S.116/02-03

Scottish Public Services Ombudsman Act 2002

Report by the Scottish Public Services Ombudsman
of an investigation into a complaint against:

West Lothian Healthcare NHS Trust[1]

Background to the complaint

1. The account of the complaint provided by Mrs C[2] relates to the management of her pregnancy and labour by St John's Hospital, Livingston (the Hospital) in 1998/9.

2. Mrs C had told her General Practitioner (GP) that she estimated her last menstrual period (LMP) had been on 24 July 1998. From her LMP, Mrs C was told that her expected date of delivery (EDD) was 1 May 1999.

3. Mrs C attended a booking appointment on 20 October 1998 at the Hospital. An ultrasound scan was performed which Mrs C understood was, amongst other things, to check the gestational age of her baby and hence the EDD. The scan indicated that the baby was 13 weeks and five days old giving an EDD of 24 April 1999. At the booking appointment Mrs C also met a Consultant Obstetrician (Consultant 1). She recalled the discrepancy between the EDDs calculated from her LMP and from the ultrasound was mentioned briefly by Consultant 1 but she was not asked in more detail about her menstrual history. The EDD of 1 May 1999 continued to be used in all subsequent discussions with her about her pregnancy.

4. Mrs C's pregnancy was uneventful although it continued beyond 1 May 1999. Mrs C met Consultant 1 on 5 May and she recalled asking about the induction of labour but instead a further appointment was arranged for

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1 West Lothian Healthcare National Health Service Trust (the Trust) was established under The West Lothian Healthcare National Health Service Trust (Establishment) Order 1998 which came into force on 2 November 1998. The Trust was dissolved under The National Health Service Trusts (Dissolution) (Scotland) Order 2004 which came into force on 1 April 2004. On the same date an Order transferring the liabilities of the Trust to Lothian Health Board came into effect. To avoid confusion, this report continues to refer to the Trust when describing actions taken by, or on behalf of the Trust. However, the recommendations within this report are directed towards the Board.

2 A key to the names and abbreviations used in this report is set out at Annex A.

11 May 1999 in case she had not delivered. By 11 May Mrs C was anxious to be delivered. She attended the appointment at the Hospital and, at her insistence, it was agreed that she would be admitted for labour to be induced on 14 May.

5. On 13 May, Mrs C started labour spontaneously. She went to the Hospital at 5.15 am where a Midwife (Midwife 1) admitted her and carried out an assessment of her and her baby's condition. After some delay she was examined by a Registrar (Registrar 1) because of concerns about her baby's condition. It was decided that the baby should be delivered by emergency Caesarean Section and, following further delay, her son Louis was born in poor condition at 7.53 am. Louis was transferred to the Simpson Memorial Maternity Pavilion, Edinburgh (SMMP) later the same day for intensive care. He died on 16 May 1999.

6. A summary of the relevant clinical events is contained in the Clinical Assessors' Report section of this report (see paragraph 26).

7. Mrs C complained formally to the Trust on 11 August 1999. The Trust arranged for an independent Obstetrician to review her care. Mrs C had concerns about the independent Obstetrician's initial report but she considered that his additional comments supported her view on the action the Trust should take in response to her concerns. However, she was dissatisfied by the Trust's response to her concerns and by the way the Trust had handled her complaint.

8. On 25 September 2000 Mrs C requested that an Independent Review Panel (IRP) consider her complaint. The IRP meeting was not held until 24 May 2002 and the final report issued on 2 September 2002. Again, Mrs C was very dissatisfied by both the substance of the IRP report and the way the IRP had been organised.

9. Mrs C complained to the former Health Service Commissioner for Scotland's office on 22 October 2002. My office was established the following day and so I took responsibility for considering her complaint.

INVESTIGATION

Matters subject to investigation

10. I decided to formally investigate Mrs C's complaint on 14 March 2003. I wrote to the Trust explaining this decision. The matters subject to investigation were that:

(a) The antenatal assessments and care provided to Mrs C were inadequate including, but not limited to:

taking an inadequate menstrual history;

inadequate consideration given to the discrepancy between the EDDs;

inadequate recording of antenatal care;

inadequate attention to the non-engagement of Louis' head at the antenatal appointment on 11 May 1999.

(b) The monitoring and care given to Mrs C while she was in labour was inadequate including, but not limited to:

delays in assessing Mrs C's and particularly Louis' condition and in obtaining medical attention when urgent assessment was necessary;

turning Mrs C onto her right hand side when there was concern about Louis' condition;

delays in making the decision to perform a Caesarean;

delays in performing the Caesarean.

(c) The care given to Louis immediately following his birth was inadequate including, but not limited to:

failure to arrange appropriate assistance resulting in delays intubating (inserting tube to assist breathing)

Louis and suctioning meconium (a green tarry substance in the bowel) from his lungs.

(d) The Trust's handling of Mrs C's complaint and the conduct of the IRP were inadequate including, but not limited to:

unreasonable delays;

failure by the IRP report to address significant aspects of Mrs C's complaint;

failure by the Chief Executive to respond to the IRP Report.

Investigation procedure

11. I authorised one of my Complaints Investigators to conduct this investigation on my behalf. Three Professional Assessors, (a Director of Nursing & Midwifery, a Consultant Obstetrician and a Consultant Paediatrician) were appointed to assist the investigation. Their report is reproduced in its entirety at paragraph 26.

12. The Trust's comments and relevant papers, including both Mrs C's and Louis' medical records, were examined. An extract of the relevant section from Mrs C's GP medical records was also obtained and examined. My Investigator interviewed Mrs C and members of the Trust's clinical and management staff. The Assessors were present at some of the interviews. I have not put into this report every detail investigated but I am satisfied that nothing of significance has been overlooked.

CLINICAL ASPECTS OF THE COMPLAINT

Complaints (a), (b) and (c)

Mrs C's oral evidence

13. Mrs C first met Consultant 1 at her booking appointment on 20 October 1998 after the Sonographer had carried out the ultrasound scan. She recalled Consultant 1 mentioning the discrepancy between the EDD calculated by her LMP and the EDD calculated by the ultrasound, but she recalled him saying it was 'all an estimation at this stage' and that he would not change her EDD.

14. Mrs C recalled telling Consultant 1 during her appointment on 21 April 1999 that she felt less movement from the baby and she understood from Consultant 1 that this was because, as the baby grew, there was less space for him to move. At this appointment, a 'pessimistic' appointment date was set for 5 May 1999 (pessimistic because the EDD was 1 May).

15. Mrs C next saw Consultant 1 on 5 May 1999 when she recalled asking about induction as she had understood from antenatal classes that women would normally be induced if they got to Term+ten days. She recalled Consultant 1 being dismissive of this suggestion and saying, 'everyone goes into labour eventually' although she accepted that she had indicated that she would prefer to go into labour naturally if it made no difference. A further appointment was scheduled for 11 May 1999. By this point she was very fed up and she raised the issue of induction and insisted on a date being scheduled.

16. When labour started Mrs C called the Hospital and was reassured by the midwives that her labour sounded normal and that there was no need to attend the Hospital at that point. She did so when her labour pains became more frequent. From the time of arriving at the hospital, she was told very little about Louis' condition throughout the period that she was at the Hospital.

Oral evidence from Trust staff

Consultant 1

17. Consultant 1 explained Mrs C's care was shared with her GP, community midwives and the Department of Obstetrics at the Hospital. Normal practice was for a patient to report the fact of pregnancy to their health centre where their GP or a community midwife would see them. The GP or community midwife completed the front sheet of the Maternity Services Antenatal Card (the antenatal card) which was sent to the Hospital and a booking appointment arranged. At this booking appointment blood tests were taken, an ultrasound scan performed and the patient was reviewed by one of a number of hospital clinicians. Consultant 1 explained that either the GP or the community midwife based at the health centre was responsible for taking the menstrual history and then completing this information on the antenatal card.

18. Consultant 1 first met Mrs C at the booking clinic on 20 October 1998. He felt that the fact that there was no information recorded on Mrs C's antenatal card about her menstrual history could be taken as an indicator that there was nothing significant in her menstrual history. As such, he did not consider that staff at the Hospital should have taken a menstrual history from Mrs C. Consultant 1 used an obstetric calculator to assess the differences in gestation ages calculated from LMP and the ultrasound. This indicated that from Mrs C's LMP her baby's gestation age was 12 + weeks whereas the ultrasound gave a gestational age of 13 + weeks. From this, Consultant 1 estimated the differential as being approximately a week and he did not consider that it was appropriate to change Mrs C's EDD based upon this differential. It was not Consultant 1's practice at that time to count the specific number of days between LMP and ultrasound gestational ages although he does now do so. His practice was to accept the LMP gestational age if the woman was confident of her dates of menstrual history, provided that the discrepancy between the ultrasound and LMP gestational ages was within the specified range of variation for the ultrasound scan.

19. Consultant 1 did not have any recollection of Mrs C's wishes about induction towards the end of her pregnancy. It would not be his normal practice to discuss the risks of post-maturity with women at that point of their pregnancies in large part because he felt that obstetricians themselves were often not clear on this issue. He made the point that 'fashions' in approaches to induction tended to change.

The Sonographer

20. The Sonographer explained women were given a blue X-ray request form marked 'booking scan' by the antenatal clinic which they took to the ultrasound department. Women did not bring their records or their antenatal card so the only clinical information available would be that hand-written on the blue X-ray request form but this information was not always completed. Accordingly, the Sonographer might well not have information regarding the date of the LMP. Normally, the Sonographer decided which measurements to use to calculate gestational age based upon the measurements and presentation observed during the scan rather than the LMP. The gestational age would be written on the back of the maternal

blood AFP antenatal screening request form which the woman would then take back to the antenatal clinic. The Sonographer would dictate a report which was typed and sent to the antenatal clinic for inclusion in the records. The blue X-ray request form was retained in the Ultrasound Department.

21. The Sonographer said it was not the radiographers' practice to calculate an EDD from the gestational age established during the scan. She felt this was the role of the midwives/obstetricians after all relevant information had been considered. However, if information on the woman's LMP was available, it would be normal practice for the radiographer to calculate the gestational age from that and to informally discuss with the woman any discrepancies between this and the gestational age calculated by the ultrasound.

