Case 201100758: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospital; Maternity ward

Overview

The complainant (Ms C) raised a concern that undue pressure was put on her to take prophylactic antibiotics during her labour by staff at the Southern General Hospital.

Specific complaint and conclusion

The complaint which has been investigated is that Ms C was unreasonably bullied into taking prophylactic antibiotics (*upheld*).

Redress and recommendations

The Ombudsman recommends that Greater Glasgow and Clyde NHS Board (the Board):	*Completion date*
(i) bring this report to the attention of relevant staff including the second registrar to ensure lessons are learned and highlight the relevant guidelines and guidance on group B streptococcus and consent;	24 November 2012
(ii) review the guidance on group B streptococcus to clarify the limited circumstances where a child protection order should be considered;	24 December 2012
(iii) consider a multi-disciplinary approach involving obstetricians and paediatricians when a patient refuses treatment in similar situations; and	24 November 2012
(iv) apologise to Ms C.	24 November 2012

The Board have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. Ms C complained about aspects of the care and treatment she received from Greater Glasgow and Clyde NHS Board (the Board) on 16 July 2010. During Ms C's labour in the Southern General Hospital (the Hospital), medical staff advised her to take prophylactic antibiotics because she had a prolonged ruptured membrane. Ms C agreed with a paediatric registrar (the first registrar) that she would not take the antibiotics and that her baby would be monitored for signs of infection after birth. However, another paediatric registrar (the second registrar) told Ms C that she had spoken to the neonatal consultant (the Consultant) and they were concerned about her decision not to take antibiotics. The second registrar told Ms C that the Consultant had made it clear that if she continued to refuse treatment, then there were options available to them through the courts to ensure that her baby would receive the treatment required. Ms C said the registrar went on to say that they would obtain a child protection order from the courts (which would apply when the baby was born). Ms C felt that she had no choice at all in the matter and took the antibiotics so that staff would not take her newborn baby away from her to directly administer antibiotics.

2. The complaint from Ms C which I have investigated is that Ms C was unreasonably bullied into taking prophylactic antibiotics.

Investigation

3. During the course of the investigation of this complaint, my complaints reviewer obtained and examined a copy of Ms C's clinical records and the Board's complaint file. She also obtained a statement from Ms C by telephone and advice from a professional specialist obstetrician adviser to the Ombudsman (the Adviser) on the clinical aspects of the complaint. Finally, she considered the relevant guidance on consent and guidelines on group B streptococcus.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Ms C and the Board were given an opportunity to comment on a draft of this report.

Clinical background

5. Ms C's two previous pregnancies were by caesarean delivery. Ms C wanted a vaginal delivery for her third pregnancy. She spontaneously ruptured her membranes when she was 40 weeks and five days pregnant. She was admitted to the ward on 16 July 2010 with confirmed spontaneous rupture of membranes at 18:15 on 15 July 2010. An elective caesarean was arranged for the following day if she did not go into labour. During the afternoon, the administration of prophylactic antibiotics to Ms C to reduce the chance of infection was discussed with her. The medical records show that after a detailed discussion with the first paediatric registrar, Ms C choose to decline the antibiotic prophylaxis and prophylactic antibiotics to the baby after delivery although she would allow swabs. A second paediatric registrar reviewed Ms C around 18:00. The discussion is documented by the second registrar in Ms C's medical records. The entry states that:

> 'Discussed with (consultant on-call) [the Consultant]
> of opinion – mum has right to make informed decision re agreement to antibiotics or not; once infant born it is a person in its own right and therefore has rights; our duty of care is to the infant once they are born; accordingly it would be appropriate and proper for us to cover the child with antibiotics once it is delivered if no maternal cover achieved; this would be best achieved with maternal agreement but if there is ongoing maternal refusal, the duty of care is to the infant and other avenues available to ensure treatment e.g. child protection order
>
> Attended ward and explained above to mum. Mum understandably upset and feels her choice to refuse has been taken from her. Explained that she does have the ongoing right to refuse treatment but, once delivered, if no PROM cover achieved antenatally, we will give IVF antibiotics to infant in addition to taking blood cultures + CRP. Antibiotics would need to continue at least 48 hours until culture results available.
>
> Mum upset but, at end of conversation, voicing opinion that she has no choice but to take antibiotics.'

6. After this consultation, antibiotics were subsequently given to Ms C. The following day, a caesarean section was performed on Ms C with the birth of her third child.

Relevant Guidance

7. The Scottish Government issued guidance on obtaining consent for healthcare professionals in NHS Scotland. This states that, generally, people have the right to decide whether or not to agree to healthcare interventions including examinations, diagnostic procedures and treatment (with certain exceptions). Healthcare professionals must respect this right, provide the necessary information about the procedure and obtain the patient's permission or agreement before proceeding with the intervention. One of the four general principles central to getting consent from the patient is freedom of choice. This means that patients' agreement to proceed must be given voluntarily without pressure, deceit or undue influence being used. Healthcare professionals should ensure that patients have reached their own decisions and understand that they can change their minds if they do not wish to continue with the procedures.

