SPSO decision report

Case: **201702799, Highland NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Ms C complained about maternity care and treatment she received at Raigmore Hospital in relation to her labour and birth. Ms C had previously had a caesarean section and had planned a vaginal delivery for this birth. Ms C went to the hospital as her waters had broken, however, she was not experiencing contractions. She was admitted and the following day, a drip was administered to augment her labour. Ms C's labour progressed with continuous monitoring of the baby's heart rate. When this dropped, the drip was stopped and Ms C had an emergency caesarean section to deliver her baby. During the operation, it was discovered that a scar from a previous caesarean section had ruptured. Ms C complained about the care she received as she considered that she was left too long without action after her waters had broken and that the drip had not been prescribed at a safe level, given her previous caesarean section. Ms C was also concerned about the board's handling of her complaint as there were delays and inaccuracies in the final response.

We tookindependent advice from a consultant obstetrician (a doctor who specialises in pregnancy and childbirth). We found that the risks and benefits of vaginal delivery following caesarean section had been discussed during Ms C's pregnancy. We found that the care and treatment Ms C received was in line with local protocols and national guidance. We did not uphold this aspect of Ms C's complaint. However, we made a recommendation that the board consider recording that the Royal College of Obstetricians and Gynaecologists leaflet on birth options after previous caesarean section is provided to patients like Ms C.

Regarding complaints handling, we found that during the board's own consideration of the case, they apologised that there had been delays in Ms C's complaint reaching the appropriate team, although we were unable to determine the reason for the delay. We found the board's final response was open to misinterpretation in terms of the timeline and plan for Ms C's care. We also noted there was an inaccuracy in relation to the rate that Ms C's drip was administered at. We upheld Ms C's complaint about the way the board handled her complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise for the inaccuracies in the final response to Ms C's complaint. The apology should meet the standards set out in the SPSO guidelines on apology available at: https://www.spso.org.uk/leaflets-and-guidance.

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

- Consider ensuring (and documenting) that the Royal College of Obstetricians and Gynaecologists Patient Information Leaflet on Birth Options After Previous Caesarean Section has been provided to patients to confirm that the risks and benefits have been appropriately shared.
- The final response to complaints should be clear, accurate and easy to interpret.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.