Midwife 1

22. Midwife 1 last worked for the Trust in 2000 and now lives overseas. When contacted by my Investigator she explained that prior to leaving the Trust she had not been made aware that Mrs C had raised a complaint. She provided written comments to questions raised by the Assessors but her recollections have been affected by the passage of time. Her comments are referred to in the Assessors' report.

Consultant 2

23. Consultant 2 (a consultant paediatrician with administrative responsibility for the Department of Paediatrics) had been happy to meet Mrs C to answer her questions although he did not have any direct involvement in Louis' care. He explained the standard procedure at the hospital was for the paediatric Senior House Officer (SHO) to attend an emergency caesarean section delivery. It would not be practical to have a paediatric registrar attend all emergency caesarean sections because of staff numbers but if the SHO required assistance with the resuscitation process, then he or she would crash bleep (urgently summon via hospital bleeper) the paediatric registrar. A registrar could be called prior to the birth of a baby if either the obstetric staff or the paediatric SHO had concerns that the resuscitation of the baby would require additional expertise although in practice it was primarily the responsibility of the paediatric staff to make this judgment. The paediatric SHO would normally

simply be told that there was an emergency caesarean section and that he or she should be there prior to delivery.

24. Consultant 2 explained that all paediatric SHO staff attended a one-day programme on resuscitation skills at SMMP. They would have received full training on resuscitation by bag and mask and he commented that, when done properly, this was generally preferable to, and often as effective as, intubation. Paediatric SHO staff would also have been shown how to intubate neonates (newborn babies), but if a neonate required to be intubated this would be done by the paediatric registrar. Consultant 2 also commented that all paediatric SHOs would be expected to be able to suction the upper part of a neonate's airway to remove meconium. However, suctioning meconium in the lower part of the airway, especially from the trachea, was a much more difficult process as by definition the child was not breathing.

Paediatric Registrar

25. The Paediatric Registrar (Registrar 2) recalled treating Louis. She had been crash bleeped to come to theatre. The paediatric SHO gave a brief handover and Registrar 2 recalled being told that Louis' scalp pH was 7.0. Registrar 2 examined Louis and noted he was in poor condition with no air getting in to his lungs with the bag ventilation. She visualised his chords, saw a plug of meconium, and removed this. Louis then gasped and breathed well. She had not been consulted about Louis' condition prior to that point but she would not have expected to have been consulted by the paediatric SHO. Registrar 2 made the point that it was difficult to predict with accuracy what the likely condition of the baby would be from his scalp pH measurement and she felt that it was reasonable for the SHO to attempt to resuscitate Louis despite the significant acidosis.

Assessors' Report

26. I reproduce next, in its entirety, the report prepared by the professional assessors who were appointed to give advice on the complaint.

Information Provided and Considered for the Purpose of this Report

- *Copies of/extract from hospital records*
- *Copies of/extract from GP records*
- *Copies of/papers relating to the complaint*
- *Participation in interviews with staff (indication will be given as to who was present where referenced)*
- *Notes of interviews with staff (indication will be given as to who was present where referenced)*
- *Documentary evidence provided by the Service following the interviews with staff*

Guidance Utilised while Considering the Events

- *<u>Midwives Rules and Code of Practice</u> UKKC (1998)*
- *<u>Guidelines for Records and Record keeping</u> NMC (2002)*
- *<u>Good Medical Practice</u> GMC (2001)*
- *Wickham, S. (2003) <u>Midwifery Best Practice</u>. London: Books for Midwives*
- *<u>Routine Ultrasound Screening in Pregnancy. Supplement to Ultrasound Screening for Fetal Abnormalities</u>. Report of the RCOG Working Party (July 2000)*
- *<u>Care of the newborn in the delivery room</u>. Patricia Hamilton. BMJ 1999; 318:1403 – 1406 (22 May)*

Chronological Overview of Events
Booking
GP Booking Clinic

(i) *The GP record of 31.08.98 clearly documents that Mrs C gave her LMP as 24.07.98 having missed a period due on 28.08.98. She had 'just stopped contraception' but we do not know what contraception was being used. If oral contraception was being used then ovulation on discontinuing the pill can be variable and would make a discrepancy in gestational age between LMP dates and ultrasound dates more likely.*

(ii) *It has been stated that at the time of this pregnancy the GP who was undertaking the booking within the GP surgery would have recorded the findings in relation to the medical and obstetric history in the maternity services liaison card. It was ascertained that there would have been no Midwives involved in this episode of care. The notes were then sent to the Hospital for the first visit with the medical/hospital team.*

(iii) *It was noted that there is no information in the maternity services liaison card of details of the menstrual history. The spaces in the records for details of the menstrual history, including whether contraception had been used and when stopped, is not completed at all.*

Hospital First Visit

(iv) *Consultant 1 saw Mrs C at the Hospital on 20.10.98 for a booking visit at 12 weeks gestation by menstrual dates. He has stated that as the records showed no information about the menstrual history he assumed that there was nothing significant in the menstrual history. He did not consider that he or other medical or midwifery staff at the Hospital should have taken a further menstrual history. Mrs C has indicated that she was not questioned in detail about her menstrual history.*

(v) *An ultrasound scan was performed at this visit. The primary purpose of a scan at 12 weeks gestation is to date the pregnancy. However, a scan at this age will also establish the number of fetuses, their viability and any major abnormalities such as anencephaly. This scan was performed by a Sonographer, who in 1998 would not have had access to the maternity services liaison card. The sole details available to the Sonographer were that which were recorded on the maternal Neural Tube Defect (NTD) and Downs syndrome screening request form (this screening test measures AFP and HCG and the relevant levels of these two substances for gestational age will give a risk assessment for NTD and Downs syndrome). This request form and the blue x-ray request form were brought by the woman when she attended for her ultrasound appointment. However, the clinical information*

was not always completed on these forms and so the Sonographer was not always aware of the gestational age by menstrual dates.

(vi) *The Sonographer has recorded measurements for the bi-parietal diameter (BPD – the diameter of the widest part of the foetus' head) and head circumference (HC) and concluded that 'measurements suggest a gestation of 13 weeks and 5 days'. The software within the ultrasound machine will have calculated the scan gestational age. The Sonographer explained that the practice at this time was to record the findings of the ultrasound scan on the reverse side of the maternal AFP screening request form which the woman then took back to the ante-natal clinic. As relevant clinical information, including the date of the woman's LMP and/or the gestational age calculated from the date of the LMP (which in this case was 12 weeks and 4 days), may not have been completed on the forms which Mrs C took to her ultrasound appointment, the Sonographer may not have had sufficient information for her to identify any discrepancy between the gestational age as calculated by the ultrasound and by the menstrual dates. However, the Sonographer explained that if the information was available on the woman's LMP, it would be normal practice to calculate the gestational age from her LMP data and to discuss with the patient any discrepancies between this and the gestational age calculated by the ultrasound.*

(vii) *The Sonographer explained that it was not normal practice for Sonographers to recalculate the EDD from the gestational age established during the scan. She considered it outside the remit of the Sonographer and considered this to be the remit of the Obstetrician/Midwife.*

(viii) *At this point in the visit Mrs C would have then been seen by her Obstetrician who would have been accompanied by a Midwife. It is apparent that at this time the Midwife's role in the consultant antenatal clinic in the hospital setting was confined to that of assistant and chaperone, with limited input to management of care.*

(ix) *When Consultant 1 saw Mrs C on 20.10.98 he has indicated that he used a 'wheel' to calculate the gestation and found her to be '12 plus' weeks. He has stated that on seeing the scan gestation was '13 plus' weeks he would not have altered the due date himself as he felt a one week discrepancy was not significant. Consultant 1 commented that he tended to take gestational ages as calculated by LMP if the woman was certain of her menstrual history. He said that he did not record the final EDD written in the records and does not know when this was filled in nor by whom.*

(x) *The Assistant Women and Children's' Services Manager at the Hospital (Officer 3) explained that normal practice would be not to change the EDD provided the discrepancy was around 7-10 days although this would depend upon a number of factors including length of menstrual cycle. Additionally, the Midwife currently in charge of antenatal clinics at the Hospital commented that the normal practice amongst consultants within the department was not to change an EDD if the discrepancy between gestational ages was up to around a week to ten days.*

(xi) *Mrs C had a blood test for serum screening for neural tube defects and Down's syndrome. The request form for this test should record the scan gestational age and it is understood that the Sonographer would normally fill this in on the form. As the report gives the gestational age by menstrual dates only it would appear that the discrepancy was not noted here either.*

Commentary on GP, Sonographer, Midwife and Obstetric Management

- *When the maternity services liaison card was received by the Trust from the GP it did not contain an adequate record of Mrs C's menstrual history*

- *Trust staff do not appear to have taken an adequate menstrual history themselves and did not complete details of this history on the maternity services liaison card. This should have been*

done because an absence of written information cannot be assumed to equate with an absence of risk factors.

- *Different biometry charts will give different gestational ages for the HC and BPD measurements obtained by scans. However it should be accepted that in Mrs C's case the scan performed by the Sonographer on 20/10/98 using the Trust's ultrasound machine and the software installed in it gave an ultrasound gestational age with an 8-day discrepancy from the menstrual age.*

- *The procedures in place meant that if the date of the women's last menstrual period was not completed on the AFP screening request form or the blue x-ray request form, then the Sonographer would not have had sufficient information to note any discrepancy between gestational ages.*

- *The discrepancy in ultrasound gestational age and menstrual age was not noted by the midwife or obstetrician.*

- *This discrepancy was not recorded in the notes clearly although there is space in the notes for this. The midwife and obstetrician both had responsibility in this area. However, as the lead clinician in this pregnancy Consultant 1 had overall responsibility for this.*

- *It is generally accepted that scan dates are more reliable than menstrual dates and the majority of hospitals would re-date the pregnancy given an 8-day discrepancy this early in pregnancy.*

- *The ultrasound department should have had a written policy as to when to redate a pregnancy. If the ultrasound department did not have a policy then the obstetric department should have had a policy. The individual clinician should note any discrepancy in dates and alter clinical management as necessary. This could alter the date when a NTD and Downs screening test was carried out as it should be performed*

between 16 and 18 weeks. Redating the pregnancy would therefore alter when the blood test should be taken and the calculation of risk. The other major effect on clinical management by redating the pregnancy would be if intervention was required in the form of an elective caesarean delivery or induction of labour. Failing to be aware of discrepant dates could result in inappropriate timing of elective delivery or induction of labour or, as in this case, not offering induction of labour or instituting tests of fetal wellbeing. Consultant 1 should have been aware of the discrepancy and tailored his clinical management accordingly.

