SPSO decision report

Case: **201808983, Grampian NHS Board**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mr C complained about the care and treatment provided to his partner (Miss A) at Aberdeen Maternity Hospital. Mr C said that when Miss A attended a pre-caesarean section assessment, the doctor failed to identify that she was in the early stages of labour. Mr C also complained that the board failed to explain why their baby required antibiotics and a breathing tube after they were born, and that the board's handling of his complaint was unreasonable.

The board acknowledged that the doctor assessing Miss A had failed to carry out a full assessment. The board noted that the reasons why their baby required antibiotics and a breathing tube had been explained to Mr C by hospital staff and later in email correspondence. The board also carried out a comprehensive review of their handling of the complaint and identified areas for learning and improvement.

We took independent advice from a consultant obstetrician and gynaecologist (a doctor who specialises in the female reproductive system, pregnancy and childbirth). We accepted the board's view that the doctor failed to carry out a full of assessment of Miss A's condition when she attended for the pre-caesarean section appointment and that their handling of the complaint was unreasonable. We upheld these complaints on that basis and made further recommendations for learning and improvement. We concluded that there was reasonable evidence it had been explained to Mr C why his baby required antibiotics and a breathing tube at the time of the event and later in email correspondence. Therefore, we did not uphold this aspect of the complaint.

Recommendations

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

- The board should have a guideline in place for the management of patients attending the pre-caesarean section clinic. This should include standard questions to ask all patients such as about presence of vaginal bleeding, fetal movements, as well as contractions and leaking fluid vaginally.
- The board should have guidelines in place about the turnover time for issuing letters following debrief meetings.
- The board should have in place template letters which can be used when inviting patients for debrief meetings that make the purpose of the meeting explicit.

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.