Scottish Parliament Region: Lothian

Case 201103956: Lothian NHS Board - University Hospitals Division

Summary of Investigation

Category

Health: Hospital; Gynaecology & Obstetrics (Maternity); clinical treatment

Overview

The complainant (Mrs C) raised a number of concerns with Lothian NHS Board (the Board) about the care and treatment she received during her pregnancy, in particular, from her community midwife (the Midwife).

Mrs C also raised concerns that medical staff, immediately following her son's birth (Baby A) on 16 May 2011 when she had a haemorrhage, refused to allow her husband (Mr C) to push her bed to the theatre.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the Midwife failed to deal with Mrs C's request for a caesarean section properly (*upheld*);

(b) the Midwife unreasonably refused Mrs C antenatal appointments (*not upheld*);

(c) the Midwife misled Mrs C about when she would be induced (*not upheld*); and

(d) the Board unreasonably refused to allow Mr C to push Mrs C's bed to theatre (*not upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) ensure that the comments of the Adviser in relation to complaint (a) are shared with community midwives, in particular, that where there is any deviation from a normal uncomplicated pregnancy, the expectant mother should be referred to an obstetrician or other medical specialist as appropriate;	11 August 2013

(ii)	ensure that the comments of the Adviser in relation to complaint (c) are shared with community midwives, in particular, that every case of an expectant mother must be considered individually and that relevant issues of a complex history, maternal age and personal anxieties are taken in to account;	11 August 2013
(iii)	review the process of record-keeping by community midwives in relation to patients' notes. In particular, to ensure that any discussions and advice given concerning requests by an expectant mother for any intervention, induction of labour or a C section are clearly and properly documented in her medical records; and	11 August 2013
(iv)	apologise to Mrs C for the failings identified in this report.	17 July 2013

Main Investigation Report

Introduction

1. Mrs C was 42 years of age at the time of her pregnancy. It was her fourth pregnancy in four years. The first pregnancy had resulted in the birth of a healthy daughter, but she had subsequently lost two babies – firstly when she was nine weeks pregnant and then when 20 weeks pregnant. Mrs C said she was, therefore, very anxious about this pregnancy.

2. On 16 May 2011, Baby A was born at the Simpson Centre for Reproductive Health at the Royal Infirmary of Edinburgh (the Hospital). Baby A was born with a broken shoulder and damaged vocal chords. An Magnetic Resonance Imaging (MRI) scan carried out after Baby A's birth showed he had blood on the brain. As a result Mrs C and her husband (Mr C) have been left with constant worry about the future health of Baby A. Mrs C believed these events were as a result of failings by the Midwife during her pregnancy.

3. Following the birth of Baby A, Mrs C had to go to theatre in order to stop a haemorrhage. There was then a delay in taking her there as she had to wait for a member of the Hospital staff to help push her bed to theatre. To avoid the wait, Mr C had offered to push her bed but this was refused. Mrs C said she was, therefore, delayed getting to theatre.

4. The complaints from Mrs C which I have investigated are that:

(a) the Midwife failed to deal with Mrs C's request for a caesarean section properly;
(b) the Midwife unreasonably refused Mrs C antenatal appointments;
(c) the Midwife misled Mrs C about when she would be induced; and
(d) the Board unreasonably refused to allow Mr C to push Mrs C's bed to theatre.

Investigation

5. Investigation of the complaint involved reviewing copies of Mrs C's medical records and the complaints correspondence received from Lothian NHS Board (the Board) and the information supplied by Mrs C. Copies of medical records for Baby A were also obtained from the Board. As the complaint included clinical issues, my complaints reviewer obtained clinical advice from one of the Ombudsman's medical advisers, an experienced midwife with both national and

international experience as a practicing midwife in the hospital and community setting (the Adviser).

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

(a) The Midwife failed to deal with Mrs C's request for a C-section properly

7. Mrs C said she had attended the Hospital at the beginning of April 2011 after becoming concerned that Baby A had not been moving about as much as usual. Various tests were carried out at the Hospital including an ultrasound scan (the scan). Whilst having the scan, Mrs C said that the sonographer told her quite clearly she was having a big baby. Later that same day she spoke with the Midwife who had telephoned her to give her results of tests she had carried out at a previous appointment. Mrs C said that she told the Midwife that she had been at the Hospital earlier in the day and had learned that she was having a large baby which terrified her. However, the Midwife told her that all the measurements she had taken throughout her pregnancy had measured a normal sized baby. Mrs C said that while the Midwife questioned her trust in her, the Midwife did not seem to be concerned about size of Baby A.

