SPSO decision report

Case: **202101013, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the care and treatment that they received from the board following a stillbirth. C complained that the board had failed to provide them with adequate support following the birth of their child. C also complained that a consultant had acted unreasonably by discussing their child's post mortem results with them, without prior warning and without the presence of their partner, during a consultation several months later to discuss the progress of a new pregnancy.

The board did not identify any failings with the support provided to C. However, they apologised for the distress caused to C during the meeting with the consultant. They said that the consultant was required to make a plan of care for the new pregnancy and that this inadvertently led to the discussion and counselling of C's previous pregnancy. The Board said that C's partner was unable to attend the meeting due to restrictions on hospital visiting in force at the time due to the pandemic.

C remained unhappy and asked us to investigate. C complained that the support provided to them was inadequate. C also complained that the consultant had acted unreasonably.

We took independent advice from a consultant obstetrician. We found that inpatient care discharge arrangements, including handover of C's care to community midwives was as expected. We did not uphold this complaint. However, we found that there had been a failure to adequately prepare for C's consultation. In the circumstances, we found that it was unreasonable to have progressed with C's consultation without offering them the choice of re-scheduling so that consideration could have been made to their partner attending, or offering a remote appointment. We upheld this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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

- The findings of this investigation should be fed back to the staff involved, in a supportive manner, for reflection and learning.

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.