# SPSO decision report

**Case:** **202206649, Grampian NHS Board**
**Sector:** Health
**Subject:** Clinical treatment / diagnosis
**Decision:** upheld, recommendations

## Summary

C complained that the board failed to provide them and their baby (A) with appropriate care and treatment both during and after A's delivery at the hospital. This included failing to advise C that one of the doctors involved in the delivery of A was a first year speciality trainee doctor and that the use of forceps in A's delivery resulted in them suffering permanent injuries, erb's palsy (a condition often caused by birth trauma that can affect the movement and feeling in a baby's arm) and phrenic nerve palsy (respiratory distress which can be caused by nerve damage during birth). C also complained that there was a failure by the board to carry out further investigations of A's erb's palsy, a failure to deal with A's respiratory distress and diagnose that they had phrenic nerve palsy and a failure to adequately monitor A's weight.

We took independent advice from two medical advisers, a consultant obstetrician and gynaecologist and a consultant neonatologist.

We found that birth injuries could occur even though there were no obvious difficulties with the birth. Given this and the evidence available, it was not possible to establish the cause of A's injuries. However, we found there was a lack of communication with C during the consent process, C was not consented for the involvement of junior trainee speciality doctors at the birth of A and it was not explained to C that teaching of staff would take place during the birth. We found that no consideration was given to the use of ultrasound to determine the position of A prior to delivery, in accordance with Royal College of Obstetricians and Gynaecologists guidance, and medical documentation around the events of A's birth was not of the expected standard in terms of the level of detail recorded. We, therefore, upheld this part of C's complaint.

In terms of the care and treatment of A following delivery, we found that, overall, this was reasonable. We found that there were no concerns about the diagnosis and treatment of A's Erb's palsy and that A did not have respiratory problems, or the key signs associated with phrenic nerve palsy. However, we found that the board failed to adequately monitor A's weight during their hospital stay, which was acknowledged by the board, and we upheld this part of C's complaint on that basis.

## Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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

- Patients should be informed when junior trainee speciality doctors are to be involved in their care and treatment and when teaching of staff will be included. These discussions should be clearly recorded as part of the consent process. The following issues should be included in the board's guidance on obtaining

consent: (i) staff should provide an explanation to the patient as to who will be overseeing the birth, and if they will be assisted by other doctors in training; (ii) that members of the clinical team introduce themselves to the patient and explain what their role will be.

- Routine consideration should be given to the use of ultrasound for determining and confirming the position of the fetal head in accordance with the RCOG Guidance, especially when rotation of the baby is required.

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.