8. Mrs C said that she again discussed her anxieties with the Midwife at her next appointment. She reiterated how terrified she was of giving birth to a large baby and the reasons for this arising out of her experiences during a previous pregnancy. She distinctly remembered asking the Midwife for Caesarean Section (C-section) because of her anxieties. Mrs C said that the Midwife told her clearly that she was not entitled to an elective C-section.

9. Mrs C said she later learned at an appointment with her consultant obstetrician (Consultant 1) in August 2011, after she had given birth to Baby A, that the Midwife should have referred her to Consultant 1 to discuss her request for a C-section. Mrs C said that Consultant 1 told her that, given her history (being an older mother, having a large baby and having lost two babies at nine weeks and at 20 weeks) she would have certainly agreed to her having a C-section had the Midwife referred her. Mrs C also said that Consultant 1 had said the Board did not have a policy that said that expectant mothers could ask for a C-section but if a patient requested a C-section they should be immediately referred to their consultant.

10. Mrs C, therefore, believed the Midwife had: failed in her duty of care to refer her to another professional when required; had made a decision that she was not qualified to make; and should have offered her an appointment to see a consultant obstetrician. Mrs C believed that, as a result of the Midwife's failure to refer her to a consultant obstetrician, both she and Baby A had nearly died. Mrs C advised that Baby A had been born with a broken shoulder and damaged vocal chords and an MRI scan carried out after the birth showed he had blood on the brain. Mrs C and Mr C were, therefore, constantly worried about Baby A's future health when they should instead be enjoying their son.

11. The Board said Mrs C had attended a meeting with the Board's Clinical Manager Community Midwifery Services and the Community Team Leader in September 2011 discuss to her concerns. At the meeting, Mrs C had raised additional issues to those in her initial letter of complaint and, therefore, further investigations were carried out by the Clinical Manager on behalf of the Clinical Management Team.

12. The Board were sorry that the care Mrs C received during her pregnancy did not meet her expectations and that, although she had always found the Midwife to be pleasant, she was not satisfied with the level of information she had received from her in relation to anxiety about her pregnancy and labour. The Midwife had reflected on the antenatal period and felt she had had a good relationship with Mrs C and had provided robust antenatal care. The Midwife had not perceived that Mrs C had a high level of anxiety about her labour and birth at any time.

13. In response to the complaint, the Board said that it was recommended that all women over 40 years of age have their care discussed with a consultant obstetrician. The Board said that Consultant 1 had seen Mrs C in the earlier part of her pregnancy as she was familiar with Mrs C from her previous pregnancies. However, as Mrs C had moved house to a different area of Edinburgh in January 2010, the Board commented that her named consultant had changed to Consultant 2 who covered the locality where Mrs C was now residing. The Board said that as Mrs C had already been seen by Consultant 1 she would not have had a further referral based on her age to Consultant 2. However, the Board commented that, had the Midwife been aware that Mrs C had anxieties of any kind relating to her pregnancy or birth, she would have

been happy to refer Mrs C to either Consultant 1 or Consultant 2 to discuss those concerns.

14. The Board also said that, when Mrs C attended the Hospital at the beginning of April 2011 her fundal height was noted to be measuring less than expected for her gestation. Therefore, she was appropriately referred for the scan. The Board said that the results of the scan were found to be within normal limits and this information along with clinical fundal height measurements were considered. Mrs C was not measuring for a large baby and the scan and the abdominal examinations also did not predict that Mrs C would have a large baby. Therefore, no action was required. Consultant 2 also said she would not have recommended any changes to Mrs C's routine care based on the scan findings at the time. Also, as Mrs C had had a previous vaginal birth, there was no indication to recommend birth by a C-section. Consultant 1 had also told Mrs C at a follow up appointment in August 2011 that she would not have taken any further action based on the findings of the scan at that time. The Board apologised to Mrs C that the comments of the sonographer had caused her anxiety.

15. The Board were also apologetic that both Mr and Mrs C had been having nightmares about Baby A's birth. The Board explained that shoulder dystocia had not been anticipated at Baby A's birth as the physical examinations performed prior to the birth, along with Mrs C's antenatal history, did not indicate any deviation from the norm. The Board further explained that all fundal measurements were within acceptable limits and although Baby A's abdominal circumference on the scan was a little high, this was not unduly concerning. While there was a delay in delivering Baby A's shoulders at birth, all emergency procedures were followed correctly and appropriately. It was recorded in Mrs C's medical records that a full debriefing discussion had taken place with Mr and Mrs C following Baby A's birth.

