SPSO decision report

Case: **201601106, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mr and Mrs C complained about the care and treatment provided to their daughter when she was delivered. At the time of, or shortly after, the delivery by forceps, she sustained a deep cut to her foot. The board were unable to provide an explanation for the cut. Mr and Mrs C complained that board staff failed to perform the forceps delivery in a reasonable manner, and that they subsequently failed to provide appropriate treatment for the injury.

During our investigation, we took independent advice from an obstetrician and a paediatrician. We found that the forceps delivery was not the cause of the cut and that the cut was most likely to have been sustained after the delivery. We did not uphold this aspect of Mr and Mrs C's complaint. Additionally, we found that the treatment given was timely and reasonable and, therefore, did not uphold this aspect of Mr and Mrs C's complaint.

Mr and Mrs C also complained about how the board handled their complaint. They said that the board had taken a long time to respond to their complaint and that they had not made efforts to contact all of the staff involved in the delivery. The board said they had initially not thought that the complaint was to be treated as such, and that they had confirmed this with Mr and Mrs C. However, they could not provide evidence of this being confirmed with Mr and Mrs C. We found this to be unreasonable. In addition, we found that the board could have made further efforts to contact staff involved in order to give a fuller explanation of events surrounding the cut. We also found that in recording the incident, the board had not made efforts to contact midwifery staff and we did not find this to be reasonable. Therefore, we upheld this aspect of Mr and Mrs C's complaint.

Recommendations

We recommended that the board:

- apologise for the complaints handling failures identified by this investigation;
- feed back the findings of this investigation to the relevant complaints handling staff; and
- feed back the comments of the obstetrician adviser to the relevant staff.