Scottish Parliament Region: Highlands and Islands

Case 201103227: Highland NHS Board

Summary of Investigation

Category

Health: Hospital; Gynaecology and Obstetrics (Maternity); clinical treatment; diagnosis

Overview

The complainants, Mr C and Ms C, raised a number of concerns about Ms C's unplanned homebirth of their daughter (Baby A), and her death. The complainants believe that the loss of Baby A was totally avoidable and blame Highland NHS Board (the Board) for what happened.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the Board failed to provide adequate advice, care and treatment before, and during, the birth of Baby A (*upheld*);

(b) the Board failed to provide adequate care and treatment to Mr and Ms C following the birth (*upheld*);

(c) the Board failed to keep adequate and timely records of the birth and aftercare provided to Ms C (*upheld*);

(d) the Serious Untoward Incident report failed to investigate and report adequately on all the issues regarding the birth and aftercare and the Chief Executive's response failed to investigate the matter adequately or to make any recommendations to avoid a recurrence (*not upheld*); and

(e) the Board incorrectly stated that Baby A was stillborn (*not upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) make a full and sincere apology for the failures identified in Complaint (a); and	22 September 2012
(ii) emphasise to all midwifery staff the necessity of compliance with the relevant rules in relation to the completion of notes.	22 September 2012

The Board have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. At the time of the events concerned (October 2009), Ms C was a 40-year-old primigravida (first time mother). Ms C's expected date of delivery was 17 October 2009 and, throughout the pregnancy, she indicated that she wished a hospital delivery at the maternity unit in Raigmore Hospital, Inverness (the Hospital). Mr C and Ms C live in a town about an hour and fifteen minutes drive north of Inverness.

2. At 03:55 on 8 October 2009, Ms C experienced a spontaneous rupture of membranes and sought immediate advice from the Hospital by telephone. She then called again at 06:30. She was advised to contact her local midwife at about 09:00. Ms C did so and the midwife appeared at about 09:30. The midwife called the Hospital at approximately 10:00 to say that Ms C would make her way there by car. No contact was made with the Hospital again until about 12:45 when the midwife advised that there was to be an unplanned home birth. A 999 call was made shortly afterwards when there was a meconium show and another call was made to the Hospital.

3. An episiotomy was performed at 13:10 to accelerate the birth and it was about this time that a breech presentation was confirmed. After what was a very difficult labour, Baby A's head was eventually delivered at 14:00. No foetal heart beat was found and Baby A was taken to the Hospital by helicopter. Mr C and Ms C followed by ambulance. No midwife or notes accompanied them.

4. Baby A was declared dead at the Hospital. After being seen by a paediatrician and been informed of the death of their baby, Ms C's episiotomy was sutured.

5. Mr and Ms C have been left with the trauma of Baby A's birth and death and Ms C has also been left with internal problems which cause her embarrassment, and have led to a long term disability. Ms C was diagnosed as suffering from post-traumatic stress disorder . Mr C was diagnosed as suffering from post-traumatic adjustment disorder . Following the death of their daughter, the Board struggled to provide them with the counselling they required. At the moment, Ms C alone is receiving psychotherapy.

6. Mr and Ms C blame Highland NHS Board (the Board) and the midwives concerned for what they consider to be the totally avoidable loss of Baby A.

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

(a) the Board failed to provide adequate advice, care and treatment before, and during, the birth of Baby A;

(b) the Board failed to provide adequate care and treatment to Mr and Ms C following the birth;

(c) the Board failed to keep adequate and timely records of the birth and aftercare provided to Ms C;

(d) the Serious Untoward Incident (SUI) report failed to investigate and report adequately on all the issues regarding the birth and aftercare and the Chief Executive's response failed to investigate the matter adequately or to make any recommendations to avoid a recurrence; and,

(e) the Board incorrectly stated that Baby A was stillborn.

Investigation

8. The investigation involved obtaining and reading all the information provided by Mr and Ms C and by the Board, including the Board's complaints file and related correspondence; copies of the relevant clinical, nursing and midwifery records; the Board's Serious Untoward Incident (SUI) investigations file; the report and the associated updated action plan; the Supervisor of Midwives' Supervisory Investigation Report and copies of relevant policies and guidelines. All the information has been given very careful consideration. I have also obtained advice from a midwifery adviser (the Midwifery Adviser) and this too has been taken into account. I have seen the Board's complaints policy.