- *We also consider that Sonographers have some responsibility for the redating of pregnancies. However, we acknowledged that given the procedures in place at the time the Sonographers may not have had sufficient information to do so.*

- *There does not appear to be any hospital policy implemented either at the time or following the investigation of this complaint regarding redating of pregnancies (and recording this) when a discrepancy between menstrual and ultrasound dates occurs at the initial dating scan.*

- *We were informed in September 2003 that the Clinical Governance Group had recently commenced consideration of this issue. General Antenatal Guidelines were developed in July 2004 and adopted in August 2004. So far as the redating of a pregnancy is concerned these guidelines state:*

  > *'Agree **final EDD** with woman. This is very important to sort out early, particularly if there are discrepancies. If the EDD is not clear or there is conflicting information, refer for an obstetric opinion. Explain that it is normal to deliver at 'term' (ie from 37-42 weeks). Ask about date of conception, cycle, bleeding, and contraception. If LMP is unsure erratic cycle or recent oral contraceptive pill, use USS date.*

If there are discrepancies, use the USS date if it is either:
>7 days difference from LMP on scan at 8-12 weeks.
>10 days difference from LMP date on scan at 16-22 weeks.'

We consider these guidelines are appropriate.

- *Mrs C suggested a 'sticker' system to highlight notes where a discrepancy in dates, or uncertainty about dates, was noted. Appropriate recording of menstrual history, recording of dating scans and a policy regarding redating pregnancies should be the norm and although Mrs C's suggestion may be acceptable in some units it should not be necessary. There was no evidence available to us that any staff training has occurred regarding these issues since this case.*

- *Although a second ultrasound scan at around 20 weeks gestation is performed in the majority of units (thought to be approximately 75% in 2000) it is not mandatory. It is unlikely that a second scan at 20 weeks would have made any significant difference to the outcome in this case. A 20 week scan is not a 'dating' scan however measurements would probably have been consistent with the scan EDD and may have alerted clinicians to the discrepancy noted at the 12 week scan. (Ref: Routine Ultrasound Screening in Pregnancy. Supplement to Ultrasound Screening for Fetal Abnormalities. Report of the RCOG Working Party July 2000). It would not be appropriate or normal practice to repeat all dating scans where there is a discrepancy in dates unless this was very marked (for example a three or four week difference). The margin of error in measurements is such that the accuracy is approximately 5-7 days hence redating pregnancies when the discrepancy is more than this.*

Subsequent Shared Antenatal Care

(xii) *A total of 12 antenatal visits were recorded in the records. Antenatal checks either occurred at the Hospital or at the Health Centre. Consultant 1 did an antenatal clinic at the Health Centre and so on some occasions saw Mrs C there. He saw Mrs C at the Hospital on 20.10.98 and at the Health Centre on 11.03.99, 21.04.99 and 5.5.99. It was noted that there would have been no midwives in attendance at the Health Centre Consultant clinics at that time.*

(xiii) *The number of antenatal visits was more than adequate and there were no major antenatal problems noted. A 20-week scan was not part of the routine antenatal management and cannot be considered to be substandard care.*

(xiv) *The records quite clearly state that the baby was 'active' or there were 'FM+' (fetal movements present). Consultant 1 has stated that it was his normal practice to arrange for cardiotocography (CTG or fetal heart rate tracing) to be carried out if any patient mentioned that fetal movements were reduced during pregnancy. The fact that it is documented that the baby was active or that movements were present on 4 occasions suggests that enquiries were made concerning this and no anxieties were expressed. Consultant 1 has no recollection of Mrs C discussing a reduction in fetal movements. If she had done so he has stated that he would have ordered a CTG to be carried out. It should be noted that throughout the antenatal period the standard of record keeping is not that which is considered acceptable to either the General Medical Council or the Nursing & Midwifery Council in that several entries failed to indicate date, time, signatures and outcomes of discussions held with Mrs C.*

(xv) *When Consultant 1 saw Mrs C on 5.05.99 she was Term+ 4 days by the menstrual dates. Consultant 1 has stated that he would not normally have discussed the complications of prolonged pregnancy at this stage and generally had a less aggressive approach to induction of labour for post maturity than some*

obstetricians. He would however have expected a plan to be made regarding induction of labour at the following week's visit when she would then have been term+10 days by menstrual dates. He has no specific recollection of Mrs C's wishes about induction of labour at the end of pregnancy but indicated that he would normally have been flexible and 'go along' with the patient's wishes regarding induction of labour. In her correspondence Mrs C acknowledged that she told Consultant 1 during the appointment on 5.05.99 that she hoped to commence labour naturally, although she also commented that she told him she understood that midwives usually wished to deliver before term +10 and that Consultant 1 had been dismissive of this. Mrs C's clinical records do not clarify precisely what was discussed at this appointment.

(xvi) *The final antenatal visit at the Hospital was on 11.05.99. Arrangements were made for Mrs C to come in for induction of labour on 14.05.99. At this visit at the antenatal clinic the records show that the presentation was cephalic and the head was 3/5ths palpable abdominally.*

Commentary on Midwife and Obstetric Management

- *There were no obstetric complications antenatally.*

- *It would appear that enquiries were made regarding fetal movements at antenatal appointments. At the appointment on 21/04/99 fetal movements were noted as being present. Mrs C describes reporting reduced movements at this appointment, but there is no note of this in her records although it should be noted that the quality of these records is poor. We cannot tell what was or was not discussed at this appointment. However, we are satisfied that Consultant 1's indication that he would arrange for CTG monitoring in response to reports of reduced fetal movement is the appropriate response to make.*

- *It would be normal obstetric practice to induce labour between Term+10 days and Term+14 days. The hospital guideline*

regarding induction of labour at the time was that induction should be offered at 'around 42 weeks' and this was reasonable as there was a very clear management plan for a pregnancy proceeding to 42 weeks which included offering induction and/or instituting regular fetal monitoring.

- *Mrs C said that at the appointment on 5.5.99 she indicated that she wanted to commence labour naturally and there was no reason for Consultant 1 to suggest otherwise as she was not 42 weeks by menstrual or scan dates. Consultant 1 said he would not normally discuss the complications of prolonged pregnancy with someone in these circumstances. It would be appropriate to discuss possible complications at the point when some decision regarding intervention is required but would not be mandatory when the pregnancy was only a few days past the due date and no intervention was indicated.*

- *Arrangements were made to induce Mrs C at Term +14 days by menstrual dates. Given the EDD that was being used this was reasonable and in line with the hospital's policy and there is no indication that Mrs C was pressing for induction of labour substantially earlier. When considering whether to induce labour the EDD should always be checked and if this had occurred the discrepancy should have been recognised. As the notes did not record the discrepancy it was however missed again.*

- *If the pregnancy had been redated at the first hospital visit or subsequently during Mrs C's antenatal care to an EDD of 24.4.99 then clearly a suitable time for induction of labour in accordance with the guidelines would have been approximately 8 days earlier. Current clinical practice indicates that where the discrepancy is greater than 7 days the EDD should have been re-dated.*

- *It would be appropriate to recommend commencing fetal surveillance by CTG monitoring and liquor volume monitoring, at term plus 10-14 days where the induction of labour is*

considered to be unnecessary or too much of an intervention by either patient or obstetrician.

- *If uncertainty about the EDD is noted as a possibility, fetal surveillance should be recommended at term plus 10-14 days by whichever date was earlier.*

- *There are significant limitations to fetal surveillance and the length of time for which fetal wellbeing can be assured in the presence of normal tests. It is impossible to know whether any such fetal surveillance would have shown any abnormalities if it had been performed prior to Mrs C's admission in labour. There is no degree of certainty that it would have.*

- *If Mrs C had been induced 8 days earlier we consider it likely that Louis would not have been in the already compromised condition that he was when Mrs C was admitted in labour. It is likely therefore that he would have been delivered in better condition than he was and would have stood a much better chance of surviving.*

- *Overall the standard of record keeping in relating to antenatal visits was noted to be poor.*

- *While technically the fact that Louis' head was 3/5ths palpable abdominally at the final antenatal visit on 11.5.99 meant the head was not engaged at term, however there would not be any obstetric concern about such a situation and no action was required.*

Care During Labour

(xvii) *It was noted that Consultant 1 had no direct involvement in the labour care. Mrs C was admitted and cared for by Midwife 1, till Mrs C was prepared for transfer to the Operating Theatre.*

(xviii) *Midwife 1 has indicated that until the Ombudsman's office commenced its investigation of Mrs C's complaint she had never*

been asked, either formally or informally, about Mrs C's care. Because she now lives overseas it was not possible for us to interview her about Mrs C's care but she willingly assisted with the Ombudsman's investigation and responded to our written questions. However, her ability to respond to these questions was inevitably restricted by the fact that over four years had elapsed.

