SPSO decision report

Case: **201702563, Fife NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mrs C complained about the care and treatment she received on the labour ward at Victoria Hospital when she was admitted with a history of reduced fetal movement for 24 hours and no movement felt during the daytime. Mrs C complained that the decision to perform a caesarean section was unreasonably delayed and that once in theatre there was further delay in the delivery of her baby (Baby A) due to the difficulty in achieving an effective spinal anaesthetic. The board carried out a significant adverse event review (SAER, a structured approach to learning from an adverse event) which identified a number of failings in relation to the care and treatment given to Mrs C. Prior to our investigation, the board accepted that there had been a number of failings and detailed the action taken.

We took independent advice from a consultant obstetrician and gynaecologist (a doctor who specialises in the female reproductive system, pregnancy and childbirth) and a midwife. We found that there were failings in relation to the clinical care given to Mrs C which led to the delay in the delivery of Baby A. We were also concerned that there had been a breakdown in communication regarding a post birth anaesthetic review and that there was no evidence that a proposed review meeting between Mrs C and the obstetric consultant had been offered, and either taken up or declined. We also noted that the SAER had failed to identify the anaesthetic involvement in the delay in the delivery of Baby A. In relation to midwifery care, we found that Mrs C's paper records had not accompanied her when she was transferred to another hospital. We considered that the care and treatment Mrs C received was unreasonable and upheld this aspect of her complaint.

Mrs C also raised concerns about the handling of her complaint. We found that the board had failed to comply with the NHS model complaints handling procedure. Therefore, we upheld this aspect of Mrs C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for the failings in care, communication and complaints handling. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

What we said should change to put things right in future:

- All relevant medical staff, including locum medical staff, should be mindful of current clinical guidelines.
- Processes should be put in place to ensure transfers of care receive a post- operative anaesthetic review.
- Accurate and full clinical records should be maintained.
- All staff directly involved in care delivery should be included in the SAER process.
- All relevant paper records should accompany a mother on transfer to another hospital.

In relation to complaints handling, we recommended:

- Complaints should be dealt with in accordance with the complaints procedure.