16. The Board provide us with copies of medical records for Baby A. Included in these records is a report from a consultant ear nose and throat surgeon at the Royal Hospital for Sick Children, Edinburgh, who reviewed Baby A in June 2011. It notes that Baby A was doing very well, with good feeding and good weight gain and had been reviewed by speech and language pathology with no concerns or feeding issue and with no evidence of respiratory distress. It also stated that a recent MRI scan had demonstrated a small subdural bleed, which has been reported as common following traumatic births. There was also

no evidence of right vocal chord palsy which had previously been seen. There also appeared to be no evidence of any developmental delay but it was noted that Baby A was shortly due to be followed up by neonatology. However, no records concerning such an appointment have been supplied to this office by the Board. A further report also from the same Ear Nose and Throat department in August 2012 records that Baby A at birth 'had shoulder distortion and subsequent paralysed vocal cord which [had] now recovered'.

Clinical Advice

17. Mrs C become pregnant in August 2010 and due to her age and her medical history had undergone amniocentesis twice, the first attempt having failed. The Adviser considered that Mrs C would, therefore, have been undoubtedly anxious during this pregnancy.

18. Adding to this already stressful time, Mrs C, when she was 35 weeks pregnant, had attended the Hospital in April 2011 because Baby A had not been moving as much as usual. Among the tests carried out was a monitoring trace of Baby A's heartbeat, during which Baby A did not move for a period of forty minutes and, therefore, Mrs C had the scan. It was during this scan that Mrs C reported that the sonographer had commented that although she was only 35 weeks pregnant, Baby A was the size of a full term pregnancy baby (usually 40 weeks). Mrs C had understood this to mean that Baby A was very large. Mrs C had said that she had been terrified at the thought of having a big baby. Taking into account all of these factors adding to Mrs C's anxious state, the Adviser told my complaints reviewer that in her clinical opinion she would have expected a competent community midwife to have assisted Mrs C by making her an appointment to discuss the mode of delivery of her baby with her consultant obstetrician.

19. The Adviser noted that according to Mrs C the Midwife had made light of her anxieties and did not facilitate an appointment for her to discuss the appropriate mode of delivery with her consultant when she requested it. The Midwife had apparently referred to the local guidelines as to why Mrs C would not be allowed a C-section. However, the Adviser has told my complaints reviewer that a midwife in terms of the National Midwifery Council's Midwives Rules and Standards 2004, as amended in 2007 and 2010 and reviewed in 2012 (the Rules and Standards) has a clearly defined role, as being the expert of what is a normal uncomplicated pregnancy. Where there is any deviation from this, the expectant mother should be referred to an obstetrician or other

medical specialist as appropriate. It is then the midwife's duty to continue to help care and provide guidance to the expectant mother and carry out the instructions of the obstetrician. In the Adviser's view, no explanation has been provided by the Midwife in her notes nor has the Board subsequently explained why the Midwife did not assist Mrs C in making an appointment to see a consultant obstetrician.

20. In the Adviser's experience, a mother to be, with the type of complicated history in Mrs C's case, would have required time to express her feelings and anxieties. The Adviser had noted from the documentary evidence that the Midwife had expected Mrs C to trust her and she considered that she had given Mrs C robust care and had not understood Mrs C to be unduly anxious. However, the Adviser told my complaints reviewer that from her review of the evidence, she was not convinced that Mrs C had been able to express her feelings and anxieties as she should have been able to. The Adviser had, therefore, concluded that the Midwife, while providing Mrs C with care according to local guidelines, had not followed the aforementioned Rules and Standards. The Rules and Standards required the Midwife to respond to the needs of the mother to be in her care using evidence gathered during interviews with Mrs C when she examined her and also her reviews of Mrs C's previous history. This was in order to provide Mrs C with appropriate levels of care, guidance support and advocacy, which would have included a referral to an obstetrician. It was not, in the Adviser's view, for a midwife to make the decision as to whether a mother to be may or may not have a C-section. The Adviser had also commented that whilst the Midwife had told Mrs C that she was having a normal sized baby, Baby A had weighed 5.200 kilograms at birth, whereas the average size of a full term baby is between 3.300 kilograms and 3.700 kilograms.

