SPSO decision report

Case: **201906625, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment provided to one of their twins (A) at delivery and in the neonatal unit after delivery at Queen Elizabeth University Hospital. C was concerned, in particular, about blood loss at birth, the delay in a blood transfusion being carried out, a delay in blood pressure being taken, record-keeping and communication.

We took independent advice from a consultant obstetrician (a doctor who specialises in pregnancy and childbirth) and a consultant neonatologist (a doctor who specialises in the medical care of newborn infants, especially ill or premature newborns).

We found generally that the evidence in the records showed a safe and appropriate delivery. We found that the blood loss at birth was within the standard parameters for twins delivered by caesarean section, although it is accepted that it was not possible to establish the total blood loss for A. We also found a blood transfusion was carried out within an appropriate timescale. However, A did not have their blood pressure taken until three hours after being admitted to the neonatal unit. We found it would be standard practice for a ventilated and unstable baby on a neonatal unit to take a non-invasive blood pressure reading. The board did not have a policy requiring this. Therefore, we upheld this complaint.

In addition the board accepted their record-keeping during delivery was not of an appropriate standard. They also recognised that communication required to be improved, and they have taken steps to address both of these issues. We identified concerns about record-keeping in the neonatal unit and this has been brought to the board's attention.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A's family for the failings this investigation has identified. The apology should meet the standards set out in the SPSO guidelines on apologyavailable at www.spso.org.uk/information-leaflets.

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.