SPSO decision report

Case: **202203466, Highland NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the care and treatment provided to their adult child (A) in relation to A's pregnancy. A attended hospital on two occasions over a weekend with no fetal movement. The baby (B)'s heartbeat was considered normal on both occasions and A left the hospital with a plan to return on the Monday. On A's return to hospital, an intrauterine death (when a child dies in the womb) was diagnosed. A requested to have their waters broken to relieve the pressure that they were experiencing. A 's labour was very quick and they delivered B in the toilet of the labour suite at the hospital. They called for a midwife to attend and assist them.

C complained that the hospital did not listen to their concerns for B to be delivered as an emergency. C and A believed that there was too much focus on B's heartrate and that further investigations, including ultrasound, should have been undertaken. C also complained about the difficult circumstances of B being born in the toilet, and the care provided in the run up to, and following, labour.

In response to the complaint, and following the completion of a Significant Adverse Event Review (SAER), the board found no specific failings of care which led to B's death. Monitoring of A and B was appropriate, and ultrasound scanning was not available over the weekend. The board noted that A had chosen to return home, rather than be admitted over the weekend which was against medical advice. The board explained that early delivery by caesarean section was not indicated given the clinical picture was reassuring. C and A met with representatives from the board following the complaints response where issues relating to the delivery of B were discussed. The board acknowledged that a midwife should have responded to A's calls that they were delivering B in the toilet, and acknowledged that A should not have been in a labour ward where they could hear other mothers and healthy babies.

C was dissatisfied with this response and brought their complaint to us. They disputed the accounts of doctors that A was advised about the risks of going home during the weekend and remained of the view that more should have been done for A and B over the weekend.

We took independent advice from a GP who worked as an obstetric and gynaecology registrar (a specialist in pregnancy, childbirth and the female reproductive system) and a registered midwife. We found that appropriate advice was offered to A about the risks of returning home over the weekend, that the level of monitoring and assessment was reasonable and that the assessments were reassuring with respect to the health of A and B. Therefore, we did not uphold this part of C's complaint.

In relation to the treatment provided to A during labour, we found that care in preparation for delivery of B was reasonable, with appropriate monitoring and pain relief provided. When A rushed to the toilet, given the recent examinations checking the progress of A's labour, it was reasonable for midwifery staff not to consider A was about to give birth. However, there was a lack of documentation and records at the time of delivery and the immediate period before and after this which prevented our office from drawing conclusions about the level of care provided. Given the board's acknowledgements that a midwife should have attended immediately to A when

they called for help, together with the lack of appropriate record keeping during labour, and the accommodation in the labour suite being inadequately soundproofed, we upheld this part of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A for the failures 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:

- Clinical and midwifery staff should keep clear and accurate records, relevant to their practice, in line with the Nursing and Midwifery Council code.

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.