21. The Adviser, however, told my complaints reviewer that the documentation concerning the events surrounding the labour and delivery of Baby A were fairly complete. The emergency situation at the birth of Baby A, when he was born with shoulder dystocia, was responded to quickly by medical staff and Baby A was born in good condition. The Adviser explained to my complaints reviewer that shoulder dystocia occurred when the fetal shoulder gets stuck behind the maternal pelvic bone following the delivery of the head. It is a rare complication which affects approximately two percent of all births and the size of the baby alone is not an indicator that a mother will experience a shoulder dystocia but is a significant risk factor. It is regarded as one of the high risk situations in obstetrics and its unpredictability continues to be a major concern for

obstetricians worldwide. Therefore, mothers to be with a larger than expected baby before onset of labour should be reviewed by an obstetrician to confirm the mode of delivery and to discuss the associated risk factors with the mother to be.

(a) Conclusion

22. I note that the Board have apologised to Mrs C that the care she had received during her pregnancy had not met her expectations, and for her dissatisfaction with the level of information she had received from the Midwife in relation to her anxiety about her pregnancy and labour.

23. However, the Adviser said that given Mrs C's complicated medical history and the undoubted anxiety she would be suffering with this pregnancy, she would have expected the Midwife to have made an appointment for Mrs C to discuss the mode of delivery of Baby A with her consultant obstetrician. In the Adviser's professional opinion, while local guidelines had been followed by the Midwife concerning the care she provided to Mrs C, the Rules and Standards had not, and I accept this advice.

24. Furthermore, based on the evidence provided to this office and the advice received from the Adviser, I am not satisfied the Board have provided a proper explanation as to why the Midwife did not assist Mrs C in making such an appointment to see a consultant obstetrician when Mrs C requested this. This has also not been helped by poor record-keeping on the part of the Midwife whose notes provide no explanation why she did not do so.

25. Therefore, for these reasons, I uphold the complaint.

(a) Recommendation

26. I recommend that the Board:	*Completion date*
(i) ensure that the comments of the Adviser are shared with community midwives, in particular, that where there is any deviation from a normal uncomplicated pregnancy, the expectant mother should be referred to an obstetrician or other medical specialist as appropriate.	11 August 2013

(b) The Midwife unreasonably refused Mrs C antenatal appointments

27. Mrs C said that when she was about 20 weeks pregnant she asked the Midwife when antenatal appointments would begin. She explained to the Midwife that the reason for this was because she had moved house since her daughter was born and so she wanted to attend some appointments to meet some other mothers and refresh her knowledge. The other reason was because of the trauma she had suffered with her other pregnancies since her daughter's birth. This had made her particularly nervous about giving birth and she thought that antenatal classes would help her and would be a good means of relaxation.

28. However, according to Mrs C, the Midwife told her that there were many young first-time mothers in the area of Edinburgh where she now lived and that as she had attended antenatal appointments a couple of years earlier during her previous pregnancy she would not be entitled to attend appointments again. The Midwife told her that nearer her due date she would give her a quick one-to-one antenatal session. Mrs C said that she had since been told she should have been allowed to attend such classes and that the Midwife did not have the authority to refuse her appointments if she had specifically requested to attend.

29. The Board in response to this complaint said that the current practice in relation to antenatal classes was to offer all women who were pregnant for the first time parenthood education classes. Those mothers to be having a subsequent pregnancy were usually offered a one-to-one session, if requested. The Board apologised to Mrs C if this had not been offered to her. The Midwife had advised that she did not recall Mrs C asking for any additional information regarding this.

Clinical Advice received

30. The Adviser could find nothing noted in Mrs C's medical records concerning the refusal to allow Mrs C to attend antenatal classes.

(b) Conclusion

31. The Midwife is unable to recall Mrs C asking about attending antenatal classes and there are no notes in Mrs C's medical records regarding this. While I accept it was likely that Mrs C asked the Midwife about antenatal classes, I do not know for certain whether the Midwife refused these. We know from Mrs C's comments that she was offered a one-to-one session and that the Board had

said those mothers having a subsequent pregnancy were usually offered a one-to-one session.

32. However, given the lack of evidence in the clinical records. I am unable to conclude with certainty whether the Midwife unreasonably refused Mrs C antenatal appointments. Therefore, I do not uphold the complaint.

(c) The Midwife misled Mrs C about when she would be induced

33. Mrs C said that after she was told she was not allowed an elective C-Section she was keen to be induced at the earliest possibility so the large baby she was having did not get even larger. At an appointment with the Midwife in April 2011 Mrs C said she had asked the Midwife when she could be induced and was told when she was 40 weeks pregnant. Two weeks later at her next appointment the Midwife told her that, as she had had a normal birth delivery two years earlier, she would let her go one week over the date she was due to give birth. Mrs C says that she was particularly distressed by this point but thought she had no choice in the matter.

