Scottish Parliament Region: Glasgow

Case TS0135_03: Greater Glasgow NHS Board

A complaints investigator with the delegated authority of the Scottish Public Services Ombudsman has conducted this investigation.

Summary

1. On 13 December 2002 the Ombudsman received a complaint from a woman (referred to in this report as Ms C) that the care and treatment afforded to her and her newborn daughter at the Maternity Unit of the Southern General Hospital, Glasgow from 17 to 27 September 2001 was inadequate. In particular, she complained that a lack of proper care during her labour may have affected her daughter's chances of survival and thus contributed to her death on 25 September 2001. My investigation upheld a number of Ms C's complaints but did not conclude that the actions of staff had contributed to Baby C's death. I found that there were shortcomings in communication with Ms C and significant deficiencies in her clinical records. In the light of these findings the Ombudsman has recommended that the Board review a number of existing practices and consider introducing a number of new processes with respect to the provision of maternity services in the area.

Background

2. On 8 September 2001 Ms C was transferred from the Western Isles Hospital to the Queen Mother's Hospital (QMH) in Glasgow, in the 24th week of pregnancy, because of threatened pre-term labour. On 17 September Ms C was transferred to the labour ward with ruptured membranes. There were no intensive care cots available at QMH at this time so Ms C was transferred to the Southern General Hospital (SGH). Ms C continued to be monitored at the SGH for several days. At 02:15 on 25 September 2001 Ms C was admitted to the labour ward, with suspected pre-term labour, but her labour was not confirmed for several hours. Baby C was born at 05:50 on 25 September 2001, in a poor condition and died shortly afterwards at 06:30.

Complaint as put to the Ombudsman

3. Ms C complained about the care and treatment afforded to her at the Maternity Unit of the SGH, Glasgow from 17 to 27 September 2001.

4. In particular Ms C complained of:

(a) an unnecessary transfer from the QMH to the SGH;

(b) a lack of monitoring of mother and baby on the morning of the 25 September 2001;

(c) failure to manage labour appropriately or sufficiently;

(d) failure to provide adequate midwifery care;

(e) failure to provide adequate perinatal paediatric care;

(f) failure to keep adequate medical records;

(g) failure to provide appropriate care prior to discharge.

Investigation and findings of fact

5. The investigation of this complaint has involved reading all the documentation supplied by Ms C; Ms C's medical records and the complaint files. I have also met Ms C. Advice has been obtained from both the medical and the midwifery advisers to the Ombudsman. Several written enquiries have been made of the South Glasgow University Hospital Division of Greater Glasgow NHS Board (the Board). I now set out, for each of the seven heads of Ms C's complaint, my findings of fact and my conclusions. The investigation has identified a concern about the standard of maternity notes transferred between hospitals and NHS Boards. I deal with this in paragraphs 58-60. Where appropriate, the Ombudsman's recommendations are set out at the end of the sections dealing with individual heads of complaint. A summary of recommendations is in paragraph 64. I have not included in this report

every detail investigated but I am satisfied that no matter of significance has been overlooked. Ms C and the Board have been given an opportunity to comment on a draft of this report.

(a) Transfer to the Southern General Hospital

6. Ms C told me that her consultant obstetrician in Lewis had expressed concern at her transfer from the QMH to the SGH. Ms C expressed concern that her medical notes at the SGH were never properly completed and that this might indicate that the SGH did not have a complete picture of her medical history.

7. The midwifery adviser commented that there are, on occasions, problems with accessing neonatal cots in maternity units not only in Glasgow but also in other units across Scotland. The availability of neonatal cots can change on a daily/hourly basis. At the time of transfer to the QMH, a neonatal cot would have been available for Ms C's baby had she been born then. In the adviser's view circumstances must have changed in the intervening period, so that the best interests of the baby meant that it was advisable to transfer to the SGH. The obstetric adviser commented that, throughout the UK, there is a shortage of neonatal unit capacity, meaning that it is not uncommon to need to transfer mothers because there is no neonatal cot available.