Relevant guidelines

8. The Board's guidelines on group B streptococcal infection and the use of intrapartum prophylactic antibiotics recommend that the antibiotics should be given with a prolonged rupture of membranes (more than 24 hours). It goes on to say that when these are declined by the mother, then further discussion of the risks should be explored with them and the baby should be observed for at least 24 hours with temperature and respiratory rates observed every four hours. Moreover, parents may not decline lifesaving therapy for their baby if signs or symptoms of infection are present.

Complaint: Ms C was unreasonably bullied into taking prophylactic antibiotics

Ms C's statement

9. Ms C said that the first registrar was informative and professional. She was very thorough and did not pressure her. The first registrar wanted to make sure the Ms C had made a fully informed decision about not taking antibiotics. Ms C understood that they had decided that she would not take the antibiotics and that her baby would be monitored for signs of infection after birth. The second registrar, on the other hand, was abrupt and forceful.

10. The second registrar told Ms C that she had spoken to the Consultant who was not happy about her decision not to take antibiotics. The second registrar said they were acting in the best interests of the child and Ms C said that she was also acting in the best interests of the child. The second registrar said that

the Consultant had made it clear that if Ms C continued to refuse treatment, then there were options available to them where they could ensure through the courts that her baby would receive the treatment required. Ms C was clear that the second registrar said that Ms C had the right to refuse treatment but if she did not take the antibiotics, they would take her baby from her at birth and directly administer the drugs. If Ms C was to refuse treatment for her baby, then they would obtain a child protection order from the courts to ensure that the child got the treatment they needed. Ms C was clear that the second registrar said 'would' because she argued with her that was not something the Board could do in the circumstances. Ms C felt that she had no choice but to take the antibiotics so that staff would not take her newborn baby away from her. Also, it would be worse if the baby got antibiotics directly rather than through her in the womb.

11. Ms C said that she had made it clear to the doctors that she is only against prophylactic antibiotics in the absence of any sign of infection. She would not have refused antibiotics for her or her baby if there was evidence of infection in either of them. Ms C said that the threat of a child protection order was a bullying tactic and that the Consultant should accept responsibility for the fact that she was told a child protection order would be obtained. She had endured many stressful hours on this matter all while in early labour and trying for a natural birth after previously having had two caesarean sections. It was very important for Ms C to focus on the labour to avoid another caesarean section. Given the second registrar's assurance that she was relating the view of the Consultant, she did not believe there was any point in continuing the disagreement with the Consultant and putting her and her baby in further distress.

Board's response

12. The Board said that the Consultant reviewed Ms C's medical records and said neonatal staff became involved in her care because of prolonged rupture of membranes. Their guidelines indicate that intrapartum antibiotics should be administered if there is a prolonged ruptured of membranes (longer than 24 hours prior to delivery). This is to reduce the incidence of overwhelming septicaemia in the newborn. Studies have shown intrapartum antibiotics, when appropriately administered with a specific risk factor prolonged rupture of membranes, can reduce the incidence of death from early group B streptococcal infection by twentyfold. The Consultant confirmed that intrapartum antibiotics is the preferred method of treatment because it is more

effective than postnatal treatment. The Board also apologised for the way the second paediatric registrar communicated this to Ms C which made her feel intimidated.

13. The Board went on to say that the Consultant had provided advice to the second registrar and could only comment on her review of the relevant case records and Ms C's comment on the content of the face-to-face discussion which occurred following her advice. The Consultant said it appeared the consultation lacked the sensitivity and empathy usually expected in such circumstances. The Consultant also confirmed that a child protection order would not routinely be sought in circumstances like this. The Board must always act as an advocate for the infant and this role can include recourse to legal options that can be utilised by neonatal staff to ensure that babies are not placed at undue risk of sudden or profound deterioration, which could lead to death or survival with handicap. If a parental decision is perceived by staff to increase the risk of morbidity or mortality of the child then, in most cases, an informed discussion and explanation from medical staff will lead to an amicable solution and a child protection order would only be considered in circumstances where harm might be expected to result. The Board noted that Ms C decided not to speak to the Consultant that evening, which resulted in a missed opportunity to address the concerns which may have obviated the distress that appears to have ensued.

