SPSO decision report

Case: **201707853, Grampian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mrs C, an advocacy and support worker, complained on behalf of her client Mrs A about the care and treatment Mrs A received at Dr Gray's Hospital. Mrs A suffered a miscarriage and attended hospital for an assisted delivery. She signed a consent form for the treatment and indicated that she wanted to take her baby home with her following the procedure. Mrs A believed she had passed her baby's foetus on the first day she was in hospital but was assured that this was not the case by her midwife. When Mrs A was to be discharged, the hospital were unable to locate the tub used for storage of what Mrs A believed to be the remains of her baby.

We took independent advice from a midwife. We found that the midwifes failed to follow the correct procedures in relation to the storage and disposal of pregnancy loss products. Therefore, we upheld this aspect of Mrs C's complaint.

Mrs C also complained that the board failed to take adequate steps to address the acknowledged failings in Mrs A's care. Mrs A contacted the hospital following her discharge to discuss her treatment and the location of the tub. After discovering it had been incorrectly disposed of, Mrs A asked for an explanation from the board. Mrs A was told that actions had been taken to prevent a reoccurrence. Mrs A contacted the board's complaint department some weeks later and was told that the incident had not been reported formally or logged as a complaint.

We found that there was no evidence of any actions taken by the board to learn from the incident. We also found that the board had told Mrs A, in their first response to her, that action had been taken and the incident formally logged, which was incorrect. The board then failed to identify this inaccuracy in their second response to Mrs A. We upheld this aspect of Mrs C's complaint.

Finally, Mrs C complained that the board failed to handle Mrs A's complaint reasonably. We found that the board's handling of the complaint failed to meet the standards expected of them by their complaints handling procedure. We considered that the board did not show an appropriate level of empathy or compassion for Mrs A in their response to the incident and failed to record or respond to the complaint properly. Therefore, we upheld this aspect of Mrs C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs A for failing to provide an appropriate level of care for her, and for failing to handle her complaint appropriately. The apology should meet the standards setout in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

What we said should change to put things right in future:

- Staff are aware of and are implementing the appropriate guidelines in relation to caring for women

suffering from a miscarriage.
- Staff are aware of what constitutes a significant incident and how this should be reported and recorded.

In relation to complaints handling, we recommended:

- Staff have the knowledge and skills to identify and register complaints in line with the board's complaint handling procedure.
- The board's complaints handling system should ensure that failings (and good practice) are identified, and that action has been taken to ensure there is learning from complaints to inform service development and improvement.
- The board should use clear and accessible language, sensitive to the patient in cases of miscarriage.