(xix) *Midwife 1 has indicated, as the Senior Midwife on duty, that she would have had a supervisory role for the unit. If she was providing midwifery care to a mother, then she would not normally be involved in providing care to others. We have however been advised by Officer 3 that there were 2 other deliveries on the morning in question, one at 06.29 hrs and one at 07.04 hrs at which, according to Officer 3, there would have been 2 staff attending each woman at the point of delivery. The unit had 3 Midwives and 1 Clinical Support Worker on duty giving an indication that at the time of the decision to proceed to Caesarian Section both of the other on duty Midwives and the Support Worker would have been caring for the other women, one in the process of delivering and the other immediately post delivery .*

Hospital Admission

(xx) *On admission at 05.15 hrs maternal and fetal assessments were undertaken and were recorded and CTG monitoring was commenced.*

(xxi) *Following the spontaneous rupture of Mrs C's membranes at 05.35 the fetal heart rate was recorded as having a baseline of 165, with poor variability of less than 5bpm (beats per minute) and meconium stained liquor was noted. If meconium is passed by the fetus while still 'in utero' the fluid surrounding the fetus becomes stained. Where this occurs in conjunction with an abnormal CTG there is an increased risk of fetal hypoxia (low oxygen levels in the fetus). As Mrs C was, at this time, in the admissions area Midwife 1 initiated a transfer to the delivery room where she deemed it more appropriate to undertake any subsequent examinations and provide the necessary monitoring.*

Transfer to Delivery Room

(xxii) *At 05.55 hrs, Mrs C was transferred to the delivery room and the CTG tracing was recommenced. On arrival in the delivery room a vaginal examination was performed at 06.05 hrs to assess progress in labour. From these findings it was clear that the delivery was not imminent with the cervix being only 4 cms dilated. The fetal heart rate was again noted as having poor variability and the liquor was noted to be 'thickly meconium stained'.*

(xxiii) *Midwife 1 has indicated that she can only assume that she did not call medical staff, at that point in time as 'Mrs C was in active labour. Talking someone through contractions, teaching them how to use entonox (a method of pain relief), explaining what is happening, making them comfortable, allowing them time to go to the toilet or change all takes time'. The reference made to the change of Mrs. C's position to her right side was, Midwife 1 assumes, her endeavouring to ascertain whether or not the poor variability was as a result of a sleep pattern or maternal position. Midwife 1 has indicated she had undergone no formal training in the interpretation of CTG but learned 'on the job'.*

Medical Assistance Called

(xxiv) *The Obstetric Registrar (Registrar 1) was not asked to see Mrs C until 06.20; approximately one hour after admission and the observation of poor variability in the fetal heart rate and meconium stained liquor.*

(xxv) *Registrar 1 was attending another patient at the time and did not see Mrs C until 06.55. Although there was also an SHO (Senior House Officer) on duty, it was explained that s/he would have been a General Practitioner trainee with very limited obstetric experience or skills and would not have been capable of acting in this situation or making any decisions. The Consultant could potentially have been called in from home and the Midwives had direct access to do this if necessary.*

(xxvi) *Midwife 1 has indicated that she thinks it would have taken 'at least 50 minutes to an hour' for the on-call consultant to come in from home. The consultant was not called and if he had would have been unlikely to arrive prior to the time when Registrar 1 attended Mrs C.*

Medical Assistance Arrived

(xxvii) *At 06.55 hrs Registrar 1 was noted to be in attendance and responded to the abnormal fetal heart rate tracing by carrying out a fetal blood sample procedure (obtaining 2 samples as would be normal practice). On obtaining an abnormal fetal pH result on the samples she decided to carry out an emergency caesarean section and discussed this with the consultant on call. The decision to deliver the baby by caesarean section was documented as 07.10.*

(xxviii) *Mrs C was prepared for and transferred to the theatre, which was situated on the labour ward. Theatre staff would have been called from main theatre, which was very close to the labour ward geographically. It would appear that there was a delay in moving Mrs C to the theatre. Midwife 1 is unable to confirm what the actual cause of this delay was, however she has indicated that it may have been in part caused by the change over in shifts.*

(xxix) *The anaesthetist on-call assessed Mrs C regarding the type of anaesthesia and judged that a spinal anaesthetic would be more appropriate rather than a general anaesthetic.*

Induction of Anaesthesia

(xxx) *The spinal anaesthetic was inserted at 07.40 and the first incision was at 07.45. The baby was delivered at 07.53.*

(xxxi) *It would appear that there was no major degree of urgency communicated to the anaesthetist or theatre staff by Registrar 1 regarding delivering the baby quickly.*

(xxxii) *The operation was uncomplicated.*

(xxxiii) *A 'traffic light system' has since been introduced to aid communications within the department regarding the degree of urgency of caesarean sections.*

Commentary on Midwife and Obstetric Management

- *It was appropriate to transfer Mrs C to a delivery room following spontaneous rupture of her membranes at 05.35.*

- *There was a failure by the midwife to call for medical aid when the fetal heart rate trace was abnormal and when the membranes ruptured and meconium was noted. In accordance with the Midwives Rules and Code of Practice (UKCC 1998) Rule 40 at 05.35 Midwife 1 should have: - called 'a registered medical practitioner or such other qualified health professional who may reasonably be expected to have the requisite skills and experience to assist her'.*

- *If a doctor had been called then the diagnosis of probable fetal compromise could have been made earlier and an earlier delivery is likely to have been effected.*

- *Because the fetal heart rate trace was abnormal from the start of the CTG monitoring it is not possible to know at what time before admission to hospital it became abnormal. The abnormal fetal heart rate trace was highly suggestive of fetal hypoxia and is likely to have developed over a period of hours. It is highly likely therefore that Louis was already compromised at the time of admission and delivery even at that time would have resulted in the same outcome as the hypoxic damage to the brain had already occurred.*

- *Some obstetricians would not have carried out fetal blood sampling and gone straight for delivery by caesarean section. However, it remained reasonable for Registrar 1 to choose to await the results of the fetal blood samples before deciding whether to perform a caesarean.*

- *It is generally accepted that emergency caesarean sections for severe fetal distress should result in delivery within 30 minutes. The October 2001 National Sentinel Caesarean Section Audit has shown an average decision to delivery time in these cases of 27 minutes but in 25% of cases it took longer than 40 minutes.*

- *A decision to delivery time of 43 minutes in this case is certainly longer than desirable, especially given the relative proximity of the labour ward to the theatre and theatre staff, but it is not completely out of the range of normal practice. It is unlikely to have made any significant difference to the outcome as the CTG appearances were suggestive of chronic prolonged hypoxia rather than an acute hypoxic insult where a time delay of 20 minutes could be a crucial factor.*

- *It appears there was poor communication regarding the degree of urgency of the caesarean section. This appears to have been a significant factor in the length of time between the decision to deliver Louis by caesarean and his birth.*

- *The 'traffic light system' has been introduced in the department to aid communications regarding the degree of urgency of caesarean sections. This was introduced promptly and is to be commended.*

- *Subsequent audits by the hospital of decision to delivery times for the most urgent 'red' coded emergency caesareans compare favourably to the National Sentinel Caesarean Section Audit of decision to delivery time for emergency caesarean sections for severe fetal distress.*

- *It would appear that there was a deficiency in CTG training for midwives. There was evidence to show that CTG training was now available for staff and this training would be assessed (see clinical Governance Strategy-West Lothian Healthcare NHS Trust 2003). It was disappointing that the aim of 'ensuring training in resuscitation is undertaken by all medical,*

nursing and midwifery staff' would only have been met in 2004 and that it would be dependent on appointment to an additional post.

Resuscitation and subsequent care of the newborn baby

(xxxiv) *The Paediatric SHO (SHO 1) was present at the birth of Louis. He commenced resuscitation but (presumably) realising that his level of expertise was insufficient for the situation summoned more senior and experienced help.*

(xxxv) *The Paediatric Registrar (Registrar 2) told us that she was nearby when she was 'crash-bleeped' and she attended very promptly. She was given brief information about Louis including the history of fetal compromise, which was the indication for emergency caesarean section. She described the steps she took to resuscitate Louis, using a laryngoscope (an illuminated instrument) to visualise the vocal cords, noting the presence of meconium, which she removed with suction. At this point he gasped and started breathing.*

(xxxvi) *The case records confirm that SHO 1 removed thick meconium from the upper airway and attempted bag and mask ventilation without improvement. Following Registrar 2's intervention at about 5 minutes of age, ventilation of Louis' lungs was established and he improved rapidly. Registrar 2 chose not to intubate Louis at this time.*

(xxxvii) *Registrar 2 arranged for neonatal nursing support to be summoned from the Special Care Baby Unit to help with Louis' continuing care. Louis was admitted to the Special Care Baby Unit where Registrar 2 handed over his care at the end of her shift. Later in the day Louis was transferred to the SMMP for neonatal intensive care.*

(xxxviii) *The subsequent course of Louis' illness indicated that he was suffering from meconium aspiration syndrome (a condition in which meconium is inhaled into the air passages and lungs) and an hypoxic ischaemic brain injury (injury to the whole brain and*

other organs caused by a lack of oxygen and impaired circulation) from which he died.

(xxxix) *During labour, the contraction of the womb reduces blood flow through the placenta and as a result the oxygen supply to the baby is also reduced. In normal circumstances a baby can withstand such intermittent stress. However, if prior to the onset of labour there is already a degree of compromise in the baby's circumstances or placental function, the baby will be less able to withstand the stresses of labour and asphyxial insult (damage to the tissues caused by a lack of oxygen) will occur far more quickly.*

(xl) *The problems that led to Louis' death had their origins in a severe and prolonged asphyxial insult that was recognised during labour and delivery. The damaging effects of such asphyxia are progressive and continue to develop after the lack of oxygen and impaired circulation have been corrected. In this case hypoxic ischaemic damage to Louis' brain had almost certainly developed before labour started and was compounded by the process of labour and by the time of his birth and this damage proved to be irreversible.*

(xli) *Registrar 2 explained that she had been under the misapprehension that Mrs C had had a general anaesthetic and so she did not attempt to communicate with her about Louis' condition when he was admitted to the Special Care Baby Unit.*

(xlii) *Consultant 2 explained the standard procedure for paediatric staff attending an emergency caesarean section at the Hospital. He indicated that the default position was that a paediatric SHO would attend. If the SHO felt that he or she required assistance with the resuscitation process, then he or she would crash bleep the paediatric Registrar. However, a paediatric Registrar could be called prior to the birth of a baby if either the obstetrics staff or the paediatric SHO had concerns that the resuscitation of the baby would require additional expertise. He outlined the additional training that was made available to paediatric SHOs*

confirming that the skill level of this group of staff was not those of advanced paediatric resuscitators. He also explained that the paediatric SHO would normally simply be told that there was an emergency caesarean section and would not necessarily enquire about the possible condition of the baby. Consultant 2 explained that it was not possible to prognosticate with accuracy on the condition of the baby from the information available prior to the delivery and that the SHO would be engaged in ensuring that all relevant equipment and preparations for the baby's care had been made.

