SPSO decision report

Case: **201201424, Ayrshire and Arran NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, action taken by body to remedy, recommendations

Summary

Miss C complained that there was a lack of continuity in the midwifery care she received during her pregnancy, and that she had ongoing symptoms after being incorrectly given a general anaesthetic. Miss C was also unhappy that the board did not acknowledge her concerns about these symptoms, which included headaches, loss of vision, vomiting and dizziness.

Miss C told us that she was concerned that blood samples had been lost, that she had to repeat herself every time she saw a new midwife, and that she did not get advice when she needed it. She said that her phone messages were not returned and there was a lack of information about antenatal classes (classes for new parents before a baby's birth) and induction of labour (treatment given to bring on the onset of birth).

Our investigation found that Miss C saw three different midwives during her pregnancy, because a member of staff was off sick. However, but we did not find evidence that her overall care was inconsistent or unreasonable, and we did not uphold this complaint. The clinical records were of a good standard and there was evidence that that antenatal matters and induction of labour were discussed with Miss C. The board did acknowledge that a blood sample had been lost, but had apologised for this.

Miss C also complained that she continued to experience symptoms after an error with anaesthetic. We found that Miss C was appropriately given a spinal block (an injection of a small volume of anaesthetic into the lower spine) during a caesarean section (a surgical procedure used to deliver a baby). However, the anaesthetist then made a mistake and gave her a general anaesthetic instead of antibiotics. This resulted in Miss C losing consciousness. Although there can be an association between headaches and spinal blocks, our adviser said that Miss C's symptoms did not suggest that they were a result of anaesthetic complications. We accepted this advice and did not uphold Miss C's complaint that the board failed to recognise the long-term effects of the anaesthetic.

However, we found that the board had not provided a response to Miss C's concerns about this. Had they done so, it might have provided Miss C with some reassurance, and we upheld her complaint about the board's complaints handling.

Recommendations

We recommended that the board:

- apologise to Miss C for failing to respond to her concerns about the potential long term effects from the anaesthetic; and
- reflect on this case and consider offering a debrief to patients shortly after significant events.