.

17. Adviser 1 said nuchal cord was a common scan finding. However, there was conflicting evidence from clinical research about whether this should be regarded as a warning sign and further monitoring required or whether this was a routine finding and did not indicate any need for monitoring or concern. Given there was no clear cut recommendation available in the research, it was not unreasonable for Doctor 1 to have reassured Mr and Ms C that further action was not required. Adviser 1 noted that Doctor 1 was a Senior House Officer who had qualified in 2003. She had some experience in this speciality and part 1 of the Membership of the Royal College of Obstetrics and Gynaecologists. However, while he considered the advice she provided was not unreasonable, he commented that she should have had direct supervision in the clinic by a doctor who had passed the Membership.[4]

[4] There was some confusion about when this advice was given. Mr and Ms C are clear that this was on the same day as the scan, on 28 September 2007, while the notes do not confirm this

18. However, Adviser 1 was concerned about the CTG taken on 18 September 2007. He said there was a clear deceleration on the scan and this should have been followed up with ultrasound and further CTG scans. The Board commented on this, saying that they accepted there had been an error in the failure to record the deceleration.[5] This had been discussed with the midwife and she had also taken part in a number of CTG training sessions, both before and following the incident. She said she had recognised the deceleration and accepted there had been an error in not recording this. The Board said they had also asked relevant staff, including consultant obstetricians and a consultant midwife, to review the CTG and, in their view, the deceleration was not clinically significant.

19. In considering the Board's comments, Adviser 1 accepted that the CTG alone may have not indicated further monitoring but the combination of this with the reporting of reduced fetal movement by Ms C meant that, in the light of the full clinical picture, this should have been pursued. Adviser 1 added this may have been a short-term event and it was not possible to say what would have been found if further monitoring had been undertaken.

20. Adviser 1 also considered the concerns raised by Mr and Ms C about the monitoring of Ms C's condition throughout the pregnancy. He noted that Ms C's Body Mass Index (BMI) was elevated but said from the records there was no sign of sustained high blood pressure. This meant there was no requirement to undertake more detailed urine monitoring. He also noted there was no sign of a streptococcal infection from swabs taken from Baby A. He did not consider, apart from the deceleration, there was any further matter of concern in the care provided.

21. Adviser 2 noted that Ms C's BMI was taken at the first and last visit. While she was not weighed at any appointment between these, observations relating to urine samples, retention of water and the size of the abdomen were all within normal range. There would, therefore, have been no clinical indication for regular weight monitoring. She said Ms C had reported instances of breathlessness, palpitations and discomfort during her pregnancy but these had

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and it may have been some days later. This does not impact on the matter under consideration, whether the action taken was appropriate, and I do not comment further on this discrepancy.

[5] What had been noted was no deceleration (see paragraph 11).

been noted and appropriate medical referrals made and follow-up arranged. She reviewed the notes carefully but said there was no apparent evidence that these had been added to or items deleted. They appear to be a contemporaneous record of events as they occurred (see paragraph 15).

22. In summary, Adviser 2 said that, apart from the deceleration and recording of telephone records, the quality and nature of clinical midwifery care and surveillance was sound and professionally appropriate; and the quality of antenatal care and treatment was in keeping with current practice. Referrals made were in keeping with current practice and were made when required and appropriate.

*(a) Conclusion*

23. Mr and Ms C had been assured that there was no cause for concern about Baby A until the point where, during labour, a fetal heart rate was not found. They were understandably devastated. They have subsequently sought to understand why this occurred and, in doing so, to prevent a recurrence.

24. Their central concern related to nuchal cord and whether the appearance of this on the 36-week scan should have merited follow-up. The advice I have received is that there is some research which indicates it should have been followed up but, equally, there is other clinical research indicating that it should not. Future research may clarify this and may lead to changes in practice. However, until the matter is clear, the advice I have received is that it remains reasonable to follow current practice, which is what happened in this case.