(xliii) *In response to a question about the Trust's comment that they do not have a policy on the level of skill of paediatricians attending the birth of a baby, in whom a degree of compromise is anticipated, he re-iterated the default position.*

(xliv) *Consultant 2 indicated that to the best of his knowledge the paediatric department had not been consulted about the introduction of the colour coding system for emergency caesarean sections.*

Commentary on resuscitation and subsequent care of the newborn baby

- *For a period of two and a half hours prior to Louis' birth there was thick meconium in the liquor associated with an abnormal fetal heart trace. These observations suggested significant risk of compromise. This risk was further confirmed by a degree of acidosis present in the fetal blood samples. Such findings would normally be taken to indicate that resuscitation of the newborn is likely to be needed.*

- *The Trust's default position was that a paediatric SHO, who is likely to have only basic neonatal resuscitation skills, attends all emergency caesarean section births to care for the baby. This was and remains common practice.*

- *The Paediatric SHO who attended Louis' birth was unable to resuscitate him but the more experienced Paediatric Registrar,*

using her advanced neonatal resuscitation skills, was able to do so. However she was only summoned after Louis' birth and whilst she attended promptly this resulted in a delay of about five minutes in Louis receiving more effective resuscitation.

- *The opportunity to have arranged for the Paediatric Registrar to attend Louis' birth in addition to the paediatric SHO was overlooked. Such arrangements would most likely have avoided the approximately five minute delay in resuscitating Louis. However, given his already compromised condition we consider it unlikely that this delay made any difference to the subsequent course of events.*

- *We consider that there is a need for the Board to review its policy regarding the resuscitation of the newborn to ensure that a member of staff with advanced resuscitation skills is in attendance at the birth of a baby who is expected to be significantly compromised.*

- *We suggest that the Board consider the introduction of a process of risk assessment to identify those circumstances where there is a significant risk of a baby needing the attendance of a member of staff with advanced neonatal resuscitation skills in addition to the paediatric SHO.*

- *Whilst we note that the Trust's Clinical Governance Strategy included the goal of 'ensuring training in resuscitation is undertaken by all medical, nursing and midwifery staff', we were disappointed that it only aimed to meet this goal in 2004 and that it was dependent on appointment to an additional post.*

- *Improved communication between the maternity staff and the paediatric resident staff would also be helpful in ensuring that the paediatrician with the most appropriate skills was present at the delivery.*

- *The Trust appears to have implemented the 'traffic light system' for emergency caesarean sections without full discussion suggesting that the need for these departments to work in partnership is not fully understood.*

- *The acknowledgement of the concern, raised by Mrs C, about poor communication about Louis' care by Registrar 2 and Consultant 2 when they met with her was clearly appropriate and helpful.*

Conclusions

(xlv) *The following conclusions have been reached in relation to each of the matters subject to investigation:*

(a) *The antenatal assessments and care provided to Mrs C were inadequate including, but not limited to:*

- *Taking an inadequate menstrual history;*
- *Inadequate consideration given to the discrepancy between the EDDs;*
- *Inadequate recording of antenatal care.*

*All of the above have been **upheld** by both the Obstetric and Midwifery Clinical Professional Advisers.*

(b) *The monitoring and care given to Mrs C while she was in labour was inadequate including, but not limited to:*

- *Delays in assessing Mrs C's and particularly Louis' condition and in obtaining medical attention when urgent assessment was necessary;*
- *Turning Mrs C onto her right hand side when there was concern about Louis' condition;*
- *Delays in making the decision to perform a Caesarean section;*
- *Delays in performing the Caesarean section.*

*The Obstetric and Midwifery Clinical Professional Advisers **upheld** that there were delays obtaining medical attention and in performing the Caesarean section.*

*They however **do not uphold** the complaint that it was inappropriate to alter Mrs C's position to ascertain whether or not it would improve the fetal heart trace, or that the delays caused by taking fetal blood samples were unnecessary.*

(c) *The care given to Louis immediately following his birth was inadequate including, but not limited to:*

- *Failure to arrange appropriate assistance resulting in delays intubating Louis and suctioning meconium from his air passages.*

*The Paediatric Clinical Professional Adviser **does not uphold** the complaint that the care given to Louis immediately following his birth was inadequate.*

Recommendations

(xlvi) *The Clinical Professional Advisers recommend that the Board:*

(a) Reviews the process of communicating clinical history/findings from GP booking clinics to hospital records.

(b) Ensures that the inadequacy identified in the taking and recording of menstrual history by both midwives and medical staff is addressed. Discrepancies between menstrual and ultrasound dates should be recorded clearly. There needs to be a written policy regarding redating a pregnancy when there is a discrepancy between menstrual and ultrasound dates.

(c) Ensures that the standards of record and record keeping in the antenatal period in general is improved to ensure effective communication and dissemination of information

between staff groups and that the records accurately reflect discussions, care planning and treatment plans.

(d) *Ensures midwifery and medical staff undergo regular updating in relation to interpretation of CTGs.*

(e) *Develops a policy for the resuscitation of the newborn that ensures that someone experienced in the resuscitation of the newborn and an assistant are available to support the midwifery staff in the labour ward at all times.*

(f) *Ensures that a programme of Neonatal Advanced Life Support (NALS) training is undertaken by all front line paediatric doctors and senior midwives who provide intrapartum care. This will ensure that staff with the appropriate skills and competencies are always available to provide emergency care of the newborn.*

(g) *Ensures that the Board has implemented a clinical incident reporting system involving all members of staff involved and that there is a feedback mechanism to the staff regarding findings and recommendations after investigation.*

Findings

27. Mrs C has many concerns about the management of her pregnancy and labour at the Hospital. These ranged from her antenatal assessments and care; the monitoring and her care in labour; and the care given to Louis immediately following his birth.

Complaint (A)

28. Mrs C estimated that her LMP had been on 24 July 1998 and from that she understood her EDD was 1 May 1999. However the result of the ultrasound scan indicated that the EDD was 24 April 1999. She was not questioned in detail about her menstrual history. She recalled telling Consultant 1 on 21 April 1999 that she felt less movement from the baby and she understood from him that as the baby grew there was less space for him to move. Mrs C raised the question of induction of labour with Consultant 1 on 5 May 1999. However, a further

appointment was made for 11 May. At this clinic visit, the records show that the presentation was cephalic and the head was 3/5 palpable abdominally. It was then agreed that Mrs C would be admitted for induced labour on 14 May. In the event, Mrs C went into spontaneous labour on 13 May.

29. Consultant 1 said he tended to take gestational ages as calculated by LMP if the woman was certain of her menstrual history. He could not recall Mrs C mentioning a reduction in fetal movements but his normal practice would be to arrange a CTG if concerns had been raised. He also did not recall Mrs C mentioning induction towards the end of her pregnancy and normally he would not discuss the risks of post-maturity with women at that point in their pregnancies.

30. The advice from the Assessors is that the primary purpose of a scan at 12 weeks gestation is to date the pregnancy but can also establish the number of fetuses, their viability and any major abnormalities. Trust staff should have taken an adequate menstrual history and completed the relevant records. It is generally accepted that scan dates are more reliable than menstrual dates and the majority of hospitals would redate the pregnancy when an 8 day discrepancy was evident at such an early stage. Such a discrepancy could have an effect on the timing of other screening tests and could result in inappropriate timing of elective delivery or induction of labour.

31. There are differences of opinion between Mrs C and Consultant 1 about what was said at clinic appointments and they cannot be reconciled due to a lack of entries in the clinical records. The Assessors have also pointed out that throughout the antenatal period the standard of record keeping is not that which is considered acceptable to either of the regulatory bodies and that several entries failed to indicate date, time, signatures and outcomes of discussions with Mrs C. I do note however that the clinical records show evidence that Mrs C attended 12 antenatal visits and it was recorded on 4 occasions that fetal movements were present. Although Louis' head was 3/5ths palpable abdominally on 11 May, which meant that the head was not engaged at term, from an obstetric view there would not be any concern and no action was required. Accordingly I have decided to uphold Complaint

(A) that the antenatal assessments and care provided to Mrs C were inadequate with the exception of the attention afforded to the non-engagement of Louis' head at the antenatal appointment on 11 May 1999.

Complaints (B) and (C)

32. Mrs C was admitted to the admissions area at 5.15 am where maternal and fetal assessments were undertaken and were recorded and CTG monitoring was commenced. Mrs C's membranes spontaneously ruptured at 5.35 am and Midwife 1 initiated a transfer to the delivery room.

33. It was noted that the fetal heart rate had a baseline of 165, with poor variability of less than 5bpm and the presence of meconium stained liquor was noted. Mrs C was transferred to the delivery room at 5.55 am and the CTG tracing was resumed. A vaginal examination was performed at 6.05 am and it showed that a delivery was not imminent. Again the fetal heart rate was noted as having poor viability and the liquor was thickly meconium stained.

34. Midwife 1 could only assume that she did not call for medical assistance at 6.05 am because Mrs C was in active labour and she was engaged in providing her with assistance and advice. She also assumes that the reference to change Mrs C's position to her right side was to ascertain whether or not the poor variability was as a result of a sleep pattern or maternal position. Registrar 1 was asked to see Mrs C at 6.20 am and did so at 6.55 am after attending to another patient. Registrar 1 carried out a fetal blood sample and decided to carry out an emergency caesarean section after speaking to the consultant on call. The decision to deliver by caesarean section was recorded as 7.10 am. Mrs C was prepared for and transferred to theatre. There was delay which Midwife 1 thought may have been in part caused by the shift changeover. A spinal anaesthetic was administered at 7.40 am, the first incision was at 7.45 am and Louis was delivered at 7.53 am.

35. The advice which I have received from the Assessors is that it was appropriate to transfer Mrs C to a delivery room following spontaneous rupture of her membranes. However, there was a failure by Midwife 1

to call for medical assistance when it was known that the fetal heart rate trace was abnormal and that meconium stained liquor was present. If medical assistance had been called then the diagnosis of probable fetal compromise could have been made sooner and an earlier delivery would have been effected. It should be noted that as the fetal heart rate trace was abnormal from the start of CTG monitoring it was not possible to know when it became abnormal. The Assessors have stated that it was highly likely that Louis was already compromised at the time of admission and even delivery at that time may well have resulted in the same outcome. It was appropriate for Registrar 1 to wait for the result of the fetal blood samples before deciding whether to perform a caesarean section. There was a 43 minute gap between the decision to proceed to caesarean section and the delivery of Louis. This raised concerns about poor communication regarding the degree of urgency of the caesarean section. I am pleased to note a procedure has been introduced to aid communications with regard to the degree of urgency of caesarean sections.