9. 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 Board failed to provide adequate advice, care and treatment before, and during, the birth of Baby A

10. Ms C's pregnancy was largely uneventful and she expected to give birth, as she wished, in the Hospital. In September and October 2009, Ms C was examined by local midwives and on the first occasion, it was concluded that Baby A's presentation was cephalic and, although Ms C said there was some uncertainty after the second examination, it was again decided that it was a

cephalic presentation. Mr and Ms C believed that both of these decisions were incorrect and that, given the uncertainty, the midwife should have opted for the 'fail safe' position and recommended a scan.

11. Later, on 8 October 2009, after a spontaneous rupture of membranes and when Ms C telephoned the Hospital for advice, she believed that she should have been told to make her way to the Hospital. Mr and Ms C said that this would have been in line with the Hospital's general advice to staff. They said that this would also have been in line with what was considered good practice for a first time mother of Ms C's age and given the distance from the Hospital. They said that this was particularly relevant after the second occasion Ms C called, by which time they said contractions had started and there had been a show of blood. Furthermore, they maintained that once the local midwife arrived at about 09:30 on 8 October 2009, she should have recognised that Ms C should have been referred immediately to the Hospital and, in all the circumstances, the midwife should not have decided to deliver Baby A at home. Mr and Ms C were aggrieved that the midwives failed to recognise that Baby A's presentation was breech.

12. As labour progressed, Mr and Ms C complained that the midwives failed to communicate fully with the Hospital and, accordingly, they did not have the benefit of expertise from there. They considered that those involved at their home failed to recognise the seriousness of the situation and seek emergency assistance. Ultimately, they said that a decision was made to proceed with a homebirth without appropriate checks and backup being available which would have allowed a safe delivery. After a very difficult and traumatic birth, Baby A was born but, regrettably, Mr and Ms C were advised at the Hospital that she had not survived.

The Board's response

13. Mr and Ms C made a formal complaint about this matter on 11 November 2009 and on 18 December 2009 received an SUI report from the Board. This identified a number of concerns: that the advice received after the second telephone call caused an unnecessary delay in transferring Ms C to Hospital; that hospital guidelines etc gave conflicting advice; that there was delay in ordering an ambulance; that the decision to change the place of birth from Hospital to home during labour and the fact that this decision was not reversed when labour slowed down; that a breech presentation was not identified; that communication had been poor; that available local expertise (an

on-call GP [Doctor 2], trained in pre-hospital emergency care) was not contacted until after the birth; and, after a breech was diagnosed, that further advice and support was not sought from the Hospital. In conclusion, the Board said that the care offered to Ms C was '… sub-optimal and below that which we would want to provide for our patients'. In the light of this, the Board recommended that the practice and decisions of the midwives involved should be further investigated; relevant guidelines and protocols were to be updated and made fully consistent; and communications were to be improved and made consistent. The Board also made recommendations associated with the Scottish Ambulance Service to: (i) seek clarification from the Scottish Ambulance Service that they would respond to 999 calls from women in labour; and (ii) revisit the protocol for transport and transfer of women in labour, taking account of geographical location.

Advice received

14. Specialist midwifery advice was obtained concerning the circumstances surrounding this part of the complaint. In particular, about the assessment that was carried out about the presentation of Baby A, it was confirmed that community midwives had examined Ms C on at least six occasions throughout the pregnancy and on the last three occasions had described the presentation as cephalic. The Midwifery Adviser said that during labour, in order to put together a complete picture, it was essential to perform abdominal examinations at the same time as vaginal examinations. In Ms C's case, while it appeared that the midwife did record an abdominal palpation at the first vaginal examination, she did not do so at three subsequent examinations. In the Midwifery Adviser's view, three opportunities were missed to palpate a breech presentation and, accordingly, reasonable assessments were not conducted. However, the Midwifery Adviser went on to say that a breech presentation could be difficult to identify and that in her experience the only way to be certain would have been by using an ultrasound scan before the onset of labour. If Ms C had opted initially for a home birth, it was pointed out that she would have been risk assessed and in all probability, in accordance with safe practice, it would have been likely that she would have been scanned at 36 weeks to confirm the presentation, particularly given the distance between their home and the Hospital.