34. At her next appointment with the Midwife in May 2011, when she was now five days over her due date, Mrs C said she asked to be induced the next day. However she was told by the Midwife that she would not get an appointment to be induced for another week as the Hospital was very busy. When the Midwife contacted the Hospital to arrange the appointment Mrs C said that she was then told the first available appointment was five days later, which was a Sunday. The Midwife told her however that it would be in her interests to wait until the following day, that is, Monday. The Midwife said this was because fewer staff were on duty at the weekend and if there were emergency deliveries on the Sunday she would in any event be told to come back on the Monday. Mrs A's induction date was therefore set for Monday 16 May 2011, when she gave birth to Baby A.

35. The Board in response to the complaint replied that it was normal practice to induce labour between term plus ten to fourteen days. Mrs C was given an appointment for term plus eleven days. The Board's guidelines for induction of labour for women who are more than 40 years of age recommend that primigravida women are offered induction of labour at term plus seven days and parous women who have had a previous delivery in the last ten years are offered induction of labour between term plus ten to fourteen days.

36. The Board explained that when the Hospital was experiencing a peak of activity, then unfortunately on occasions elective procedures such as postdate inductions of labour or elective C-sections may need to be delayed in order to deal with emergency workloads and to ensure safe care. The Board apologised to Mrs C if this had not been adequately explained to her at the time and that it was not a common practice to send women home in such situations.

Clinical Advice received

37. The Adviser said that in the scant summary of records of care provided by the Board, there was no evidence that Mrs C was misled in any way about when she was to be induced. The Adviser explained to my complaints reviewer that in relation to arranging a date for induction of labour for Mrs C, the Midwife was apparently following local guidelines and was strictly adhering to these guidelines. However, the Adviser also explained that guidelines are flexible and intended to be a guide only, not an absolute policy. While the decision as to when it is the appropriate time for induction of labour is guided by local service guidelines every case must be considered individually. In the Adviser's view, the Midwife by adhering to these guidelines had not taken the wishes of Mrs C into account. In addition, the Adviser was of the view that as Mrs C had relevant issues of a complex history, maternal age and personal anxieties then the correct time for Mrs C to have been induced should have been negotiated and agreed between Mrs C and her consultant obstetrician.

38. The Adviser also noted the Midwife's records about Mrs C's request for induction were very brief and that the scant documentation by the Midwife only recorded that Mrs C was 'keen for induction' but did not record the discussion that took place between them and the advice shared.

(c) Conclusion

39. The Adviser has found no evidence that Mrs C was misled in any way about when she was to be induced. I accept that advice. For this reason, I do not uphold the complaint.

40. Nevertheless, I note the comments of the Adviser once again that Mrs C's medical history and anxieties about the pregnancy do not appear to have been taken into account by the Midwife in relation to when Mrs C would be induced. Also, that the time for induction should have been agreed between Mrs C and her consultant obstetrician. In view of this, I have made the following recommendation.

(c) Recommendation

41. I recommend that the Board:	*Completion date*
(i) ensure that the comments of the Adviser are shared with community midwives, in particular, that every case of an expectant mother must be considered individually and that relevant issues of a complex history, maternal age and personal anxieties are taken into account.	11 August 2013

Additional comments on Complaints (a) (b) and (c)

42. The Adviser has told my complaints reviewer that, in her experience of working in both NHS Hospitals and community midwifery services, she had not encountered any situation where a mother to be requesting any intervention; induction of labour; or a C-section, had not had such a request clearly documented in her medical notes. There were no such requests recorded in Mrs C's medical notes by the Midwife.

43. Furthermore, the Board, in their response to these complaints, had replied in such a way that, in the Adviser's view, had not fully answered Mrs C's concerns and experiences. The Adviser considered that the Board had failed to provide transparent evidence about the decisions taken by the Midwife during Mrs C's pregnancy and the events surrounding Baby A's delivery. According to the Adviser, there should have been contemporaneous records made at the time of each of Mrs C's appointments or attendances. The Adviser also told my complaints reviewer that the computer clinical records summary supplied by the Board were not sufficiently detailed to be able to come to any conclusion of adequate care and consultation between Mrs C and the care professionals looking after her.