36. SHO 1 was present at Louis' birth. He commenced resuscitation and summoned assistance from Registrar 2. Registrar 2 received brief information about Louis' history and ventilation of Louis' lungs was established at about 5 minutes of age. Neonatal nursing support was summoned from the Special Care Baby Unit. Louis was transferred to the Unit and then later to SMMP. I note that the Assessors have commented about the default position where the Paediatric SHO attends all emergency caesarean sections. The policy does not allow for a Paediatric Registrar to be present but if that had been the case then the 5 minute delay in resuscitating Louis could have been avoided.

37. Accordingly I have decided to uphold Complaint B that the monitoring and care given to Mrs C while she was in labour was inadequate with the exceptions of the need to turn Mrs C onto her right hand side when there was a concern about Louis' condition and that there were no delays in making the decision to perform a caesarean section. I have also decided not to uphold Complaint (C) that the care given to Louis immediately following his birth was inadequate.

Recommendations

38. I welcome the changes already made by the Trust/Board. However, I believe that further action is required, and in addition to the recommendations made by the Assessors, I **recommend** that:

(a) The Board conducts an immediate retrospective review of maternity records from the Hospital to establish whether appropriate menstrual histories are consistently being taken and recorded and to establish whether appropriate consideration is consistently being given to discrepancies between gestational ages calculated from LMP and ultrasound. Should this review identify that menstrual histories and/or discrepancies between gestational ages are not being both appropriately and consistently considered the Board should develop and implement an action plan to address this.

(b) The Board ensures that the Head of Midwifery at the Hospital reviews the midwifery care Mrs C received while she was in labour and the concerns raised during the course of Mrs C's complaint and in this report. As part of this review, the Head of Midwifery should consider whether any shortcomings in the care Mrs C received, and in particular around the interpretation of CTG traces, have been appropriately addressed in the intervening period through the Trust's Clinical Governance structures and the provision of staff training. Should this review identify that any issues have not been appropriately addressed, the Board should develop and implement an action plan to address these.

(c) The Board conducts a review of the West Lothian Healthcare Division's policy regarding the resuscitation of the newborn and considers the introduction of a process of risk assessment to identify those circumstances where

there is a significant risk of a baby needing the attendance of a member of staff with advanced neonatal resuscitation skills in addition to the paediatric SHO.

COMPLAINT HANDLING ASPECTS OF COMPLAINT

Guidance on complaint handling

39. The Guidance on the NHS Complaints Procedure, 'The NHS Complaints Procedure: Guidance for Hospital and Community Health Services Complaints' (revised May 1999), in force at the time of Mrs C's complaint stated:

> **'LOCAL RESOLUTION**
>
> 1.28 A full investigation of a complaint should be completed, wherever possible, within twenty working days. Where this target is not being met, the complainant must be informed of the delay.
>
> 1.31 We expect the Chief Executive to 'sign-off' all formal complaints …
>
> **INDEPENDENT REVIEW**
>
> **The Role of the Convener**
>
> 2.8 In reaching a decision, the convener must:
> - consult an independent panel lay chairman;
> - take appropriate clinical advice where the complaint relates in whole or part to action taken in consequence of the exercise of clinical judgement;
> - this process must be completed within 20 working days of the date of receipt of the complainant's request by the convener…
>
> 2.10 Where a complaint relates in whole or in part to action taken as a consequence of the exercise of clinical judgement, the convener must seek appropriate clinical advice. Clinical advice should initially be sought from the medical or nursing director of the Trust, or the appropriate local professional head. Where these officers are the subject of the complaint, or where possible conflict of interest arises (for example, if this person has already been

involved in the handling of the complaint) then the advice of an independent professional person should be sought.

2.20 Having decided to establish a panel, the convener must define its terms of reference drawing on the complainant's written statement of complaint. Terms of reference set out what the panel is to investigate… If the complainant disagrees with the terms of reference he/she may ask the convener to reconsider them. While the convener's decision is final, the complainant should be advised of their right to take the matter up with the Ombudsman if they remain dissatisfied.

2.22 Once the convener's decision is known, the Trust's convener's office will make contact with the Health Board to provide the panel members…

2.23 Once notified by the Health Board responsibility for communicating with, ascertaining availability and formally appointing the chosen panel members and assessors rests with the Trust's convener's office.

The role of the Independent Lay Panel Chairman

2.26 The role of independent lay chairman is to:

- chair the panel when established;
- issue the report of the panel timeously.

2.27 The panel and its assessors should be provided with appropriate administrative support.

Conduct of the Panel

2.29 The Chairman, in consultation with the other members of the panel, will decide how to consider the complaint keeping in mind the directions and this guidance. However, the general rules of conduct for the panel are:

…

- the complainant, and any person complained against, must have a reasonable opportunity to express their views;

…

Panel's Report

2.31 At the conclusion of the panel's work, a report will be produced. The chairman is responsible for writing the report within the target timescale of 60 working days from the date of the formal appointment of the panel and assessors… the final report remains the responsibility of the Chairman.

Completion of the Complaints Procedure

2.38 The Chief Executive is also responsible for ensuring the board's decisions are communicated quickly and clearly to the complainant. A letter should be sent by the Chief Executive or a designated senior Director within the Trust to the complainant, within twenty working days from the receipt of the panel's report; to inform him/her of:

- any matters such as a formal apology or approval of an ex-gratia payment;
- action being taken as a result of the panel's deliberations and an indication of the timescale for its implementation;
- his/her right to refer the complaint to the Ombudsman…

2.39 The issue of this letter completes the NHS complaints process.'

HISTORY OF THE COMPLAINT HANDLING

40. I set out below a summary of the main events:

1999

June	Mr & Mrs C met Consultant 1 in an attempt to understand the circumstances leading up to Louis' death. No formal record of this meeting was made but Mrs C wrote to Consultant 1 on 29 June 1999 summarising her understanding of their discussion.
July	Mr & Mrs C met Consultant 1 a second time on 16 July

	1999. Again, no formal record of the meeting was made but Mrs C summarised her understanding in a further letter to Consultant 1.
August	Mrs C and Consultant 1 met for a third time on 2 August 1999.
11 August	Mrs C met Consultant 2 and Registrar 2 who summarised the care Louis received. Consultant 2 noted that Mrs C raised a number of valid comments and criticisms which primarily related to poor communication at the time of delivery and when Louis was transferred to SMMP. On the same day Mrs C wrote to the Trust's Director of Performance Management (Officer 1) making her formal complaint and set out her concerns.
2 September	Mrs C met Officer 1 and the Medical Director. Mrs C was given a copy of Consultant 1's written response to her complaint and it was agreed that the Trust would arrange for an independent Obstetrician to review Mrs C's care.
November	The independent Obstetrician met both Mr & Mrs C and Consultant 1. His report appears to have been received by the Trust at the beginning of November 1999. The Trust's records indicate that the Medical Director distributed this internally and arranged for a copy to be sent to Mrs C.
December	The Trust arranged to meet Mrs C to discuss the independent Obstetrician's report however Mrs C had to cancel this as she was unwell. She subsequently wrote to the Medical Director on 19 December 1999 making a number of comments on both the accuracy of the independent Obstetrician's report and the adequacy of its conclusions.

2000

February	The Medical Director acknowledged Mrs C's letter on 24 December 1999 and sought further comments from Consultant 1 and the independent Obstetrician. The independent Obstetrician suggested meeting Mrs C to discuss her continued concerns and the Medical Director wrote to Mrs C on 4 February 2000 making this suggestion.
April	It appears Mrs C responded by writing and explaining that she would prefer a written response and wrote again in April 2000 pursuing this matter. The Medical Director responded on 14 April 2000 explaining that because of a breakdown in communication, for which he accepted responsibility, the independent Obstetrician had not yet submitted his further report in the light of points Mrs C had raised on his original report.
May	The independent Obstetrician's further comments were received by the Medical Director on 8 May 2000.
	It appears the Medical Director wrote to Mrs C on 12 May 2000 summarising the independent Obstetrician's further comments but without including a copy of them.
June/August	Correspondence was exchanged between Mrs C and the Medical Director. Mrs C noted that the independent Obstetrician supported the recommendations she had suggested and asked that she be provided with full details of changes instituted and actions the Trust intended to take in this respect. The Medical Director explained that the Department of Obstetrics would consider and implement any necessary changes in light of the independent Obstetrician's report but Mrs C remained dissatisfied without confirmation of the remedial action taken. The Medical Director said he was sorry that Mrs C remained dissatisfied, but the Trust had done all it could to address her complaint and he suggested she could request an IRP be convened or seek legal advice.

During this exchange of correspondence Mrs C had also written to Officer 1. She spoke to him on 14 August 2000 and he wrote to the Medical Director explaining that Mrs C had 'indicated that all she was looking for was a list, which might not be a long list, of actions to be taken and whether or not we agreed with further action'.

September

After repeated telephone contact from Mrs C the Medical Director replied to her on 7 September detailing the action taken as a result of her son's death and the independent clinical review.

Mrs C wrote to Convener 1 on 25 September 2000 requesting that an IRP consider her complaint. Convener 1 acknowledged Mrs C's complaint on 28 September 2000 and wrote to her on 5 October 2000 explaining that he needed to take clinical advice when making his decision whether to convene an IRP and that he would normally seek such advice from the Medical Director. However, in light of the Medical Director's prior involvement in responding to her complaint he was seeking this advice from outwith the Trust and he warned her that this might result in delay.

December

Mrs C wrote to Convener 1 on 12 December 2000 and 1 February 2001 chasing his decision. She noted that she and her husband were fast losing faith in the complaints procedure and she asked that the IRP addressed not only the clinical issues but also the entire complaints process.

2001

February

Convener 1 decided that an IRP would be convened to consider Mrs C's complaint. This decision appears to have been made on 13 February 2001. Convener 1 wrote to Mrs C proposing the terms of reference for the IRP.