Transfer to the Southern General Hospital: conclusions

8. I understand that it was distressing for Ms C to be transferred between hospitals for a second time. Nevertheless, I have concluded that the transfer to the SGH was in line with practice and necessary in the best interests of Baby C, however, I have concerns at the impact of this transfer on the record-keeping (see my comments on medical records below). The Ombudsman has no specific recommendation to make on this point.

(b) Monitoring of labour

9. Ms C said that on previous nights, when she had been admitted to the SGH labour ward for observation, she had had a CTG (cardiotocography) trace, vaginal examination and regular monitoring of her blood pressure. Staff had often come into her room to chat to her throughout her admission. On the early morning of 25

September 2001 she was simply told to 'jump into bed and go to sleep'. She had the clear impression that this was being regarded as 'another false alarm'.

10. Ms C did not have any CTG monitoring that night and no vaginal examination until 05:05 on 25 September 2001, when she was examined by the senior obstetric SHO (Senior House Officer), who had been called at 04:40. By this time, her labour was well advanced. The midwifery notes indicate that Ms C was examined by the registrar at 04:20 who did not think her contractions were suggestive of active labour (there is no corresponding entry in the medical notes).

11. The Board have provided a copy of the hospital guidelines for CTG monitoring, including for women in premature labour. The guidelines assume a 30 minute CTG being performed on admission and then a period of further monitoring for a number of maternal (mother), foetal (baby) or intrapartum (during labour) conditions one of which is 'foetal preterm'. The Board have commented that while there are guidelines for premature labour:

> 'the problem in [Ms C's] case is that the evidence was (incorrectly, as it turned out) that she was not in labour and, therefore, that is the reason she was not monitored.'

12. The obstetric adviser commented that, when the membranes are ruptured, any vaginal examination runs the risk of introducing an infection, which is potentially harmful to the mother and baby or may stimulate premature labour. There were, therefore, appropriate clinical reasons for avoiding vaginal examination to assess the progress or potential progress of labour. The adviser also commented that there is a considerable degree of difficulty in assessing women at risk of premature delivery, since many episodes of contractions will settle spontaneously, but some women will progress in labour with relatively little evidence. He further commented that the registrar's assessment at 04.20 (that Ms C was not showing signs of active labour) reflected a common problem affecting the assessment of premature labours, which can affect even experienced clinicians when labour progresses despite minimal signs. His assessment is that it might have been appropriate to start a CTG simply to assess contraction frequency but that premature labour can

be rapid and relatively silent so that contractions which do not seem significant may in fact be causing cervical dilation.

13. The adviser further commented that he was not surprised that events overtook staff on the labour ward that night, once it became apparent that Ms C was in advanced labour. The very difficulty of assessment in such circumstances means that the staff have to be highly vigilant. The adviser expressed concern that it is not clear from the notes that there was appropriate vigilance.

Monitoring of labour: conclusions

14. I am satisfied that there were sufficient clinical reasons not to undertake internal examination or CTG monitoring at this time. I note, however, that the adviser suggested that this was not a clear cut decision and I am concerned that the hospital records – specifically the medical records - do not reflect any consideration of monitoring or reasons why monitoring was not done on this occasion. This is of particular concern, as monitoring had been done on previous evenings.

15. It is a matter of regret that the lack of any clear evidence from the medical notes prevents me reaching any meaningful conclusion on this heading of complaint. I consider that there was a lack of consistency in the application of the monitoring protocol over the days of Ms C's admission. This inconsistency caused unnecessary anxiety and distress for Ms C and emphasises the importance of proper understanding and application of a protocol by all staff concerned.

16. The Ombudsman has no specific recommendation to make. However, she refers to the recommendations on medical record-keeping below, which are of particular relevance to this complaint heading.

(c) Management of labour

17. Ms C told me that, following a scan on 19 September 2001, she discussed the possibility of the need for a caesarean delivery with a consultant obstetrician at SGH and from this point on she considered that this was the planned method of delivery should she go into premature labour or have a significant bleed. Ms C told

me that, in her view, had Baby C been delivered by caesarean, as was the intention, it would have been less stressful for Baby C and might, therefore, have increased her chance of survival.