25. Mr and Ms C raised a number of other concerns about monitoring and the advice I have had is, with one exception, that this was appropriate. The exception is the CTG taken on 18 September 2007 which showed a deceleration. The Board have reviewed this and they have indicated that this alone would not have caused concern. They have said there was a failure to note this on the clinical record. However, the clinical record shows that what was noted was no deceleration (see paragraph 11). This is simply wrong. The advice I have had is that, given other factors, the deceleration should have been followed up. It is not possible to say what the outcome of this would have been. Adviser 1 has said it is possible this may have been a short-term event and, as I have said, the other monitoring was noted to be appropriate. However, in the circumstances, I uphold this complaint, given that this deceleration was not recognised, recorded or followed up appropriately.

26. Concerns were also raised about whether the notes had been altered and it is clear that the records do not always match Mr and Ms C's recollection of events. The advice I have received from Adviser 2, who has experience of working with maternity records, is these do not appear to have been altered. However, it is the case that there was a failure to record any information about the telephone call of 18 October 2007. The Board apologised for this in response to Mr and Ms C's complaint and have said this was not in line with their own procedures. The Board only provided details of the interview with the midwife on this point following further questions by me after the draft report had been issued. The details of these interviews had not been communicated to Mr and Ms C as part of the complaint response and I refer to this later. Mr and Ms C remain of the view that the information given in that telephone call should have led the midwife to recommend that Ms C attend the hospital. The advice I have received is that the version given by the midwife was of signs which would not cause concern. Given that there was no note taken at the time, and given the conflicting accounts, it is not now possible to be clear on what basis the midwife made her decision. I am, therefore, unable to make a finding on this point. This is clearly a far from ideal outcome in these circumstances and is reflected in the recommendations. I also reflect in the recommendations the fact that, in reviewing the file in response to comments on the draft report, a further badly completed telephone note was identified.

27. In upholding this complaint, I have found there were clearly some deficiencies in the care provided. While these did not amount to all the concerns that Mr and Ms C raised about the care, these are sufficient to cause concern and the Ombudsman would ask the Board to consider seriously the recommendations made.

*(a) Recommendations*

28. The Ombudsman recommends that the Board:

(i) reassess the training provided to midwives on CTGs, given the failure to recognise, record or follow up the deceleration correctly;

(ii) review the use and purpose of the Board's telephone call records, given the failure to complete any record on 18 October 2007 and the presence on file of a badly completed record;

(iii) review the supervision arrangements for their ante-natal clinics taking into account the advice received in paragraph 17 and inform the Ombudsman of action taken as a result of this review; and

(iv) apologise to Mr and Ms C for failing to recognise, record and respond appropriately to the deceleration.

**(b) There were failings to ensure appropriate support was provided following the death of Baby A**

29. Mr and Ms C have said they were not given appropriate support following the death of Baby A. They said they were given the number of local parents' groups but not offered professional counselling. When they met their GP some weeks after Baby A's death, he was unaware that she had died and had expected to be discussing Baby A's care. They found this, understandably, very distressing.

30. In response to my enquiries, the Board accepted that the discharge letter had not been sent to Ms C's GP until 22 January 2008, some months after she had left the hospital. This was because of a leave of absence by the relevant consultant. However, the Board advised they had sent a midwifery transfer document on the day of Ms C's discharge to her GP. I have viewed this document and it did indicate a stillbirth occurred – this option was circled and a neo-natal section scored through. While sending such a document was normal procedure in all deliveries, if a stillbirth had occurred, the Board said they would also inform the GP by telephone. This was part of their standard care pathway in such cases. This did not occur in this case and the Board said they have investigated this failing and staff have been reminded of the importance of ensuring GPs are informed quickly.