Convener 1 assured Mrs C that the terms of reference were intended to be broad enough to cover any concerns that she had.

March	Mrs C requested an explanation of the process for IRPs and for an indication when the process would be completed. The Trust Board Secretary (Officer 2) replied on 1 March 2001 explaining the IRP process and that two Clinical Assessors had been appointed and that realistically their reports could be expected in 6-8 weeks and the Panel would meet after this. Officer 2 explained that a new Convener would need to be appointed but that this would not necessarily delay the process. Officer 2 also asked Mrs C to let him know if she agreed with the proposed terms of reference for the IRP.
	Mrs C replied on 5 March 2001 noting that while she accepted the proposed terms of reference so far as the clinical aspects of her complaint were concerned, she had asked that the Panel consider the entire complaints process. Officer 2 wrote to Mrs C on 30 March 2001 acknowledging her comments and explaining that Convener 2 would now be part of the Panel. In subsequent correspondence to Convener 2, Officer 2 noted that Mrs C had not entirely accepted the terms of reference and that this would need to be addressed.
June	On 8 June 2001 Mrs C wrote to Officer 2 chasing action on her complaint.
	On 12 June 2001 one of the IRP Clinical Assessors sent his report to the Trust. Amongst other things, this highlighted questions about the midwifery care Mrs C received but indicated that a midwifery opinion would need to be sought on whether the care was of an appropriate standard. Officer 2 sent Mrs C a copy of this report on 29 June 2001 and noted that in light of these comments it was necessary to obtain a report from a midwife. Officer 2 apologised that the process was taking longer than he had originally estimated.

August	On 8 August 2001 the second Clinical Assessor sent his report to the Trust. This was forwarded to Mrs C by Officer 2 on 17 August 2001.
October	On 12 October 2001 Officer 2 wrote to Mrs C asking that she contact him about the IRP arrangements. They appear to have spoken on 22 October 2001 and it appears that they agreed that the IRP meeting would be on 26 November 2001 although the Trust's records do not contain details of this conversation.
November	On 7 November 2001 Officer 2 appears to have taken steps to obtain a report from a Midwife Clinical Assessor.
	Mrs C wrote to Officer 2 on 9 November 2001 enquiring about the proposed IRP meeting. It appears that Mrs C subsequently left repeated telephone messages requesting details of the meeting and was only informed in the afternoon of the proposed day for the meeting that it had been postponed although the Trust's records do not contain details of Mrs C's telephone calls.
December	Officer 2 wrote to Mrs C on 6 December 2001 providing further details about the IRP.
	It appears from Mrs C's correspondence that on 17 December 2001 Officer 2 suggested either 4 or 8 February 2002 as possible dates for the IRP meeting and that Mrs C left repeated telephone messages in response, although the Trust's records do not contain details of any of these contacts.
2002	
January	Mrs C wrote to Officer 2 on 29 January 2002 explaining that she was increasingly dissatisfied with the service provided by the Trust and asked, as a matter of some urgency, that he confirm the arrangements for the IRP meeting.

The Trust was sent the Midwife Clinical Assessor's report on 30 January 2002.

February — It is not clear what response, if any, Mrs C received to her letter dated 29 January 2002 as the next contact available in the Trust's records is a letter to Mrs C dated 20 February 2002 from Officer 2 explaining that Convener 2 could no longer continue in this role but reassuring her that both Officer 2 and the Trust's Chairman were aware of the considerable delay in her complaint and were anxious to resolve the situation.

March — It appears there were a number of subsequent conversations between Mrs C and Officer 2 about the IRP meeting. On 26 March 2002 he wrote to her with the identity of Convener 3 with an indication that it looked as if the meeting could be held at the end of April. He wrote again on 26 April 2002 referring to their previous conversation and stating that 29 May was the likeliest date.

May — The IRP meeting took place on 24 May 2002. Convener 3 could not attend the panel and her place was taken by Convener 4. Mrs C was sent a copy of the minutes from the IRP meeting on 11 June 2002.

July — The draft IRP report appears to have been issued by the Chairman of the IRP (the Chairman) to the other panel members and Mrs C towards the end of July 2002.

August — Mrs C responded with comments on the draft IRP report on 3 August.

The Chairman wrote to Officer 2 on 8 August 2002 explaining:

> 'I have had a good long thought about the Report but have decided to make minimal changes. I realise that

[Mrs C] wanted something more detailed about the management of the pregnancy but I deemed it appropriate to concentrate on the essentials with regard to the death'.

September The final version of the IRP report was issued by Officer 2 on 2 September 2002. Mrs C replied the following day noting that she was disappointed that no account had been taken of her suggestions in her letter dated 3 August. Officer 2 replied on 16 September assuring her that the Chairman had received her letter but had decided not to alter the report to any great extent.

October On 18 October 2002 Mrs C wrote to the Chief Executive noting that she was still awaiting the Trust's confirmation of action to be taken as a result of the report as noted in the leaflet about the Complaints Procedure.

December Mrs C wrote to the Chief Executive on 2 December 2002 noting that she continued to wait for a response to the issues she raised in her letter dated 18 October 2002.

The Chief Executive wrote to Mrs C on 18 December 2002. He explained the action taken with regard to the management of her pregnancy. In addition the issues raised in the report of the Independent Review Panel and also the independent expert reviews had been considered as part of the Clinical Governance Processes within the Trust and within the Department of Obstetrics and Gynaecology.

2003

January Mrs C replied to the Chief Executive on 20 January 2003 acknowledging his comments and urging him to reappraise her case with a view to improving the general handling of complaints in order that they may form part of a continuous improvement philosophy at the Hospital.

March The Chief Executive replied on 3 March 2003 explaining that

a major review of how the Trust deals with complaints was underway and ended by reiterating the apology on behalf of the Trust for the distress caused to her by the delays which had formed an unacceptable part of the handling of her complaint.

Mrs C's oral evidence

41. Mrs C said that she was 'raging' about the way the Trust had handled her complaint and she felt that she had had to 'battle' with them throughout. She felt she had had to persuade the Trust to allow her to see the independent Obstetrician's report and to provide her with minutes from the IRP meetings which she had attended. The Chief Executive had only written to her in response to the IRP report after she had twice written to him and asked him to do so and he had not responded to her concerns about the way her complaint had been handled until 3 March 2003.

Oral evidence from Trust staff

42. **Consultant 1** explained that the Department held regular perinatal review discussions and he was confident that Mrs C's case would have been discussed at one of these meetings. He also explained that more generally, following an incident such as Mrs C's pregnancy, a Consultant would talk to the junior staff about the issues that had arisen and the lessons that could be learnt.

43. Consultant 1 had been interviewed by the independent Obstetrician but he was never approached about being interviewed by the Clinical Assessors during the Independent Review Panel process. He could not recall a meeting being held to consider the recommendations made in the independent Obstetrician's report nor could he recall any meeting to consider the reports from the Clinical Advisers to the Independent Review Panel. He commented that these reports tended to be sent to the Medical Director and presumed they were then passed to the Clinical Governance meeting but he was not sure what would happen subsequently. Consultant 1 was sure that there had been no departmental review of the contents of the independent Obstetrician's supplementary report and the Independent Review Panel reports.

44. **Officer 3** explained that the Trust did not have a clinical incident reporting mechanism at the time of Mrs C's delivery in 1999 although one was now in place. There were perinatal review meetings in place at the time but in addition incident reports are now reviewed on a regular basis by a staff grade obstetrician and clinical midwifery specialist. Regular weekly lunchtime meetings are now held to discuss significant incidents and they are now also reviewed by the Medical Director, Risk Manager and clinical staff, when this is felt appropriate. Officer 3 was aware that Mrs C's pregnancy had been the impetus for the introduction of the traffic-light scheme to indicate the urgency of an emergency caesarean section. However, she was not sure whether the outcome of Mrs C's pregnancy had been formally discussed during a perinatal mortality review meeting nor was she aware whether a Departmental teaching review had been arranged following the outcome of Mrs C's pregnancy.

45. Furthermore, Officer 3 stated that the Head of Midwifery at the time of Mrs C's pregnancy, who had now returned to this post, had not been made aware of Mrs C's complaint, nor had she been made aware of the Independent Review Panel nor of the Assessor's Report on the midwifery aspects of Mrs C's complaint prepared for the Independent Review Panel. It was only at the beginning of 2003 that the midwifery services became aware of Mrs C's complaint after the involvement of the Ombudsman's office.

46. Officer 3 confirmed that she thought the traffic-light system worked well and that the process of preparing a woman for caesarean section had been reviewed in an attempt to ensure that it was streamlined to expedite the delivery of the baby. She explained that an e-learning package to improve training on the interpretation of CTG traces had been purchased, and all staff would be expected to complete this on a yearly basis and she noted that the current policy on the induction of labour stated that staff should confirm EDD prior to induction.

47. **Officer 1** explained that he had operational responsibility for a wide range of issues within the Trust and this included delegated responsibility as the Trust Complaints Officer. When investigating a complaint, he would normally request detailed reports from whomever

he felt to be the interested parties. Normally he would seek comments from the appropriate Consultant or the General Manager of the relevant directorate and would expect them to base their response on information provided by more junior staff if relevant.

48. Officer 1 investigated Mrs C's complaint by writing to both Consultant 1 and Consultant 2. He believed that the thrust of Mrs C's complaint had been about her medical care and the care of her son and as a result his focus was mostly upon these issues rather than midwifery issues. He accepted that the Service Manager and Head of Midwifery should have been informed about Mrs C's complaint.

49. Officer 1 said it was his practice to seek early advice from the Medical Director on some complaints. He did so where he felt, based on his experience, the complaint might raise clinical governance issues or where he felt that it was important for the Medical Director to be involved in face to face meetings with the complainant to lend both credibility to the Trust's consideration of that complaint and reassurance to the complainant. This was the reason he sought the Medical Director's involvement in Mrs C's complaint at an early stage.