18. This possibility of a caesarean arose from the suggestion, from the scan, of placenta praevia. This condition was in fact discounted by a further scan the following day (20 September 2001). There is no mention in the medical record of any further discussion between the consultant obstetrician and Ms C on the subject. A record made by the Senior House Officer (SHO) attending Ms C on 23 September 2001 indicates 'If in established labour for caesarean section - see [the consultant obstetrician's] notes from 19.9.01'. There are no further medical notes until 02:50 on 25 September 2001 and I can find no record of any conversations between Ms C and medical staff regarding any plans in the event of premature labour.

19. The obstetric adviser commented that one of the most difficult parts of obstetric practice is decision making when the baby is at the margins of viability, that is when the pregnancy is between 24 and 27 weeks. At this stage, a baby's chance of survival is so marginal that it is unclear whether caesarean section is appropriate, since it is a more difficult operation in very premature babies. He suggested that the best way to deal with these difficulties is to discuss them with the parents and engage them in the decision making. The parents can also be forewarned of the difficulties of deciding if labour is occurring. The adviser commented once again that he could not find any evidence from the notes that such discussions took place.

20. The obstetric adviser concluded that, since the notes contain a number of CTG traces recorded during Ms C's admission, it is likely that the presumption amongst staff was that caesarean would be considered if there was evidence of the baby being in distress. Once it became apparent that labour was far advanced, the registrar would have had to make a rapid decision about the management of the remainder of labour and whether to allow a vaginal delivery or attempt caesarean section. This placed the registrar in a difficult position because there had been no clear prior planning for this situation. The obstetric adviser considers that once Ms

C was found to be so far advanced in labour, it was a reasonable decision to opt for a vaginal delivery on the basis that there would not be time to perform a caesarean section.

21. The midwifery adviser commented that, from her review of the notes, it is likely that the baby had been compromised in the period leading up to delivery. This was possibly due to hypoxia from cord compression and/or overwhelming infection associated with prolonged rupture of membranes. There was no way of knowing if this occurred in the interval between transfer to the labour suite and birth or before this time.

22. The midwifery adviser also told me that the decision to deliver the baby by caesarean section would normally be dependent on other factors, such as how quickly the cervix was dilating, the estimated delivery time, and risks associated with the method of delivery.

23. The Board commented that there was a discussion between the consultant obstetrician and Ms C on 19 September 2001, when the difficulties of a caesarean section at this early gestation were discussed. The consultant obstetrician commented that:

> '[Ms C] always seemed remarkably unconcerned by this; I suspect this being an after effect of her having delivered very prematurely last time round and her previous baby doing well.'

Management of labour: conclusions

24. I consider that the decision taken in the early hours of 25 September 2001, not to deliver by caesarean, was a reasonable one. I am, however, concerned by the lack of evidence of prior discussion with Ms C. The medical records fully support Ms C's belief that from 19 September 2001 the plan was for a caesarean birth in the event of premature labour. This plan may have been modified, based on further medical evidence, but the notes do not indicate that this was ever communicated to, or discussed with, Ms C. I also note that comments I have

received from the Board do not indicate that such a conversation took place after 19 September 2001.

25. The General Medical Council (GMC) (the organisation established to protect the public by ensuring that doctors provide high standards of care to their patients and clients) makes recommendations within its guidance on *Good Medical Practice 3rd Ed 2001*. The guidance is brief but says:

> '(Doctors should) keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed.'

26. The obstetric adviser commented that, since the plans for monitoring and delivery were not communicated to Ms C (or if they were, they were not written down), there was a clear breach of these standards. Because of the lack of records there is not sufficient evidence to show that the labour was properly managed, and I, therefore, uphold the complaint to this extent.

27. In light of this failure to meet the GMC guidelines, the Ombudsman recommends that the Board review their current practice regarding communication with patients and documentation of discussions with patients by medical staff and produce internal guidance to meet the GMC guidance, as outlined above.

(d) Midwifery care

28. Ms C said that she believes that staff shortages were the main reason she was not more closely observed and monitored on 25 September and the progress of her labour was not noted.

29. During the local resolution stage of the NHS complaints process the Board acknowledged that the pressure of work that night prevented the hospital from providing their normal standard of one-to-one midwifery. The Board also commented that they are of the view that one-to-one care that night would not have altered the situation.

