Scottish Parliament Region: Highlands and Islands

Case 201203251: Highland NHS Board

Summary of Investigation

Category

Health: Hospital; Gynaecology and Obstetrics (Maternity)

Overview

The complainant (Miss C) raised a number of concerns about the level of care provided to Ms A by Highland NHS Board (the Board) during her pregnancy and subsequent delivery of her baby daughter who was sadly stillborn.

Specific complaint and conclusion

The complaint which has been investigated is that the Board failed to provide Ms A with an appropriate level of care during her pregnancy and subsequent delivery at Raigmore Hospital in December 2011 (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) apologise to Ms A for the failings identified in this report;	22 January 2014
(ii) review their guidance to staff on the antenatal management of women to ensure that the risks of recurrent shoulder dystocia are discussed with expectant mothers together with birthing options; and	26 February 2014
(iii) draw to the attention of the antenatal midwife who looked after Ms A, the importance of documenting previous history of shoulder dystocia in the handover note to the labour midwife.	22 January 2014

Main Investigation Report

Introduction

1. Ms A was admitted to Raigmore Hospital (the Hospital) on 20 December 2011 as her waters had broken. The next day labour was augmented (speeded up) but her baby was stillborn following shoulder dystocia (when the baby's shoulders become caught in the mother's pelvis).

2. Miss C complained to Highland NHS Board (the Board) on behalf of Ms A who was concerned that the management of her pregnancy and labour could have been handled better had staff been aware of previous complications she had experienced during the birth of her first child in 1997 and her second child in 2004.

3. The complaint from Miss C which I have investigated is that the Board failed to provide Ms A with an appropriate level of care during her pregnancy and subsequent delivery in December 2011.

Investigation

4. In order to investigate the complaint, I have reviewed copies of the complaint correspondence and Ms A's clinical records. I also sought independent advice from a midwifery adviser (Adviser 1) and a consultant in obstetrics and gynaecology (Adviser 2) who have reviewed the clinical records and relevant correspondence.

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

Complaint: The Board failed to provide Ms A with an appropriate level of care during her pregnancy and subsequent delivery in December 2011

6. Miss C complained to the Board that Ms A had no extra scans or checks carried out during her pregnancy despite being on an amber pathway[1] for maternity care and having being told that her baby was big.

[1] Women with any potential medical/obstetric/social risk factors should be further assessed or referred to the appropriate health professional for further assessment and support - NHS Quality Improvement Scotland Pathways for Maternity Care (March 2009).

7. Miss C said that Ms A had felt that different birth plans should have been in place given her medical history and size of her baby. In addition, Ms A felt that more checks should have been carried out on 20 December 2011 between 11:00 and 23:00 when she was in a lot of pain. Ms A was also concerned that staff did not have her previous clinical notes and did not know about difficulties she experienced during the birth of her first child in 1997 and birth of her second child in 2004.

8. In response to the complaint, the Board outlined that the hand held records Ms A brought to her antenatal clinic appointments detailed all her contact with community and clinic midwives and that staff were aware of her previous pregnancies but there was no indication of any concerns about fetal growth to warrant extra scans or checks.

9. The Board further stated that Ms A was placed on the red pathway[2] for Prolonged Rupture of Membranes when her waters broke and her contractions were monitored on eight occasions within the 12 hour period along with her baby's heart rate on 20 December 2011.

10. The Board also said that staff had access to all Ms A's maternity notes and were aware of her previous history when she was admitted on 20 December 2011. However, when raising the complaint with our office, Miss C told us that Ms A had met with her consultant obstetrician who advised her that, in hindsight, the records of her previous births should have been available to staff.

Antenatal

11. Adviser 1 told my complaints reviewer that there was evidence in the clinical records to support that during Ms A's pregnancy, the midwives were aware of Ms A's previous birthing complications because she had been placed on the amber pathway. At the birth of her first child, Ms A had a problem with the placenta in that it did not separate normally from the uterus and had to be removed under anaesthetic by an obstetrician. At the birth of her second child, Ms A experienced slight shoulder dystocia. In light of this previous history, Adviser 1 considered that Ms A was sufficiently monitored during her pregnancy from a midwifery perspective in that she was referred for a detailed scan at

[2] Women with significant medical/obstetric factors should have a consultant obstetrician as the lead professional sharing care with midwives, GPs and other care providers as appropriate - NHS Quality Improvement Scotland Pathways for Maternity Care (March 2009).