50. He acknowledged that the local resolution stage of Mrs C's complaint took too long. He commented that there were a number of reasons for this. It was difficult to contact Mrs C as he said she did not wish to provide her home phone number and had asked that she be called back at specific times when this was not always practical. In addition, the report from the independent Obstetrician had led to a delay. He also noted that there was 'an ever increasing precision' to Mrs C's questions and while the Trust tried to deal with these sympathetically, he felt that Mrs C found it difficult to accept that it was not always possible in medicine to provide precise responses to her questions.

51. The **Medical Director** explained that it was normal practice for Officer 1 to seek his counsel on complex complaints. He arranged for an independent report from the independent Obstetrician, fed back the results of this report to Mrs C and then became involved in subsequent correspondence with her. The Medical Director acknowledged that the

timescales in dealing with correspondence were unacceptable. He commented that he felt this was a particularly difficult complaint because each response to Mrs C seemed to generate more questions from her. As a result, it was not clear to him what a satisfactory response would have been for Mrs C. He also commented that he felt that a significant part of the reason for delays in responding to the correspondence was due to resource limitation.

52. The Medical Director commented that he had essentially three channels of discussion with clinicians about this complaint. Firstly, with Consultant 1, secondly with the Head of Midwifery, and lastly with the Chair of the Clinical Governance Implementation Group who is one of the Consultant Obstetricians.

53. When it was pointed out to him that the Head of Midwifery was not apparently aware of the report prepared by the independent Obstetrician or the subsequent reports on Mrs C's care prepared for the IRP, he acknowledged that she should have been made aware of these reports. He believed he did have discussions with her about this complaint but such discussions were often informal and in passing. More generally, he acknowledged that there were no formal mechanisms for ensuring that all relevant staff were aware of the existence and contents of such reports. The Medical Director acknowledged that the Trust failed to have appropriate mechanisms in place to cascade such reports to the relevant individuals and more broadly within the Trust.

54. The **Panel Chairman** was appointed as Chair of the IRP in March 2001. It was pointed out that the eventual IRP hearing was held on 24 May 2002 and it was his responsibility as Chair of the IRP to arrange the IRP meetings. He confirmed he was aware of this responsibility but commented that he had been given assurances that these arrangements for meetings would be looked after by Trust staff. He felt that in practice he had to rely on the support mechanisms provided by the Trust and 'left them to get on with it'. He accepted that the arrangements for Mrs C's IRP hearing had dragged on but said that in his position there was not much he could do to expedite the process. He recalled that some delays had been due to (a) delays caused by the need to request a midwifery report which had not been initially

identified, (b) delays in receiving the advisers' reports and (c) delays caused by the ill-health of one of the advisers.

55. The Panel Chairman confirmed that neither the Clinical Assessors nor IRP members took evidence from anyone other than Mr & Mrs C. He felt the Clinical Assessors to the IRP had provided full reports and could be relied upon without further evidence. He had considered asking the midwife to give evidence but in the end decided against this. He acknowledged that this was a judgment for him to make. More generally, he saw the panel hearing as being basically an opportunity for Mrs C to ask the Clinical Assessor her questions and he felt she received her answers.

56. The Panel Chairman was asked about his decision that the IRP report should concentrate on the essentials of Louis' death and so should not be altered greatly despite Mrs C's representations on the draft version of the report. He commented that the panel had felt that Louis' death was the key matter in this complaint and that, had he survived, Mrs C would not have pursued her complaint. He acknowledged that the terms of reference had been deliberately drafted so as to allow a wide ranging report but he felt that the Clinical Assessor's reports, which were incorporated in the IRP report, as well as Mrs C's questions to the Clinical Assessors, had covered all the relevant issues. Accordingly, he felt it was appropriate for the panel to focus on specific issues in their part of the report.

Findings

Complaint D

57. Mrs C raised her formal complaint on 11 August 1999. As part of local resolution the Medical Director arranged for an independent report from the independent Obstetrician. His report was received in November 1999 and on 19 December 1999 Mrs C made comments on its accuracy and adequacy. Due to a breakdown in communication the independent Obstetrician provided further comments on 8 May 2000. Mrs C was not content with the explanations provided by the Trust as to what actions they would take in response to the independent report and issues which she had suggested. She requested an IRP on 25 September 2000. She sent reminders in December 2000 and

1 February 2001 and asked that the IRP also address the handling of her complaint. The decision to hold an IRP was made on 13 February 2001 and Mrs C was told the terms of reference would be broad enough to cover any concerns she had. Mrs C told Officer 2 on 5 March 2001 that she accepted the terms of reference so far as the clinical aspects of her complaint were concerned but she also wanted the complaints process to be considered. The IRP took place on 24 May 2002. The draft IRP report was issued towards the end of July 2002. Mrs C provided comments on the draft report on 3 August 2002. The final report was issued on 2 September 2002. Mrs C replied the next day saying she was disappointed that no account had been taken of her suggestions for the draft report. On 18 October 2002 Mrs C wrote to the Chief Executive seeking confirmation of action to be taken as a result of the final report. She sent a reminder on 2 December 2002. The Chief Executive responded on 18 December 2002 detailing the action taken. On 20 January 2003 Mrs C wrote to the Chief Executive asking him to comment on improving the general handling of complaints. The Chief Executive sent a final response on 3 March 2003.

58. The local resolution stage for this complaint spanned from 11 August 1999 to 7 September 2000 (13 months). The guidance sets out the period for local resolution should take 20 working days and where it cannot be met then the complainant must be informed of the delay. Whilst I do not doubt that Trust staff were attempting to reach a resolution to the complaint, the decision that local resolution was not going to be successful should have been taken at a much earlier stage. The Independent Review process spanned 25 September 2000 (request for IRP) to 3 March 2003 (signed off by the Chief Executive (30 months)). The guidance sets out timescales for the independent review process and this case by far exceeds the timescales.

59. The NHS complaints procedure was revised on 1 April 2005 and the independent review stage has been abolished. Complainants now have the option to contact my office once local resolution has been completed. This should ensure that delays such as those encountered in this complaint are not repeated. NHS Boards have 20 working days to issue a final response to formal complaints and where this cannot be achieved a further period of up to 20 working days is allowed providing

they keep the complainant informed of developments. At the end of this period the complainant has the right to contact my office even if the local resolution is continuing.

60. It is clear from the evidence that the IRP failed to consider the complaints handling aspect despite Mrs C being advised that the terms of reference would be wide ranging to address all her concerns. Again the pre-April 2005 guidance is clear that within 20 working days of the final report the Chief Executive or a designated senior director should write to the complainant and inform them of any action taken and that this letter completes the NHS complaints process.

61. It is quite clear that the Trust have failed to comply with the guidance on the NHS complaints procedure which was in force at the time of Mrs C's complaint. The whole procedure took three and a half years to complete which is an unacceptable length of time and hardly instills confidence in the system. The delays encountered in the local resolution stage were compounded by those in the independent review stage. Although Mrs C was assured that the terms of reference for the IRP would be wide enough to address all her concerns, they did not include her concerns about the complaints handling. She should have been advised of her right to contact this office if she disagreed with the terms of reference. Mrs C was denied this opportunity. Finally, the letter from the Chief Executive to Mrs C completing the complaints procedure took over three months to issue and only then after Mrs C had sent two reminders. I have therefore decided to uphold Complaint D in full.

Recommendations

62. The abolition of the independent review process negates any useful recommendations I can make in this regard. However, I have also identified serious failings in the local resolution process and I feel the following recommendations are appropriate.

63. I **recommend** that:

(a) The Board conducts a review of complaint handling by the West Lothian Healthcare Division to establish whether they

are managing complaints in accordance with the revised NHS complaints procedure and are providing timely and appropriate responses to complaints. Should this review identify continued shortcomings in the Division's response to complaints, the Board should develop and implement an action plan to address these.

(b) The Board makes an offer to pay Mrs C £500 in recognition of the time, trouble and distress caused to her by the Trust's unacceptable handling of her complaint.

64. This is a very sad case and it has clearly been distressing for Mrs C to pursue her complaint. She has told my office that a key motivation for doing so has been to bring about improvements in the health service, and particularly in maternity care. I hope she will feel that the recommendations made in this report will serve to meet that aim. I shall ask the Board to keep my office informed of progress in implementing those recommendations. I shall also request the Board to write to Mrs C to apologise for the shortcomings identified in this report and to establish whether, and if so how, she might wish to be kept informed of changes resulting from this case.

Professor Alice Brown
Scottish Public Services Ombudsman

11 November 2005

ANNEX A

GLOSSARY OF ABBREVIATIONS

At Mrs C's request, I have continued to use her son's first name throughout this report. In line with the requirements of the Scottish Public Services Ombudsman Act 2002, all other names used in this report have been anonymised. The names and abbreviations used are:

Consultant 1	The Consultant Obstetrician who cared for Mrs C during her pregnancy.
Consultant 2	The Consultant Paediatrician with administration responsibility for the department who met with Mrs C following Louis' birth but who was not involved in his care.
Convener 1	The Trust's Complaints convener who made the initial decision to convene an IRP into Mrs C's complaint.
Convener 2	The convener who took over from convener 1.
Convener 3	The convener who took over from convener 2.
Convener 4	The final convener.
GP	Mrs C's General Practitioner at the time of Louis' birth.
independent Obstetrician	Consultant Obstetrician appointed by the Trust to review Mrs C's care.
Medical Director	Trust Medical Director.
Midwife 1	The Midwife who primarily cared for Mrs C while she was in labour.
Mrs C	The complainant.

Mr C	The complainant's husband.
Panel Chairman	Chairman of the IRP.
Louis	Mrs C's son who was born on 13 May 1999 and died three days later.
Officer 1	The Director of Performance Management.
Officer 2	The Trust Board Secretary
Officer 3	Assistant Women and Children's Services Manager who was the former acting Head of Midwifery although not at the time of Louis' birth and who had not been involved in Mrs C's care or the responses to her complaint.
Registrar 1	The Obstetric Registrar involved in Mrs C's care during labour.
Registrar 2	The Paediatric Registrar involved in resuscitating Louis following his birth.
SHO 1	Paediatric Senior House Officer present at Louis' birth.
The Hospital	St John's Hospital, Livingston.
EDD	Expected date of delivery.
IRP	Independent Review Panel.
LMP	Last menstrual period.
SMMP	Simpson Memorial Maternity Pavilion.