SPSO decision report

Case: **201102909, Highland NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mrs C became pregnant at the age of 40. Her pregnancy appeared to progress well, but at just over 37 weeks it was discovered that her baby had died. Mrs C's baby was stillborn the following day. Mrs C made a number of complaints about the care that she, her baby and her husband received both during and following her pregnancy.

Mrs C was concerned that she had been placed on a midwifery led care pathway. Having taken advice on this from our medical advisers, we found that this was appropriate, as she had no apparent risk factors. Her age was taken into account appropriately, with an extra appointment for a fetal growth scan (a scan to detemine the growth and health of the baby) with an obstetrician at 12 weeks. We also found that Mrs C's care complied with the governmental guidelines 'Pathways for Maternity Care' and did not uphold this complaint.

Mrs C also complained that the systems of routine scans and antenatal checks did not provide enough care to mothers and babies. She was concerned, in particular, that no further midwifery appointments were offered after 35 weeks, and that additional checks were not carried out on her. We found, however, that the care in place was appropriate, that Mrs C had had a suitable number of midwifery appointments at the appropriate stages throughout her pregnancy, and that a balance had to be struck between positive elements of providing reassurance and detecting disease for which there is an intervention, and negative elements of creating anxiety and possibly unnecessary early delivery. We did not uphold this complaint.

Mrs C said that the postnatal care offered to her and Mr C was inadequate and did not offer enough support for their bereavement. We found that, although the postnatal care by the midwives was adequate, Mrs C was not contacted by a health visitor. The board said that a health visitor would not visit in the event of a stillbirth, but the advice we received indicated that contact would have been appropriate. We upheld this complaint and recommended the board reconsider their policy in this regard.

Mrs C also complained that the information offered by the board about loss in pregnancy was inadequate. We did not uphold this complaint as we found the information offered by the board through parentcraft classes was proportionate and appropriate.

Finally, Mrs C complained that the board did not fully address some of the issues she raised with them. We upheld this complaint as we found a number of errors in the information the board gave Mrs C throughout their correspondence with her. There was also an unnecessary delay in providing the results of a second opinion post-mortem report that Mr and Mrs C had requested.

Recommendations

We recommended that the board:

- provide us with evidence that they have reviewed their policy and clarified the role of health visitors in the event of stillbirth and neo-natal death, to ensure sufficient information is communicated effectively during

the midwifery discharge process;

- provide Mrs C with a copy of the second opinion post-mortem report and offer her an appointment to discuss the findings; and
- provide Mr and Mrs C with a full apology for the failings identified.