SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201404375, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Ms C's second child was stillborn. She said that for a number of weeks prior to the birth she had expressed concern but had not been listened to. She said that staff at the Southern General Hospital failed to respond appropriately when she told them that her waters had broken, and that she was not properly assessed or seen by a doctor. Ms C believed that these failures led to her child's stillbirth.

We took independent advice from a consultant obstetrician. We found that Ms C's temperature had not been monitored as it should have been and that, after two examinations following the rupture of her membranes, she should have been immediately induced. There was also confusion about the responsibility of her care and, thereafter, there were failures in providing her with information. We upheld these complaints.

Although Ms C further complained about the quality of information she received about her child's post mortem, it was considered that reasonable explanations were given, so we did not uphold this part of her complaint.

Recommendations

We recommended that the board:

- make a formal apology for these failures;
- confirm to us that the recommendations made as a consequence of their Significant Clinical Incident Investigation report have since been carried out; and
- recognise this shortcoming in their apology.