20 weeks gestation on 3 August 2011 that showed no abnormality. Adviser 1 noted that it was documented that Ms A was to be referred if there were any concerns but there was no indication for early induction and the plan was to await development in the pregnancy and manage accordingly. Adviser 1 said that there were no indications that the midwives were concerned about the size of her baby during the antenatal period because it was documented at 15, 35 and 38 weeks that the gestational age was equal to the symphysis fundal height measurement (measurement of the mother's abdomen). These measurements were carried out in line with guidance issued by the National Institute of Clinical Excellence for antenatal care and did not raise concern about the baby's size because they were within the normal range. Therefore, there would have been no reason for the midwives to request additional checks or scans to assess fetal growth.

12. Adviser 2 noted Ms A's previous history of shoulder dystocia at the birth of her second child in 2004 but agreed that there were no concerns about fetal size from the measurements documented. Adviser 2 also highlighted that national guidance issued by the Royal College of Obstetricians and Gynaecologists (RCOG) states that 'the large majority of babies over 4.5kgs do not experience shoulder dystocia'.

13. Adviser 2 said that the amber pathway states that midwives should 'consider an obstetric plan for delivery' in women with a previous shoulder dystocia. Whilst Adviser 2 said it was unclear from Ms A's records whether it was an obstetrician or a midwife who had written the note about referring Ms A if there were any concerns, the record represented an acknowledgement of her previous pregnancy history and a plan in light of this. In commenting on a draft version of the report, the Board confirmed that it was an obstetrician who had made the entry in the medical records.

14. Adviser 2 said that, although the RCOG guidelines states that the risk of shoulder dystocia in women with previous shoulder dystocia is up to ten times the general population, it also states that:

> 'There is no requirement to recommend elective caesarean section routinely but factors such as the severity of any previous maternal or neonatal injury, predicted fetal size and maternal choice should all be considered and discussed with the woman and her family when making plans for the next delivery.'

15. The RCOG guideline in place at the time stated:
'Either caesarean section or vaginal delivery can be appropriate after a previous shoulder dystocia. The decision should be made jointly by the woman and her carers.'

16. Despite this, Adviser 2 highlighted that it was unclear from the records whether or not any discussions took place with Ms A during her pregnancy about her previous birth where slight shoulder dystocia occurred and plans for her forthcoming birth. Adviser 2 said that it was not possible to speculate what decision Ms A would have made about birth given that the shoulder dystocia experienced with her second child was not severe and there appeared to have been no injury. Nevertheless, it would have been appropriate for a discussion regarding mode of birth and the risk of recurrent shoulder dystocia to have been documented in the clinical records.

Labour

17. Adviser 1 said that there was evidence that the midwife who admitted Ms A to the antenatal ward with Spontaneous Rupture of Membranes had been aware of Ms A's past history because it was documented on the admission page that there had been manual removal of placenta at the birth in 1997 and slight shoulder dystocia at the birth in 2004. However, Adviser 1 highlighted that there was nothing documented in the labour notes to indicate that the midwife on the labour ward had been aware of Ms A's past history or the need for the amber pathway because there was no formal handover of care from the antenatal ward midwife to the labour ward midwife. The labour ward midwife only appeared to be aware of Ms A being on the red pathway for Prolonged Rupture of Membranes. Adviser 1 said that formal handover of care should be documented in the records to ensure the labour midwife was aware of any risk factors at the time of delivery or particular choices made by the woman. In commenting upon a draft version of the report, the Board said that although there was no written record, there was a verbal handover and staff were aware of Ms A's previous history. The Board also commented that the midwifery sister, who was in charge at the time Ms A was transferred to the labour ward, had been present at the delivery of her second child when slight shoulder dystocia occurred.

18. Whilst Adviser 1 was critical of there being no handover record of previous shoulder dystocia, she considered that even if the labour ward midwife had been aware of the past history, it was unlikely to have affected the care Ms A

received. Adviser 1 highlighted that there can still be significant perinatal morbidity (death of the fetus) and mortality even when shoulder dystocia is managed appropriately as set out in guidance issued by the RCOG in 2012.

19. Adviser 2 explained that scans cannot predict shoulder dystocia and that it is not possible to diagnose shoulder dystocia until the baby's head is born and a normal attempt has been made to deliver the shoulders and failed. Adviser 2 said that there are warning signs that shoulder dystocia might occur which midwives and obstetricians can observe. These include the baby's head delivering very slowly and failing to restitute (rotate back to the former position). In such cases it would be normal practice for midwives to make preparations for a possible shoulder dystocia by calling for additional help. Ms A's records show that an emergency call was put out at the time of delivery and an obstetrician was in immediate attendance.

20. Adviser 2 further commented that the cardiotocograph (CTG) during Ms A's labour did not give cause for concern but there was no recording of the fetal heart after 06:20. Adviser 2 explained that it was common to lose contact with the fetal heart at the end of labour as the baby descends but it would have been good practice to adjust the monitor to maintain a continuous recording. Having said that, Adviser 2 did not believe this changed the outcome as it would not have been possible to deliver the baby any more quickly than she actually was, even if the fetal heart rate had given cause for concern after 06:20.