15. The Midwifery Adviser said that, from the records, the midwife was not sure of the breech presentation until after she had performed an episiotomy. The Midwifery Adviser explained that during a vaginal examination the midwife

would feel for 'landmarks' of the foetal skull. At six centimetres dilated an experienced midwife should have been able to identify one of these landmarks and at eight centimetres at least two should have been felt. The Midwifery Adviser pointed out that the absence of these landmarks at eight centimetres should have alerted the midwife to the possibility of a breech presentation.

16. Ms C's choice of place of birth was the Hospital and the Midwifery Adviser said that in her view, there was adequate time for transfer considering that it was her first baby. She added that if the midwife had assessed that Ms C was progressing rapidly in labour or that there had been difficulty in Mr C driving, there was always the option of an emergency ambulance transfer. She said that although it was clear from the notes that both Mr and Ms C were involved in a discussion to remain at home for delivery, the decision was clearly the midwife's. The Midwifery Adviser said that it was the midwife who was the experienced professional who was aware of the risks of delivering a primagravida at home when there would be a long journey to hospital in an emergency. But in Ms C's case, as far as the midwife had assessed, she was dealing with a normal healthy woman progressing well in labour. The Midwifery Adviser pointed out that had this been the case, that is, had the presentation been cephalic, there would have been no reason to contact the Hospital other than to inform them that she was proceeding with an unplanned home delivery, which was within her sphere of practice. There was no reason to request advice until the situation deviated from the norm, that is, when a breech presentation was identified.

17. The Midwifery Adviser said that when there was a show of meconium at 12:50, Ms C's cervix was fully dilated and the midwives were still anticipating a normal delivery. She said that the meconium was a warning sign of foetal distress but at that time, the foetal heart rate was normal (as recorded in the Active Labour Partogram chart). In her view, the Midwifery Adviser said that labour was too advanced at this stage to arrange a safe and rapid transfer to the Hospital. However, a doctor trained in advanced neonatal resuscitation was available in the local hospital and she said he would have been the most appropriate medical person to call to attend. In commenting on a draft of this report, the Board said that the midwives concerned would not have this information but that at 13:32 a call was issued to the Out of Hours GP [Doctor 1] with a request that he attend.

18. It became apparent that a breech delivery was required and the Midwifery Adviser said that while such a delivery at home was a very infrequent emergency procedure, it was one for which all midwives had theoretic training (though not experience). She said that the two midwives who were present at the birth discussed the mechanisms of delivery but, as far as she could ascertain from the records and from NHS Highland Midwifery Guidelines, they failed to follow the correct procedure in positioning Ms C (which advocated placing Ms C across the bed with each foot on a chair and buttocks at the edge of the bed). In the Midwifery Adviser's view this reflected best practice and the most favourable approach in a non hospital environment in emergency circumstances. She added that the episiotomy should not have been performed until the presenting part was distending the perineum. The Midwifery Adviser said that the midwife who sutured the episiotomy described it as 'small' and in her opinion, it was probably too small to allow the head to be delivered. The midwife concerned described the physical effort needed to deliver Baby A's head and the Midwifery Adviser said that in a hospital situation, forceps would probably have been used.

(a) Conclusion

19. I have considered the extensive documentation provided by Mr and Ms C and the Board in relation to this matter and I have had the benefit of independent specialist advice. I have given careful consideration to it all and I have concluded that the Board did not provide adequate advice, care and treatment before, and during, the birth of Baby A. It is clear to me that a series of opportunities were missed: Ms C was not properly examined during the antenatal period; she was not advised to make her way to the Hospital after telephoning for advice on the morning of 8 October 2009; midwives were not alerted to the possibility of a breech birth when, on examination, they could not identify any landmarks on the foetal skull; the safe option to have transferred Ms C to the Hospital was not taken, there was plenty of time; the option of an emergency transfer was not taken up and the midwife decided that Ms C should remain at home for the birth. Later, local expertise, the Out of Hours GP, was not called until after the birth and Ms C was not correctly positioned for delivery. The episiotomy was too small.

