SPSO decision report

Case: **201604513, Forth Valley NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: not upheld, no recommendations

Summary

Ms C complained on behalf of her daughter (Miss A) about the care provided to her at Forth Valley Royal Hospital following an ultrasound scan which confirmed that she had lost her baby. Ms C was concerned that a sonographer, rather than a midwife, had told Miss A that the baby had died, and that she then had to wait for 45 minutes to see the doctor and midwife. She was also concerned that her daughter was not given a full explanation of the medication she would receive and of the process which would lead to the birth of her baby. She felt that the level of support and information provided to her daughter was inadequate. Ms C was also unhappy with what happened when her daughter returned to the hospital two days later to give birth to her stillborn baby. She felt that the support provided by the midwife was poor and this meant that her daughter eventually gave birth without the midwife being present. She was also concerned about the level of pain relief provided, documentation which suggested the baby would be cremated when this was not the intention of the family, and that the time of the birth was misreported in the records.

We took independent advice from a midwifery adviser. We found that it was appropriate for the sonographer to report the ultrasound findings to Miss A. We noted the subsequent delay in seeing a doctor or midwife, but we did not consider that this delay was unreasonable for the hospital at that time. We were satisfied that the records showed that Miss A was provided with a reasonable level of support and advice and that she was given the opportunity to ask any questions she had at that time about medication or the birth process. Following her attendance at hospital two days later, we were satisfied that the level of support provided to Miss A was reasonable. We noted the issues with the form suggesting cremation, but we also noted that the board had agreed to review this literature when they responded to Ms C's complaint. As we were satisfied that the level of care and support provided was reasonable, we did not uphold these complaints. However, we did highlight to the board the importance of ensuring that their record-keeping is accurate as we did note a discrepancy in the times recorded in the midwifery records.