SPSO decision report

Case: **202209839, Lothian NHS Board - Acute Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained to the board about the midwifery care and treatment that they received during and following the birth of their baby. In particular, C complained that they had been unsupported during the birth, that their birth plan had not been followed, that the umbilical cord had snapped during delivery and that no meeting had been arranged to discuss the incident despite requesting one. C also complained that there had been a failure to recognise that this had been a traumatic incident for them, and that the board's response to the complaint had lacked empathy.

The board's response advised that C had been assisted during the birth, however they apologised that C's expectations had not been met at the time. The board also apologised that it had not been understood that C had intended to use the water pool for pain relief only, and that they did not want to give birth in the pool. In relation to the cord snapping, the board explained that this had been recognised as an emergency incident straight away, but on reflection, the emergency buzzer could have been activated sooner. In terms of communication, the board explained that the circumstances of the birth had been discussed with C by the delivery midwife during a post-natal visit to C's home. When a further meeting was requested, the board said a meeting date had initially been offered by text message which C declined. In hindsight, the board recognised it would have been better to arrange this with C by phone. It was further explained that C had been given contact details to arrange discussion with a consultant in keeping with their request, however C had not gone on to take up that offer.

We took independent advice from a consultant of obstetrics and gynaecology. We found that a minimum standard of care had not been met on this occasion. We noted that key aspects of the medical notes and birth plan had not been read, as C's preference not to birth in the pool was clearly documented but had not been known by the midwife. In reference to the cord snapping, we found that it can snap spontaneously after either an attended or unattended birth, and in the pool or out. It was difficult to say what this was attributable to the birth, nevertheless bringing the baby above the surface of the water was likely to have been more important than care of the cord. We highlighted that the board's complaint response had said it was recognised by the midwife that the cord snapping was an emergency incident, however we could see no evidence from the notes of an acute crisis.

In reference to communication, we found that the board had recognised that it would have been better to phone C rather than text them to arrange a time to discuss their concerns. We found that it would have been better for the board to arrange the debrief meeting with the consultant, rather than to expect C to arrange this themselves. On balance, we upheld C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified in this decision notice. 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:

- Midwifery care should be informed by the patient's records.
- Midwifery care should be clearly and accurately recorded and include reference to any incidents and the actions taken in response.

In relation to complaints handling, we recommended:

- Complaint responses should be clear and fully respond to the issues raised. This should include a full explanation of what occurred and a description of what happened and/or what should have happened at the time.
- The board should offer C a debrief meeting at a mutually convenient time to discuss the events which occurred and to answer C's questions regarding the circumstances of the birth.

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.