44. Not only am I critical of these failures in record-keeping but it is of concern that the Board have failed to appropriately address the concerns raised by Mrs C about the decisions taken by the Midwife during her pregnancy and the events surrounding Baby A's delivery. In my view, it is essential that proper records of such important discussions and events are made especially at what is an undoubtedly anxious time for mothers to be, such as Mrs C. Therefore, I have made the following recommendations:

(a), (b) and (c) Recommendations

45. I recommend that the Board:	*Completion date*
(i) review the process of record-keeping by community midwives in relation to patients' notes. In particular, to ensure that any discussions and advice given concerning requests by an expectant mother for any intervention, induction of labour or a C-section are clearly and properly documented in her medical records; and	11 August 2013
(ii) apologise to Mrs C for the failings identified in this report.	17 July 2013

(d) The Board unreasonably refused to allow Mr C to push Mrs C's bed to theatre

46. Mrs C said that immediately following the birth of Baby A medical staff told her that she would need to go to theatre in order to stop a haemorrhage. There was then a delay in taking her to the theatre. She was told the reason for this was because a member of staff was needed to come and help push her bed to theatre. Mrs C said that she and Mr C were surprised as there appeared to be many staff in the room. As far as she was aware, only one member of the staff was pregnant and was, therefore, not allowed to push the bed for health and safety reasons. To avoid the wait, Mr C said he would push the bed to the theatre. However, he was refused permission to do this. Mrs C said she was, therefore, delayed getting to theatre and was concerned that her health was deteriorating whilst waiting.

47. The Board in their response to the complaint said that there was no policy that said that a husband cannot push their wife's bed to theatre. However, from a health and safety perspective it was not good practice.

Clinical Advice received

48. The Adviser told my complaints reviewer that following on from the emergency situation of Baby A's birth, when he was born with shoulder dystocia, the next emergency that Mrs C experienced was a haemorrhage. The Adviser explained that a haemorrhage is associated with traumatic delivery and larger than expected babies. However, in the Adviser's view, the situation was quickly and efficiently dealt with by the Hospital staff involved in the delivery.

49. The report by the Board and the recollections of Mr and Mrs C about these events differs. Due to a lack of evidence and as there were no statements from the Hospital staff involved, the Adviser was, therefore, unable to draw any conclusions about what actually occurred. However, in the Adviser opinion, there appeared to be a minor delay whilst another person was arranged to push Mrs C to theatre to have the haemorrhage dealt with and her tear sutured, which would have been distressing to Mr and Mrs C.

(d) Conclusion

50. Understandably this was a distressing and concerning time for Mrs C, particularly as she had just experienced an emergency situation during the birth of Baby A. However, due to the conflicting evidence presented to me and lack of evidence regarding the situation, I am unable to conclude with certainty what actually occurred. Therefore, I do not uphold the complaint.

Annex 1

Explanation of abbreviations used

Mrs C	the complainant
Baby A	Mr and Mrs C's son
The Hospital	Simpson Centre for Reproductive Health at the Royal Infirmary of Edinburgh
Mr C	the husband of Mrs C and the father of Baby A
The Midwife	the community Midwife who attended to Mrs C during her pregnancy
The Board	Lothian NHS Board
The Adviser	a clinical adviser to the Ombudsman
The scan	an ultrasound scan
Consultant 1	Mrs A's consultant obstetrician
Consultant 2	Mrs A's consultant obstetrician
The Rules and Standards	The Nursing and Midwifery Council Midwives Rules and Standards 2004, as amended in 2007 and 2010 and reviewed in 2012

Annex 2

Glossary of terms

Amniocentesis	a diagnostic test carried out during pregnancy to assess whether the unborn baby could develop an abnormality or serious health condition
Caesarean section (C-section)	an operation to deliver the baby without labour
Fundal height	a measure of the size of the uterus used to assess fetal growth and development during pregnancy
Gestation	the period of time between conception and birth
Parous	having given birth to one or more children
Primigravida	A women who is pregnant for the first time
Shoulder dystocia	when the baby's head has been born but one of the shoulders becomes stuck behind the mother's pelvic bone
Sonographer	a diagnostic medical professional who operates ultrasonic imaging devices to produce diagnostic images, scans
Subdural bleed	bleeding in the head between the skull and the brain
Vocal cord palsy	paralysis of the vocal chords

Annex 3

List of legislation and policies considered

The Nursing and Midwifery Council Midwives Rules and Standards 2004, as amended in 2007 and 2010 and reviewed in 2012