20. What had begun as a normal physiological event, regrettably, ended in tragedy with a very difficult breech delivery. Ms C's community midwife, along with another midwife, made a bad decision not to transfer her to the Hospital when labour was established. What flowed from there was a series of events

with disastrous consequences. Had the transfer taken place following the community midwife's initial visit and assessment, the breech presentation could probably have been identified before the cervix was fully dilated and Ms C could have been delivered in a hospital setting with a full medical team to give appropriate care. I uphold this complaint.

21. In all the circumstances, I recommend that the Board make Mr and Ms C a full and sincere apology for their failures in this regard. I am aware that the Board have already made their own recommendations and I will address those below (Complaint (d)).

(a) Recommendation

22. I recommend that the Board:	*Completion date*
(i) make a full and sincere apology for the failures identified in Complaint (a).	22 September 2012

(b) The Board failed to provide adequate care and treatment to Mr and Ms C following the birth

23. On 14 March 2010, Mr and Ms C wrote to the Chairman of the Board making a second formal complaint. They were unhappy with the medical care given to Ms C on 8 October 2009 and were dissatisfied with the aftercare provided to them both since that date. They outlined a number of key issues which they said they were questioning. Specifically: Ms C was not accompanied to the Hospital by a midwife; neither were the notes sent; Ms C was given an insufficient examination (both at home and in the Hospital) prior to suturing and this was delayed for some four hours; there was a failure to acknowledge and report on the internal damage caused to Ms C as a part of the SUI investigation; and that although they had requested counselling, no appropriate counselling had been provided.

The Board's response

24. The Board responded to this complaint by letter from the Chief Executive of 10 May 2010. The letter said that initially, after the birth, the midwives' main priority was to arrange a transfer to the Hospital. It added that a vaginal examination did not take place at Mr and Ms C's home because there was not felt to be a clinical need (there was no excessive bleeding) and also because there was a wish not to distress Ms C further. It was agreed that Ms C should have been accompanied to the Hospital by a midwife and the Board apologised for this. The letter added that notes did not accompany Ms C because there

was no midwife escort. It was pointed out that normally the midwife would take the notes with her and complete the record en route. It was acknowledged that Ms C's notes were incomplete and not recorded contemporaneously as was required because of the emergency situation. However, a verbal handover had been made by telephone. The Board apologised that Ms C's notes did not accompany her.

25. With regard to the examination before suturing at the Hospital, the Board said that the midwife concerned made a professional assessment of the wound; that there was no deep trauma to indicate additional damage or that the episiotomy had extended. Accordingly, she went on to suture. They added that the delay in suturing Ms C was attributed to the transfer time and also because it was considered more appropriate for both Mr and Ms C have time with Baby A (although, in commenting on the draft of this report, Mr and Ms C said that the fact that a doctor was unavailable contributed to the delay).

26. Mr and Ms C raised concerns about the SUI report and said that this did not acknowledge or report the consequent damage caused to Ms C and it was the Board's view that the report's scope followed the remit initially agreed at a meeting of the SUI team on 12 October 2009. At that time, the Board said, Ms C's internal damage had not been determined.

27. On the matter of further support and counselling for both Mr and Ms C; essentially, the Board said that they had tried to meet their needs, but, the type of counselling required was not available. However, the midwives caring for Ms C had continued to explore all possible options. They had identified a gap in maternity services in relation to trauma counselling and this aspect of care was being explored on a national level and by the Board. A senior midwife is currently being trained in counselling and computer based training and training events are being run for midwifery and neonatal nursing staff on pregnancy loss and neonatal death. The Board also highlighted that on a national level, Healthcare Improvement Scotland has published a 'Sudden and Unexpected Death in Infancy' toolkit.

