SPSO decision report

Case: **201800745, Lothian NHS Board - Acute Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Miss C complained about the antenatal care and treatment she received when she was pregnant with her child (Baby A). Miss C also complained that the board did not communicate reasonably with her about her antenatal care and treatment. At Miss C's 20 week anomaly scan it was identified that Baby A was measuring larger than expected. Baby A was born prematurely with severe and complex needs and died a few days later.

We took independent advice from a midwifery adviser and a sonography (the medical diagnostic imaging technique used to see internal organs, muscles, etc) adviser. We found that

No alternative arrangements were made for bloods to be obtained as requested by Miss C's GP during one of her antenatal appointments.

There were no records of:

one of Miss C's antenatal appointments

discussions that the midwife had with the sonographer and the consultant obstetrician (a doctor who specialises in pregnancy and childbirth)

the management plan, reason for changing the management plan and the details of what was communicated to Miss C.

The reason for not repeating the anomaly scan and requesting a growth scan instead was not explained to Miss C.

The sonographer did not seek medical advice regarding Baby A's measurements at the time of Miss C's 20 week scan or as soon as reasonably practicable.

The board identified that inappropriate comments were made to Miss C about Baby A's size.

The sonographer did not communicate Baby A's measurements to Miss C at the time of her 20 week anomaly scan.

Therefore, we upheld Miss C's complaints. We noted that the board had already apologised for some of these failings and had taken action to prevent these reoccurring. We asked the board for evidence of these actions and made further recommendations.

Miss C also complained that the board failed to handle her complaint reasonably. We found that the board did not inform Miss C at the earliest opportunity that a Significant Adverse Events Review would result in a delay in

responding to her complaint or keep her updated as the review was progressing. We also found that the board failed to let Miss C know the outcome of the complaint investigation in writing. Therefore, we upheld this aspect of Miss C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Miss C for the failure to provide her with reasonable antenatal care and treatment, the failure to communicate reasonably with her and the failure to handle her complaint reasonably. The apology should meet the standards set out 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:

- Bloods should be obtained as requested by GPs.
- Midwives should keep clear and accurate records in accordance with the Nursing and Midwifery Code: professional standards of practice and behaviour for nurses and midwives.
- Clear explanations should be given to expectant mothers about decisions to change the care they will be receiving.

In relation to complaints handling, we recommended:

- The board should ensure that they are adhering to the NHS Scotland Model Complaints Handling Procedure.