# SPSO decision report

**Case:** **201801306, Greater Glasgow and Clyde NHS Board - Acute Services Division**
**Sector:** health
**Subject:** clinical treatment / diagnosis
**Decision:** upheld, recommendations

## Summary

Ms C complained about the care she received from Queen Elizabeth University Hospital's maternity assessment unit (MAU) when she called for advice with heavy bleeding at 33 weeks of her pregnancy. She also complained about the treatment she received ten days later following her admission to the hospital, at which time her baby was stillborn.

In responding to the complaint, the board apologised that they could not account for Ms C's phone contact with the MAU because there was no record of the phone call.

We took independent advice from a consultant obstetrician (a specialist in pregnancy and childbirth) and gynaecologist (specialist in the female genital tract and its disorders). We considered that the record-keeping practice was of an unacceptable standard and that the advice Ms C had received was incorrect because she should have been asked to attend hospital to have a clinical assessment of her pregnancy, in line with national guidance. We also considered that it was likely that Ms C would have been admitted to hospital for monitoring but given her bleeding stopped, it was also likely she would have been discharged. Whilst we found that it was possible that follow-up with Ms C could have been earlier than when she was seen 10 days later, we considered that the large placental abruption (separation of the placenta from the inner wall of the uterus), which she had no obvious risk factors of, could not have been prevented or predicted. We upheld the complaint.

In terms of the treatment Ms C received at the hospital when she attended by emergency ambulance with heavy bleeding 10 days later, we considered that her initial management of her abruption was inadequate and not in accordance with national guidelines. However, we also considered that these failings were unlikely to have altered the outcome for Ms C's baby. We upheld the complaint.

## Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms C for failing to fully assess and treat her on arrival to the maternity unit. 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:

- The Maternity Assessment Service should maintain adequate records of phone consultations and advice given. Staff responding to patient phone queries should be aware of guidance on the management of significant antepartum haemorrhage.
- All staff attending patients with life threatening complications such as antepartum haemorrhage should be aware of national/local guidelines on emergency management of patient collapse.
- Staff handling complaints should ensure that the issues are fully investigated with action taken to address

any failings identified.