SPSO decision report

Case: **201507572, Greater Glasgow and Clyde NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Ms C complained to us about the care and treatment she was given when she went into the Princess Royal Maternity Unit to give birth to her daughter. When her labour was slow to progress and other alternatives were unsuccessful, her baby was delivered by caesarean section (an operation to deliver a baby which involves cutting the front of the abdomen and womb). However, doctors noted that she was not recovering from surgery as expected. She was taken back into surgery when she collapsed, two hours and twenty minutes after her caesarean section, and was found to have had a major internal bleed. Ms C raised concerns that her caesarean section was not carried out appropriately, and that doctors did not notice her deterioration quickly enough. She said that this resulted in a prolonged recovery time for her, and difficulties relating to her time with her new-born baby.

We sought independent advice from an obstetric adviser. They reviewed Ms C's medical notes in detail and did not raise any concerns about the way Ms C's caesarean section had been carried out. However, they did raise concerns about how medical staff responded to her deteriorating condition in the two hours after her caesarean section. They noted that a blood test had been taken but not followed up. They noted that medical staff did not maintain appropriate records of their decisions and plans. They also considered that Ms C's deterioration was not appropriately escalated to both anaesthetic and obstetric teams. They said that, if all this had been done, it was likely that Ms C's second operation could have been undertaken 45 minutes earlier, before her condition had become so critical.

We noted the obstetric advice on Ms C's care and treatment and upheld her complaint. We made a number of recommendations to address the failings we identified.

Recommendations

We recommended that the board:

- review the post-operative escalation policy, to ensure concerns are escalated to both obstetrics and anaesthetics when post-operative concerns persist;
- share these findings with the staff involved, and remind them of the need to record their findings, working diagnoses, plans and timescales for review;
- review mechanisms for receiving blood test results to ensure that results are identified and acted on promptly;
- review staff competencies and potential training needs on the early diagnosis of occult/internal haemorrhage and on scanning an acute surgical abdomen; and
- apologise to Ms C for the failures we identified, and for the distress caused to her and her family.