21. Adviser 2 noted that the obstetrician caring for Ms A clearly documented the manoeuvres attempted when shoulder dystocia was diagnosed and these actions were in line with the RCOG guidelines. Adviser 2 concluded that the care during labour was reasonable although a discussion should have taken place with Ms A during her pregnancy about birthing options.

Conclusion

22. I acknowledge the trauma and loss Ms A has suffered and recognise the emotions this report will invoke. I have carefully considered the complaint correspondence provided to our office along with information the Board sent to us, including copies of Ms A's clinical records. I have also considered the independent advice we obtained on the care and treatment Ms A received during her pregnancy and labour.

23. I recognise Ms A was concerned about being told that her baby was big. The advice I have received is that the measurements documented at 15, 35 and 38 weeks supported that the baby's growth was within normal parameters during pregnancy and that the 20 week scan showed no abnormality. Therefore, I consider it was reasonable not to consider further scans at that time.

24. However, taking into account clinical guidelines and Ms A's previous history, I am not satisfied that a discussion took place with her about the risks of recurrent shoulder dystocia and the birthing options in line with the RCOG guidelines. Therefore, although it is not mandatory to recommend elective caesarean section routinely, there is no evidence to support that Ms A was given the opportunity to make an informed choice about birthing options. It is not possible for me to say what birthing options Ms A would have considered had these discussions taken place. However, I am clear that she was not given the opportunity to make a considered choice in relation to birthing options and I am critical of this.

25. I am satisfied that reasonable reviews were carried out on 20 December 2011 after Ms A was admitted to the Hospital and that the emergency situation of shoulder dystocia was appropriately managed, in that reasonable manoeuvres were attempted after shoulder dystocia was diagnosed at the time of delivery.

26. Nevertheless, I am concerned that there is no clear evidence to support that the midwife on the labour ward was clearly aware of Ms A's previous complications from the handover notes from the antenatal midwife. I noted that Ms A's previous history of shoulder dystocia had been documented when she was admitted to the antenatal ward at 10:00 on 20 December 2011. It would have been good practice for the antenatal ward midwife to have noted this information in the handover note to the labour ward midwife who would thereafter be on the alert to call for assistance if required. That being said, the advice I have received is that it was unlikely to have changed the outcome as appropriate staff were duly summoned when shoulder dystocia was diagnosed.

27. In view of the above, I uphold the complaint and make the following recommendations.

Recommendations

28. I recommend that the Board:	*Completion date*
(i) apologise to Ms A for the failings identified in this report;	22 January 2014
(ii) review their guidance to staff on the antenatal management of women to ensure that the risks of recurrent shoulder dystocia are discussed with expectant mothers together with birthing options; and	26 February 2014
(iii) draw to the attention of the antenatal midwife who looked after Ms A, the importance of documenting previous history of shoulder dystocia in the handover note to the labour midwife.	22 January 2014

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

Annex 1

Explanation of abbreviations used

Ms A	the aggrieved
The Hospital	Raigmore Hospital
Miss C	the complainant
Adviser 1	a midwifery adviser to the Ombudsman
Adviser 2	a consultant in Obstetrics and Gynaecology
The Board	Highland NHS Board
RCOG	Royal College of Obstetricians and Gynaecologists

Annex 2

Glossary of terms

amber pathway	a process for assessing pregnant women with any potential medical/obstetric/social factors
placenta	an organ attached to the lining of the womb during pregnancy and which is expelled after birth. It keeps the unborn baby's blood supply separate from the mother's
Prolonged Rupture of Membranes	when a woman's waters or membranes burst from the vagina and persists for more than 24 hours and prior to the onset of labour
red pathway	a process where women with significant medical/obstetric factors should have a consultant obstetrician as the lead professional sharing care with midwives, GPs and other care providers as appropriate in line with NHS Quality Improvement Scotland Pathways for Maternity Care (March 2009).
shoulder dystocia	when the baby's shoulders become caught in the mother's pelvis
Spontaneous Rupture of Membranes	the breaking of the water or membranes from the vagina

Annex 3

List of legislation and policies considered

Pathways for Maternity Care (2009) NHS Quality Improvement Scotland

Royal College of Obstetricians and Gynaecologists Green Top Guidelines No:42 Shoulder Dystocia 2nd Edition/March 2012

Royal College of Obstetricians and Gynaecologists Green Top Guidelines No.42 Shoulder Dystocia December 2005

NHS Institute for Innovation and Improvement : Quality and Service Improvement Tools and Clinical Guideline 62 Antenatal Care (2008)