30. I reviewed the staffing levels for that night. There was a member of staff absent and the senior midwifery manager was unable to cover this with overtime or bank staff. The records also indicated that there were six births in the six hours from 02:00 to 08:00. This is significantly higher than the usual average of eight births in 24 hours.

31. As part of my enquiries, I have obtained a copy of the *Birth Rate Plus* audit undertaken by the SGH in September 2004. This report identifies and compares the current levels of demand and service provision; it assesses the resources required by a particular hospital to provide a safe service at a quality standard; and it estimates that there was a shortfall in 2004 of eight midwives. The total number of births at this time was 10% higher than in 2001. The Board have told me that they believe this is largely due to an increased demand from women in Argyll and Clyde NHS. The Board have obtained additional funding to cover some of this shortfall and continue to negotiate for further funding.

Midwifery care: conclusions

32. While there was a shortage of midwifery staff that night, I am satisfied that there were unusual, though not unique, circumstances, that is the number of women in active labour. Even with a full complement of staff, it is my view that it might not have been possible to provide one-to-one care that night.

33. The Board have taken steps to ensure proper assessment of their midwifery provision and are actively seeking to match the demand for services in the area. I do not consider it would be reasonable to ask the Board to provide a continuous level of cover to match exceptional and unpredictable peaks. Because of this I do not uphold this aspect of the complaint.

34. It is, however, clearly important that the Board can provide staffing to match the expected level of demand identified by the Birth Rate Plus audit report. The Ombudsman requests that the Board inform her of their plan to achieve the staffing levels identified by the Birth Rate Plus audit report and that the Board keep her appraised of its progress towards achieving this level of staffing.

(e) Paediatric staff levels

35. Baby C was born at 05:50 on 25 September 2001. Her condition was described as 'poor' and resuscitation commenced immediately. This was initially carried out by a senior paediatric SHO with a bag and mask. The SHO took 18 minutes to intubate. The paediatric consultant was called by the SHO at 05:40 and arrived at 06:30.

36. The obstetric adviser commented that 18 minutes was an unusually long time to take to intubate a baby and that the SHO appeared to be conducting the resuscitation alone. He also commented that:

> 'Given the poor condition that Ms C's baby was born in, I doubt that the earlier arrival (of a paediatric consultant) would have made any difference in this case, but there may be circumstances in the future when such a delay will be critical.'

37. Both advisers commented that there is an expectation that a consultant can attend within 30 minutes of an emergency call-out and that, in fact, this is a condition of contract within the English NHS.

38. The Board commented that they are not aware of any specific requirement in Scotland, but that in any event they would expect a consultant to attend as soon as possible once notified.

39. The *Framework for Maternity Services in Scotland* (the Framework) published by The Scottish Executive in February 2001, sets out the template for best practice in maternity care. It establishes several principles for aspects of maternity care. Principle 9 concerns the importance of obstetric and neonatal services responding to the needs of new-born babies and includes the following action statement for Boards:

> 'All professionals directly involved with care during childbirth should be given appropriate neonatal resuscitation and immediate care training.'

40. To help Boards achieve this The Scottish Multiprofessional Maternity Development Programme (SMMDP), part of NHS Education Scotland, has established courses to deliver this training.

Paediatric staff levels: conclusion

41. I recognise that there is no equivalent requirement in Scotland to the 30-minute attendance rule for paediatric consultants. However, I am aware that this is considered to be good practice by a number of NHS Boards in Scotland and I would endorse this view. The Ombudsman requests the Board to consider adopting this practice and advise her of the outcome of their considerations.

42. I am concerned at the time taken to intubate Baby C. The Ombudsman requests the Board to provide her with details of the action they have taken to fulfil the action statement of the Framework (see paragraph 39) and to consider using the SMMDP to achieve this goal. The Ombudsman would ask that the Board again advise her of the outcome of this consideration.

(f) Medical records & record keeping

43. Ms C expressed concern that her medical notes from the SGH did not contain the details of her previous and current medical history or next of kin.