31. Following the stillbirth, the discharge notes record that Ms C was given information about support groups. Ms C did receive postnatal visits from midwives. At a meeting held as part of the complaint process in February 2008, Mr and Ms C were asked if they had had counselling and, on being informed they had not, were told they would be contacted with further details. Internal emails show that the Board sourced details about SANDS (the Stillbirth and Neonatal Death Society) but had been informed that they could only provide group meetings locally. The emails also noted that Mr and Ms C had been told by their GP there would be a nine month wait if he referred them to a psychologist. Attempts were made to gain clinical psychology support from another Board area but this was unsuccessful. As a result of the Board's enquiries, Mr and Ms C were provided with details of the local SANDS group and given a number for CRUSE (a bereavement care charity). After Mr and Ms C complained about the failure to offer bereavement support or counselling,

the Board suggested in a letter dated June 2008 that they raise this with their GP and that, if referred, the Board would expedite this appointment.

32. Adviser 2 noted that referral to agencies such as SANDS and CRUSE, who can offer professional counselling and support, was appropriate given the lack of onsite bereavement counselling within the midwifery service. However, it appeared this was only offered late in the process. She noted it had taken some four months to send the discharge letter and this was an inordinate delay in the circumstances.

*(b) Conclusion*

33. The Board have acknowledged that their standard process was not followed and that, although the midwifery transfer document was sent immediately to the GP, there was no telephone call and the discharge letter was not sent for some considerable time.

34. Mr and Ms C were encouraged to pursue counselling and provided with details of where they could obtain this, following their meeting with the Board in February 2008, but there appear to have been limited options. SANDS did not offer professional counselling in their area and it was accepted there was a waiting list for a referral to clinical psychological services provided by the Board. I note that the reference itself to external agencies was not inappropriate but I am concerned that it took until February 2008 for this to be raised directly with Mr and Mrs C[6]. Mr C had been in contact with the Board on a very regular basis, often several times a week, and it is clear from the emails that he and his partner were, understandably, suffering considerable distress. In addition, the couple's GP was not made aware of the stillbirth in the normal way (ie, by a discharge letter and telephone call). In the circumstances, I feel that advice and support should have been more proactive rather than reactive and I uphold this complaint.

*(b) Recommendations*

35. The Ombudsman recommends that the Board:

(i) review their standard care pathway for bereaved parents, in light of the concerns raised in this report and the best practice examples elsewhere in

[6] There is evidence some standard information was provided at the time of Ms C's discharge. However, given the level of contact, I would expect this to have been raised again.

NHS Scotland, and ensure that parents are given timely advice about counselling; and

(ii) apologise to Mr and Ms C for failing to communicate with their GP, in line with their procedures, and for the time taken to provide them with information about counselling.

**(c) The response to Mr and Ms C's complaint was not adequate**

36. Mr C first contacted the Board with a Freedom of Information request on 2 November 2007. Following this contact, it was clear Mr and Ms C had concerns and a Service Manager met with Mr and Ms C on 6 November 2007 to discuss these. On the same day Mr C made a formal complaint.[7] The response was posted on 5 December 2007 and then emailed to Mr C in mid-December 2007. A meeting was held on 20 December 2007 and further meetings on 7 February and 4 April 2008. The meeting notes on 7 February 2008 recorded that it was suggested by the Board one of the regular seminars held for clinicians at the Hospital be on umbilical cord accidents. Mr and Ms C asked if they could attend and were told they would be informed of the date and given a copy of the programme flyer. On 4 April 2008, Mr C asked if Doctor 2 could attend. He would be in the UK at the time. On 16 April 2008 the Board sent a further letter with meeting notes from 4 April and answers to specific questions. The Board said it would not be appropriate for Doctor 2 to attend the seminar. The Board indicated that the local resolution procedure should now be regarded as at an end. Mr and Ms C were also informed that it would not be appropriate for them to attend the seminar, which would cover other cases.

37. Mr and Ms C continued to contact the Board to encourage them to allow Doctor 2 to attend the seminar. They also contacted their MSP, support groups and the First Minister. In a letter to the MSP dated 26 June 2008, the Board said that the seminar would discuss various cases, not only Baby A's, and also that they were of the view that there was sufficient local expertise and there was need for a Scottish healthcare perspective given the differences in healthcare systems across the world.