Advice received

28. In her advice about the matter of the hospital transfer, the Midwifery Adviser was clear that a midwife should have accompanied Ms C because, following delivery, there was always the risk of further bleeding. Although there was a paramedic in the ambulance, she said that a midwife would have been

the most appropriate person to deal with such an emergency had it occurred. The midwife would also have been able to give an accurate handover to staff at the Hospital. The Midwifery Adviser pointed out that as there were two midwives present at this time, there was no reason why one could not have accompanied Ms C and completed the notes en route. The Midwifery Adviser said that in her view the handover was inadequate.

29. The Midwifery Adviser explained the episiotomy. She said that this entailed cutting through the skin and the muscle of the vaginal wall. The notes showed that the episiotomy was examined at home after delivery and described to be satisfactory.

30. In the Hospital, she said that the midwife who repaired the episiotomy referred to it as 'small'. The examining midwife did not say that the cut had extended or that it had reached the anal sphincter. The Midwifery Adviser told me that the midwife undertaking the repair would first look at the area which had been cut. If the episiotomy had extended or torn down into the anal sphincter, the midwife would identify this as a 3rd or 4th degree tear which would require to be sutured by a doctor. From the records, the Midwife Adviser confirmed that the midwife did examine the area before she began suturing and noted that '… small episiotomy … skin quite ragged but came together fine'. The Midwifery Adviser stated that as this was a procedure being done with the midwife's hands, by the nature of things, there would be a physical examination. The Midwifery Adviser also confirmed that perineal suturing of minor tears and episiotomies was within a midwife's sphere of practice. In her view, the midwife carrying out the procedure carried out an adequate assessment prior to the repair and her decision to undertake the repair was a reasonable one. She also advised that given the traumatic nature of the birth, but in the absence of 3rd or 4th degree tears, it was not unreasonable for the midwife to commence suturing prior to examination by a Doctor. She went on to explain that the area concerned would have been swollen, bloody, stretched and injected with lignocane and a greater tear may have been missed but this would not have been unreasonable in the circumstances. However, she commented that the midwife's record of the procedure could have been better.

31. Under normal circumstances, the Midwifery Adviser said that the episiotomy would usually be sutured within an hour of delivery. However, she said in this case the circumstances were not normal. Ms C did not arrive at the Hospital until 16:10 and the priority at the time was to give her the very sad

information regarding Baby A. Mr and Ms C then spent time with her. The advice I received was that, in these circumstances, the delay was reasonable and was unlikely to have been detrimental to Ms C's future health.

32. Advice was also requested about the situation with regard to counselling. In the Midwifery Adviser's view, the Board had made every effort to support Mr and Ms C over an extended period. She said that with regard to Ms C this was evidenced in the records by the many post natal visits and contacts by community midwives. In addition, the lead midwife made nine recorded visits or contacts. She said that she acknowledged that the Board had tried, but had been unable to meet Mr and Ms C's expectations in this regard. She made the point that, given the limited resources available, the Board's efforts were acceptable.

(b) Conclusion

33. I am satisfied from the advice received that Mr and Ms C should have been accompanied by a midwife when Ms C was taken to the Hospital. Similarly, Ms C's notes should have accompanied her. The Board have already accepted that these were failings on their part and have apologised.

34. However, the advice I received on the matter of the examination of Ms C's episiotomy prior to suturing was that it was adequately assessed and that the midwife's decision to complete the repair was a reasonable one. I have no reason to doubt this advice and, accordingly, I have no criticism to make on this aspect. Neither am I critical of the time lag before Ms C was sutured as I consider that the Board's reasons were acceptable taking into account, as they did, travel time from Mr and Ms C's home to the Hospital, the findings of the initial assessment carried out on arrival and the time spent with Baby A. The Board's explanation of the reason why the SUI did not include reference to Ms C's internal damage was also reasonable, in that this matter had not been made as part of the original complaint to which the SUI purported to reply (the matter of the SUI is addressed later).

