SPSO decision report

Case: **201303319, Lothian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mrs C complained about the treatment she received from the board in the lead up to the birth of her twins. During her pregnancy she developed HELLP Syndrome (this is the term used to describe a range of symptoms that can affect women with pre-eclampsia or eclampsia; HELLP Syndrome is characterised by the breakdown of red blood cells, elevated liver enzymes and low platelet count). Following diagnosis of her condition, Mrs C's caesarean section was brought forward. Whilst one of her daughters was born healthy, the other was stillborn. Mrs C complained that staff did not monitor her and her babies adequately, and that there was an unreasonable delay to the diagnosis of her HELLP Syndrome and to the delivery of her twins.

We took independent medical advice from a consultant obstetrician (a doctor specialising in pregnancy and childbirth) and gynaecologist (a doctor specialising in the female genital tract and its disorders). We were generally satisfied that Mrs C's condition, and that of her twins, was monitored adequately and in line with national guidance. Blood tests raised concerns for Mrs C's wellbeing but gave no indication of a problem with the twins. When abnormalities were identified, staff acted appropriately. However, we found that one of Mrs C's blood test results was checked and action taken by clinical staff before the full extent of the test results was known. Crucial information about Mrs C's liver enzyme levels was not identified until the day after the information was entered onto the hospital's system. Whilst appropriate action was taken to prioritise Mrs C's delivery once this information was highlighted, we accepted advice from our adviser who considered that the delivery would have taken place sooner had the blood test results been noted on the day they were reported. The available evidence suggested that, had this happened, both twins would likely have been alive at birth.

We were also critical of excessive delays and poor communication in the board's handling of Mrs C's complaint.

Recommendations

We recommended that the board:

- apologise to Mr and Mrs C for the failings identified;
- review their systems for reviewing blood results to ensure those taken in clinic and those taken on the ward are seen and acted upon in a timely fashion;
- take steps to ensure clear communication of the urgency of non-elective c-sections, and to develop a policy for escalation at times of high workload when c-sections are delayed longer than expected; and
- review their procedures for conducting root cause analyses to ensure they follow a structured process in keeping with the principles of the NHS Scotland complaints handling procedure.