SPSO decision report

Case: **201604903, Tayside NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mrs C complained about the care and treatment that was provided to her following her admission to Ninewells Hospital for induction of labour. Mrs C complained that the midwifery care around her induction, labour and birth was unreasonable. She also complained about the way the board handled her complaints.

During the birth, Mrs C's baby became stuck after delivery of the head due to shoulder dystocia (where one of the shoulders becomes trapped behind the mother's pubic bone) and additional help had to be called to assist the midwife who was attending to her. The baby was delivered following this, but died a few days after the birth.

After Mrs C raised her complaints with the board, they carried out a local adverse event review and also had an external review conducted by a senior midwife from another NHS board area. These reviews identified some failings with regards to aspects of Mrs C's care. However, it was found that these failings did not affect the outcome, which was considered to be unavoidable.

After taking independent advice from a midwife, we upheld Mrs C's complaint about the induction of her labour. We found that there had been delays which affected her access to pain relief and that there had been poor communication. We did not make any recommendations relating to this as these failings had already been addressed by the board.

We also upheld Mrs C's complaint about her care during labour. We found that the board had already identified issues, including the way that examinations were carried out to monitor Mrs C's progress. The advice we received highlighted further concerns about monitoring of blood pressure and listening to and recording Mrs C's preferences during labour. We made recommendations to address these matters.

We did not uphold Mrs C's complaint about the care that was provided to her during the birth of her baby. The advice we received was that this care was timely and that the shoulder dystocia could not have been identified earlier or avoided.

We upheld Mrs C's complaint about the way her complaint was handled by the board. We found that the timescale for completing the investigation of her complaint had not been met and that Mrs C had not been kept updated during the process. We made a recommendation in relation to this.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for failing to provide reasonable care during induction and labour, and for failing to handle her complaint reasonably. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

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

- Patients should be listened to. Their preferences and concerns should be responded to. Clear and accurate records of this should be kept.
- Blood pressure should be recorded in line with national guidance.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.