35. Finally, as part of this complaint, I looked at the Board's provision of support and counselling to Mr and Ms C. It was clear to me that they were dissatisfied with the level of care offered. Nevertheless, it was also clear that the Board made every effort to meet their needs from the services which were available to them. They acknowledged that there was a gap in the type of provision Mr and Ms C were looking for and the Board have taken steps to

remedy this. The Midwifery Adviser confirmed that, in the circumstances, what the Board had done was acceptable. I have taken account of all the evidence in this matter and while I recognise Mr and Ms C's strong feelings and their needs (particularly Mr C, whose needs, I understand, have not been met), I consider the Board have done all they could. In concluding this, I should make it clear that the Ombudsman's power does not extend to that of directing any public body or body under jurisdiction to take particular action or to provide a particular service.

36. Generally, the aftercare offered to both Mr and Ms C was acceptable but there were significant failures in that Ms C was sent to hospital on a long road journey immediately after giving birth without being accompanied by a midwife. A midwife would have been the appropriate person to assist in the event of a problem occurring. Nor did her notes accompany her and this must have caused some problem when she was admitted at the Hospital. The Board have already acknowledged these failures and apologised. Nevertheless, on balance, I uphold the complaint but, in view of the apologies made, I have no recommendations to make with regard to this complaint.

(c) The Board failed to keep adequate and timely records of the birth and aftercare provided to Ms C

37. Generally, Mr and Ms C complained of the quality of the records and notes taken. They alleged that these were exceptionally poor and that notes were made on scraps of paper and post-it notes. The labour notes were written retrospectively.

Advice received

38. The Midwifery Adviser has already said that the notes completed when Ms C's episiotomy was repaired (see paragraph 28) could have been better. However, she also said that, overall, while the clinical notes appeared to be adequate, they were not written contemporaneously and some of the timings were incorrect and had been altered (my complaints reviewer has seen the notes to which this refers). The Midwifery Adviser went on say that this breached the Midwives Rules (Rule 9.1. – A practicing midwife shall keep, as contemporaneously as is reasonable, continuous and detailed records of observations made, care given …') She said there were two midwives and a nurse present during labour and in her view, despite the circumstances, there was no reason why accurate and detailed records could not have been made by one of the midwives as events took place.

(c) Conclusion

39. My complaints reviewer has seen the relevant notes and has seen the changes and matters referred to. I note the Midwifery Adviser's view that this breached the Midwives Rules. Accordingly, I uphold the complaint. In the circumstances, the Board should emphasis to all midwifery staff the necessity of compliance with the relevant rules in relation to the completion of notes.

(c) Recommendation

40. I recommend that the Board:	*Completion date*
(i) emphasise to all midwifery staff the necessity of compliance with the relevant rules in relation to the completion of notes.	22 September 2012

(d) The SUI report failed to investigate and report adequately on all the issues regarding the birth and aftercare and the Chief Executive's response failed to investigate the matter adequately or to make any recommendations to avoid a recurrence

41. Mr and Ms C raised their first complaint with the Board on 11 November 2009 and the Board responded by way of providing an SUI report dated 18 December 2009 on 22 December 2009. It was Mr and Ms C's view that this did not provide an adequate response. In the circumstances, they pursued this by letters of 14 March and 3 July 2010. They stated their opinion that their complaints had not been fully addressed and that a sufficiently in-depth investigation had not been carried out. They asked a series of questions.

The Board's response

42. With regard to the SUI, the Chief Executive said in his letter of 10 May 2010 that the scope of the SUI had been agreed on 12 October 2009 by the relevant team dealing with it and, at that time, Mr and Ms C had not yet raised their concerns about Ms C's internal damage (see Complaint (b)). In his letter of 23 September 2010, the Chief Executive expanded upon the role of an SUI and that its remit was to investigate Ms C's unplanned home birth and its tragic consequences. He detailed the purpose of the investigation and what happened when action points were identified. His letter then went on to address outstanding concerns arising from post natal care but he concluded that, after reviewing the records and discussing the matter with staff, the post natal care provided by the Hospital was appropriate.

Advice received

43. The Midwifery Adviser told me that in her view the SUI was carried out well, clinical and organisation failings were identified and an admission made that 'the care offered was sub-optimal and below that which we would want to provide for our patients'. She said that 14 recommendations were made and that a robust action plan was put in place. In addition, she said that there was an investigation by supervisors and that the midwives involved were properly assessed and, where appropriate, remedial action taken.

