SPSO decision report

Case: **202003881, Highland NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C and their pregnant partner (A) attended a local hospital as A was experiencing abdominal discomfort. A was examined and recommended to attend the main regional hospital, advising C to drive them there. The journey time was approximately 3 hours and on arrival A was examined and advised that labour may be starting. A was later told that labour was unlikely to be starting but remained in hospital overnight and discharged the following day.

The following week, A suffered vaginal leakage and attended the local hospital where they were examined by a clinician and advised that they suspected A's waters had broken. A was advised to go to the main regional hospital and they were told that an ambulance was not needed. C therefore drove A to the main regional hospital.

An examination at the main regional hospital revealed that A's waters had broken and in the early hours of the following day they went into labour. Later that afternoon clinicians gave A and C a number of options: continue with natural labour, attempt a process of augmentation (helping along a labour that's not progressing as it should), or an immediate caesarean delivery (an operation to deliver a baby that involves cutting the front of the abdomen and womb). A and C both agreed to a caesarean. The procedure was carried out and the baby (B) was delivered. However, clinicians had to resuscitate B.

A scan of B's brain three days after birth revealed a likely injury which was later confirmed as periventricular leukomalacia (PVL, a softening of white brain tissue near the ventricles which often causes problems later with muscle control and thinking or learning problems). Following repeated scans over several weeks as the cysts continued to form, this was eventually categorised as grade three level of severity.

C raised concerns with the board regarding the care and treatment that A and B had received. C met various clinicians but remained dissatisfied. The board offered to have the events subjected to an external review but terms could not be agreed and the review was not carried out.

We took independent advice from a neonatal consultant. We found that, during both admissions, the board failed to provide reasonable care to A and their unborn child and that the board failed to fulfil their obligations under duty of candour. We upheld the complaints.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C and A for failing to provide optimal care, for failing to carry out adequate assessment, for failing to complete suitable documentation and for failing to make safe transport arrangements. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.
- Apologise to C and A for failing to provide reasonable care by omitting to timeously administer prophylactic

antibiotics to A on arrival at the regional hospital and apologise for the board failing to fulfil their duty of candour obligations when the antibiotic incident was identified. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.
- The board should offer C a final opportunity to address their outstanding questions in relation to the care of A and B in a format agreeable to both parties.

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

- Establish record keeping systems that prompt midwives to detail a full assessment and ensure there is cross checking with the consultant unit at the regional hospital.
- Establish a protocol for managing premature rupture of membranes in remote locations and commence treatment where appropriate, prior to transfer.
- Establish standard documentation and standard operating procedures for risk assessing pregnant women in remote locations, to determine the most appropriate mode of transfer to the obstetric units.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.