[7] As is indicated above (see paragraph 34), Mr and Ms C were in contact with the Board regularly for some months. In this section, I do not detail all contact but highlight the most significant points. I have reviewed the full file as part of my investigation.

38. Mr and Ms C's complaint was received by the Ombudsman's office on 17 June 2008.

*(c) Conclusion*

39. From reading the full complaint file, it is clear that Mr and Ms C used all resources available to them to research and understand what may have caused the stillbirth of Baby A. Mr and Ms C were persistent in their questions to the Board and it is also clear that the initial wish was for this to have a local resolution and the Board to accept their position. The level and detail of contact was significant. I deal above with my concerns that this did not lead to an offer of additional support earlier and do not deal with those further here. I would commend the Board for realising at an early stage that meetings were appropriate and for holding three of these, in an attempt to answer Mr and Ms C's questions. From the notes I have seen,[8] these were difficult meetings and Mr C indicated that he felt they had been rushed.[9] Ultimately, the meetings were unsuccessful in resolving Mr and Ms C's concerns. However, I have considered this carefully and do not consider that there was a failing in the process or intent.

40. Mr and Ms C were very unhappy that Doctor 2 was not allowed to attend the seminar. The Board have given their reasons for this. This was a regular, internal seminar and this was a matter within their discretion. I do not comment further.

41. In response to further questions raised by me, the Board issued a note of two interviews with midwives which had been taken by a manager who had been asked to collect information in response to the original concerns raised by Mr C in November 2007. This note was undated and not held in the complaint file. However, the Board said one of the midwives had confirmed that this interview had occurred not long after the complaint was received (see footnote at paragraph 13). Of the two interviews, one did not add to the information held in the clinical records. However, the interview which related to the telephone call on 18 October 2007 did demonstrate that the midwife likely had a different recollection of this telephone conversation. Her recollection was that, in particular, no reference was made of pain or fever. While Mr and Ms C were

[8] I have both the Board's and Mr C's notes.

[9] The meeting of 7 February is recorded in the Board's notes as taking two hours and on 4 April, one hour and 40 minutes.

told that the Board did not consider Ms C should have been given any different advice on 18 October they did not communicate the midwife's different recollection of the telephone call. While it may have been difficult to communicate this difference, this call was very important to Mr and Ms C and they should have been given all the information available and the opportunity to comment on this.

42. I recognise that the Board did endeavour to respond to Mr and Ms C's concerns and have commended their use of meetings. Nevertheless, as stated above, I have a concern that Mr and Ms C were not provided with full information in response to the complaint and, to that extent, I partially uphold this complaint. The Ombudsman makes the following recommendation.

*(c) Recommendation*

43. The Ombudsman recommends that the Board, when responding to complaints, take into account the need to provide as full information as possible, particularly where interviews have been held with staff.

44. The Ombudsman asks that the Board notify him when the recommendations have been implemented.

**Annex 1**

## Explanation of abbreviations used

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| Mr C | The complainant and father of Baby A |
| Ms C | The complainant Mr C's partner and mother of Baby A |
| Baby A | The aggrieved |
| The Board | Lanarkshire NHS Board |
| The Hospital | Wishaw General Hospital |
| Doctor 1 | The Doctor who saw Mr and Ms C when they raised concerns about a nuchal cord finding |
| Doctor 2 | An overseas doctor consulted by Mr and Ms C |
| Adviser 1 | Medical adviser with obstetric and gynaecological experience expertise |
| Adviser 2 | Midwifery adviser |
| BMI | Body Mass Index |

**Annex 2**

## Glossary of terms

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| Braxton Hicks | Contractions which occur during pregnancy and can mimic labour – sometimes known as false labour pains |
| Cardiotocograph (CTG) | A record of the fetal heart |
| Nuchal cord | Where the umbilical cord is noted to be around or near the neck of the fetus |