(d) Conclusion

44. This matter has been considered carefully and the Board's comments about the remit of the SUI have been noted. It was carried out in accordance with the Board's incident management policy and procedures but, from the Patient Focus Manager's letter to them of 25 June 2010, it purported to address the terms of their complaint. However, this was not in accordance with the Board's complaints policy and had not been previously made clear. Mr and Ms C were not advised at the outset that this was how the Board intended to deal with their complaint nor were they asked whether they were content with this approach. While the Board were fully entitled to investigate the circumstances surrounding the birth of Baby A at home by way of an SUI, they were required to specifically address the terms of Mr and Ms C's formal complaint made to them on 11 November 2009. While I do not criticise the findings of the SUI, and the Midwifery Adviser said that it was carried out well, it did not provide a formal complaints response and this matter will be brought to the Board's attention. However, with regard to the terms of the complaint, I am of the view that the SUI was sufficiently full and made proper investigation into the circumstances of the birth of Baby A. It did not have the remit to consider matters of aftercare as Mr and Ms C's complaints on these matters post-dated it.

45. I have further considered the Chief Executive's responses to Mr and Ms C and while it was clear that they were not happy with his replies, I am satisfied that the Chief Executive provided adequate responses to the terms of the complaint. Notwithstanding my comments about the Board's failure to follow the complaints procedure, I do not uphold this complaint.

(e) The Board incorrectly stated that Baby A was stillborn

46. Mr and Ms C said that in a written statement made by Doctor 2 on 20 October 2009, he referred to Baby A being 'moribund'. Mr and Ms C said

that Baby A was not declared dead until she reached the Hospital. This led them to conclude that, in fact, she was not dead at birth and that the Board had incorrectly told them that Baby A was stillborn.

The Board's response

47. In correspondence with this office on 21 December 2011, the Board pointed out that it was documented in the medical records by a paediatrician that Baby A had been stillborn. They said other correspondence also referred to her birth as being a stillbirth.

Advice received

48. The Midwifery Adviser was asked to consider the relevant medical records on this matter and she confirmed that when Baby A was delivered she had no heartbeat and no 'respiratory effort'. She said there were no signs of life and in her view, Baby A was correctly registered as stillborn. She commented that the term 'moribund' was confusing and meant 'in a dying state'. She said that as there were no signs of life at delivery, in her view, the term was used incorrectly.

(e) Conclusion

49. My complaints reviewer has had sight of all the documentation on this matter and has seen that, with the exception of the GP's statement, everything referred to Baby A as being stillborn. My complaints reviewer has seen the appropriate certification signed by the Assistant Registrar (the Certificate of Registration of Still-Birth) and I have taken into account the Midwifery Adviser's view. My complaints reviewer has spoken to Doctor 1 present at the birth who has confirmed that the details within both the Paediatric and Labour and Birth Records were accurate and that there were no signs of life at birth. I am of the view that the Board correctly stated that Baby A was stillborn. I do not uphold this complaint.

50. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mr C and Ms C	The complainants
The Hospital	Raigmore Hospital, Inverness
Baby A	Mr and Ms C's daughter
The Board	Highland NHS Board
SUI	Serious Untoward Incident
The Midwifery Adviser	A midwifery adviser to the Ombudsman
Doctor 2	On call GP who attended after the birth
Doctor 1	Out-of-hours GP who was present at the birth

Annex 2

Glossary of terms

Abdominal palpation	An examination of the abdomen, feeling with the hand
Active Labour Partogram Chart	a graphical illustration (usually paper) that enables midwives and obstetricians to record maternal and foetal observations simply and pictorially
Breech presentation	Where a baby enters the birth canal buttocks or feet first as opposed to the normal head presentation
Cephalic presentation	A presentation when the baby's head enters the pelvis first
Episiotomy	A surgical cut in the perineum
Lignocaine	is a common local anesthetic and antiarrhythmic drug used topically to relieve itching, burning and pain from skin inflammations, injected as a dental anesthetic or as a local anesthetic for minor surgery
Meconium	The earliest stools of an infant
Perineum	The muscular area between the vagina and the anus
Primigravida	A first time mother
Suture	A stitch used to hold tissue together