SPSO decision report

Case: **201204565, Lothian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mrs C complained that when she was in labour in the Royal Infirmary of Edinburgh, a doctor conducted an intimate examination without introducing herself or obtaining Mrs C's consent for the examination. Mrs C also complained that the examination was very painful, and that although she asked the doctor to stop, she did not do so right away. The doctor told Mrs C that she needed a forceps delivery (where a specially designed instrument is used to assist with the delivery of the baby) and would need to go to theatre. The baby was successfully delivered but Mrs C had been hoping for a natural birth and complained that she was not offered any alternative options.

Mrs C wrote to the board three months after the birth to complain about her care and treatment. Although the letter of complaint was acknowledged promptly, she then waited almost three months for the response. Before she received the response, Mrs C brought her complaint to us. She also complained that, while she was still waiting for the board to respond, she had to attend an out-patient appointment. She was upset to be met there by the doctor about whom she had complained. We also investigated this additional complaint.

Our investigation included taking independent advice from a consultant in obstetrics and gynaecology. We upheld Mrs C's complaints about her care and treatment during the delivery. The adviser was of the view that Mrs C had been unable to give informed consent for the examination or the forceps delivery, due to her level of pain and distress and the lack of information about alternative options. The adviser was also critical that, when asked to do so, the doctor did not immediately stop examining Mrs C. The adviser considered that there was no immediate danger to Mrs C or her baby at the time of the decision about forceps delivery, and said that she should have been given time to have additional pain relief and then consider all the options, including no treatment or intervention.

On the matter of the out-patient appointment, the NHS guidance on complaints handling says that information about complaints should not normally be kept in a patient's clinical records. Because of this, neither the board nor the doctor concerned could have anticipated that Mrs C would been seen at the clinic by the doctor about whom she had complained. When the doctor realised who Mrs C was, she arranged for her to be seen by the consultant instead. That was appropriate and we did not uphold this complaint.

In regard to the delays in complaints handling, the board acknowledged the delay and that Mrs C had not been kept informed about this or about the reasons for it. We upheld this complaint, but noted that the board have since made changes within the complaints department.

Recommendations

We recommended that the board:

- ensure that all relevant staff are reminded of the guidance on taking consent from women in labour (in particular the need to record oral consent) and, where necessary, provide refresher training;
- provide a copy of our decision to the doctor involved to allow her to reflect on her practice in relation to the

complaints and discuss any learning points at her next appraisal;

- provide the Ombudsman with evidence to demonstrate that the changes put in place within the complaints department have improved response timescales; and
- issue a written apology for the failings identified during this investigation.