# SPSO decision report

**Case:** **202101722, Greater Glasgow and Clyde NHS Board - Acute Services Division**
**Sector:** Health
**Subject:** Clinical treatment / diagnosis
**Decision:** not upheld, no recommendations


## Summary

C complained about the maternity care they received from the board when they gave birth to their twins. C was suspected to have COVID-19 and this was confirmed the day after delivery.

C complained that they were placed in a room that wasn't equipped for labour and that they were pushed towards a vaginal delivery, rather than a planned caesarean section. The board explained that the labour room was set up with equipment stored outside the room for infection control purposes. C also complained that they weren't provided with appropriate postnatal care.

We took independent advice from a midwife. We found that the records supported reasonable decision making surrounding the delivery method and that appropriate discussions had taken place with C in this regard. We also considered that the records evidenced a reasonable standard of postnatal care and that the decision to store equipment outside the room was reasonable. Therefore, we did not uphold this part of C's complaint.

C was unable to see their babies in the neonatal intensive care unit (NICU) until after their COVID-19 isolation period ended. C complained that it wasn't explained to them why they weren't allowed skin to skin contact before the babies were taken away to the NICU. C also complained that there was no clear process in place for them to see their babies and that staff were initially unable to tell them when this would happen. The board acknowledged that C did not receive an explanation as to why skin to skin contact was not allowed. We noted that the board had asked staff to reflect on C's negative experience of communication and we were satisfied they had demonstrated learning from this.

We found that the restrictions in place for visiting the NICU were reasonable, that there were clear processes and guidelines in place to support this, and that the records showed this was appropriately communicated to C. Therefore, we did not uphold this part of C's complaint. We provided complaint handling feedback to the board as we noted some inaccuracies in their responses to C.