SPSO decision report

Case: **201807820, Lanarkshire NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the care and treatment provided to them and their child (A) by the board during their pregnancy and after A's birth. A was diagnosed with microcephaly (a condition where the head circumference is smaller than normal) and associated issues around six weeks after their birth, and C felt that the diagnosis could have occurred at an earlier point.

During our investigation, we took independent advice from a midwife, an obstetrician (a doctor who specialises in pregnancy and childbirth) and a neonatologist (a doctor who specialises in the medical care of newborn infants, especially ill or premature newborns).

In relation to the care and treatment provided to C during their pregnancy, we identified the following failings:

A lack of documentation in the care plan in relation to detail surrounding verbal discussions midwives had with medical staff during the antenatal period.

A lack of a planned schedule for obstetric reviews as per the 'Keeping Childbirth Natural and Dynamic' (KCND) pathways.

No scan carried out at 36 weeks as per the plan and no documentation to support the reasons for not adhering to this planned care pathway.

Lack of clear documentation resulting in it being difficult to accurately determine if or when an obstetric doctor saw C, and what they communicated to the midwives or C.

Lack of documentation regarding information given to C about the External Cephalic Version (ECV) procedure (a process by which a baby in the womb can sometimes be turned from buttocks or foot first to head first), delivery options, and induction.

No evidence within the files that there were discussions about risks associated with shoulder dystocia (when one or both of a baby's shoulders get stuck inside the mother's pelvis during labour) or that risk assessments in relation to previous pregnancy outcomes were undertaken.

As a result of an external Significant Clinical Incident Review (SCIR) carried out by the board, some improvement actions had been taken to address the issues identified with the lack of documentation of discussions between midwives and medical staff, and the failure to discuss induction of labour. However, we upheld this aspect of C's complaint and made further recommendations to the board.

We did not identify any failings in relation to the care and treatment provided to C during labour; C and A's discharge from hospital; or the care and treatment provided to A after discharge. We did not uphold these aspects

of C's complaint.

However, we found that there was an unreasonable failure to identify A's tongue tie when still in hospital after being born. Therefore we upheld C's complaint that the board failed to provide reasonable care and treatment to A whilst in hospital after being born.

C also complained about the board's involvement in the external SCIR, and the board's handling of their complaint. We found that the board's involvement in the SCIR was reasonable and did not uphold this aspect of C's complaint. However, we considered that their complaint handling was unreasonable, as C was not informed of their right to bring their complaint to us in a timely manner, and the board did not reasonably manage the multiple streams of communication during the complaint process. We upheld this aspect of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failure to provide reasonable care and treatment during C's pregnancy in relation to documentation, schedules for obstetric reviews and scans, communication, and risk assessments; the failure to identify a tongue tie; and the failure to handle C's complaint reasonably. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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

- Clear documentation should be made when care plans change, which reflects the rationale for change and the new plan to be followed.
- Discussions between midwives and medical staff, and medical staff and patients, should be clearly documented.
- ECV procedure and delivery options should be discussed and documented as appropriate.
- Obstetric reviews should be scheduled in line with the KCND pathways.
- Risks associated with previous shoulder dystocia should be discussed, and risk assessments in relation to previous pregnancy outcomes undertaken.
- The names and roles of all providers of clinical care should be identified within the records, and discussions.
- Tongue ties should be identified as promptly as possible.
- Where meetings are held between patients and clinicians, the discussions should be documented.

In relation to complaints handling, we recommended:

- Complainants should be informed of their right to take their complaints to the SPSO in a timely manner.
- Efforts should be made to manage communication when there are multiple streams of communication during the complaint process.

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.