Advice received

14. The Adviser said that there is no evidence in Ms C's records that she is a carrier for group B streptococcus and concluded that the medical decision to prescribe prophylaxis was based on one risk factor of prolonged rupture of membranes (approaching 24 hours). National clinical guidelines differs between different professional bodies. National Institute for Clinical Excellence guidelines suggest that if there are no signs of infection in women, antibiotics should not be given to either the mother or the baby even if the membranes have been ruptured for over 24 hours and Royal College of Obstetricians and Gynaecologists suggest that two or more risk factors makes the argument for antibiotic prophylaxis stronger. The Adviser said that Ms C's decision not to have intrapartum prophylaxis and for her baby to be observed for signs of infection after birth is an appropriate management strategy. The Board's own guidelines have a low threshold to offer intrapartum prophylaxis and suggest that they should be given with a prolonged rupture of membranes (more than 24 hours). However, it also states that when these are declined by the mother,

then further discussion of the risks should be explored with them and the baby should be observed for at least 24 hours with temperature and respiratory rates observed every four hours. It implies a court protection order might be sought only if life-threatening therapy is declined. It is the Adviser's view that while it was appropriate to offer Ms C the antibiotics as this was in line with their own guidance, the Board then failed to follow its guidance when antibiotics were declined.

15. My complaints reviewer asked the Adviser what would be good practice in such circumstances. The Adviser replied that Ms C's view should have been respected. She should have been allowed to decline intrapartum antibiotics providing she remained well. If Ms C developed signs of infection of the placenta and womb prior to her caesarean section, she would have required antibiotics for herself and it would be likely that the paediatric team would want to treat her baby. This should have been clearly explained to her and a multi-disciplinary approach (such as a joint review with paediatrics and obstetrics) may have been helpful. However, if she remained well and there were no signs of infection and her baby was born well, she should have been clearly told that if she chooses to refuse empirical treatment and investigations for the baby, then the baby will need to stay in hospital for 24 hours for observations. If she needed a caesarean section then the typical stay for the mother would be two to three days so this would not delay her discharge as the baby could have been monitored on the ward while she was an in-patient. The only issue for Ms C would be if she had laboured and delivered successfully, then she would need to understand that her baby would need to stay in for at least 24 hours.

16. On whether the Board properly obtained consent to administer the prophylactics, the Adviser said that in his view Ms C was put under undue pressure to give consent which was not in keeping with NHS Scotland's guidance on consent.

Conclusion

17. Ms C complained that the Board unreasonably bullied her into taking prophylactic antibiotics. It is clear to me that undue pressure was put on Ms C into consenting to treatment. Her oral account of what happened is supported by the medical records and implicitly accepted by the Board in their response to the complaint. Furthermore, the advice I have accepted is that the Board failed

to follow its guidance of administering prophylactic antibiotics in Ms C's case. I uphold the complaint.

18. The failures by the Board led to a significant personal injustice to Ms C. She did not properly consent to the treatment administered and was wrongly put under extraordinary pressure during labour when she was in a very vulnerable situation. I am highly critical of the second registrar's actions in this respect. This was not a life-threatening situation and Ms C's preferred management strategy was acceptable under the Board's guidelines. I am also critical that the Board failed to acknowledge this in their responses to Mrs C.

19. Turning now to the Consultant's role, it is clear that the second registrar's note of the conversation (see paragraph 5 above) does not reflect the Board's guidelines. However, I cannot establish with any certainty what the Consultant said to the second registrar and whether the second registrar emphasised some aspects of the advice over others. Having said that, the Consultant does not dispute that the option of seeking a child protection order was discussed. In the circumstances, therefore, I have concluded that at the least it was the Consultant's responsibility to ensure the second registrar was clear about the advice and the context of the option of obtaining a child protection order given that Ms C was not refusing life-threatening therapy.

Recommendations

20.	I recommend that the Board:	*Completion date*
(i)	bring this report to the attention of relevant staff including the second registrar to ensure lessons are learned and highlight the relevant guidance on group B streptococcus and consent;	24 November 2012
(ii)	review the guidance on group B streptococcus to clarify the limited circumstances where a child protection order should be considered;	24 December 2012
(iii)	consider a multi-disciplinary approach involving obstetricians and paediatricians when a patient refuses treatment in similar situations; and	24 November 2012
(iv)	apologise to Ms C.	24 November 2012

21. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Ms C	The complainant
The Adviser	A professional specialist obstetrician adviser to the Ombudsman
The Hospital	Southern General Hospital
The first registrar	Paediatric registrar
The Consultant	Neonatel Consultant
The second registrar	Paediatric registrar

Annex 2

Glossary of terms

group B streptococcal	the commonest cause of early infection in a newborn
intrapartum prophylactic antibiotics	where the mother receives intravenous antibiotics (usually penicillin) at least four hours before delivery

Annex 3

List of legislation and policies considered

A Good Practice Guide on Consent for Healthcare Professionals in NHS Scotland HDL (2006) 34

Greater Glasgow and Clyde Neonatal Guidelines – Group B Streptococcal Infection