44. The midwifery adviser commented that the midwifery records were of a reasonable standard.

45. The obstetric adviser commented that, where a woman is transferred in the middle of the night and in mid-pregnancy, it is not uncommon for details not to be filled out in the receiving hospital notes, if these are available in the notes sent on by the referring hospital. However, the adviser also commented several times on the deficiencies in the medical notes, There are, for example, no entries between 23 September 2001 and the early hours of 25 September 2001, contacts with doctors are referred to in the midwifery notes with no corresponding medical note, lack of evidence of discussions with Ms C of the plan for managing premature

labour, no evidence of decisions not to undertake CTG monitoring or speculum examination on the 25 September 2001.

46. I note that the convener, considering Ms C's request for an independent review of her complaint, also commented on the lack of clarity in the case notes and drew this to the attention of the Chief Executive at the time. I have not seen any evidence from the Board of action taken to address this point.

47. In their response to my enquiries, the Board commented that the failure by medical staff to document findings is 'clearly disappointing' and that the fact the labour ward was busy that night 'is not an adequate excuse for this lack of documentation'. The Board advised me that there is no policy on the quantity or quality of medical record-keeping within the department.

48. The Board also provided me with consultant obstetrician's comments which were that he did discuss the serious potential complications of a premature delivery with Ms C.

49. NHS Quality Improvement Scotland has recently published (March 2005) *Clinical Standards for Maternity Services*. Standard 1C relates to Information, Communication and Support. In particular 1C.7 states:

> 'Information giving (verbal, written and other media) is monitored and evaluated.'

50. I also refer again to the GMC guidance, mentioned above, that doctors should:

> 'keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed'.

Medical records & record keeping: conclusions

51. There is evidence in the medical records of discussions between the consultant obstetrician and Ms C, but not of any update after the scan on 20 September 2001. The advisers found no evidence to suggest that medical actions and decisions were not appropriate. However, there is a clear lack of written evidence of the full extent of these or of the planning/decision making processes of medical staff prior to and including the 25 September 2001. The Board acknowledged the shortfall in medical record-keeping, as the clinical adviser previously pointed out to the independent review panel. I uphold the complaint that there was a failure to keep adequate medical records.

52. The Ombudsman recommends that the Board monitor and evaluate the quality of their maternity records, in line with *Clinical Standard for Maternity Services 1C.7*. The Ombudsman requests that the Board provide her with the plan for and results of such monitoring and evaluation.

(g) Postnatal discharge care

53. Ms C said that she considers the doctors should not have discharged her home when the ultrasound scan had shown her to have retained products of pregnancy.

54. The midwifery adviser commented that it could be difficult in the immediate postnatal period to identify retained products clearly on ultrasound scans. She believed it was a reasonable decision, in discussion with Ms C, to advise her that she could return to Stornoway with suitable antibiotics and to contact the hospital if she noticed an increase in blood loss. She considered that the advice given at this stage was consistent with current practice.

55. The medical records show evidence of discussions with Ms C and stress her understandable anxiety to return home as soon as possible. The records indicate that advice was given as to signs Ms C should look out for and which might have suggested problems were occurring.

56. The obstetric adviser commented that, while the decision to discharge to home with adequate explanations was a reasonable one, it would have been better practice to inform Ms C's general practitioner directly of her discharge and the retained products which might require local treatment. The medical records indicated the general practictioner was contacted by telephone on 25 September 2001but this was prior to the scan. There is no further indication of contact with the general practicitioner at the time of discharge.

Postnatal discharge care: conclusions

57. The information given to Ms C by hospital staff prior to her discharge was comprehensive, and the decision to allow her to discharge to home was a reasonable one in light of Ms C's strong desire to return home. It would, however, have been preferable to inform the medical authorities on Lewis of her imminent return and possible complications. The Ombudsman recommends that the Board review their guidelines for transfer into the community and post-transfer care and that they should consider how guidelines might best ensure that the relevant primary care staff are aware of any possible significant complications.

Maternity notes for women transferring during pregnancy and/or labour

58. The midwifery adviser commented that the standard of midwifery record keeping in this case was reasonable. She expressed concern that the movement of women between hospitals during pregnancy and labour is becoming more common and that, as in this case, there may be gaps in the records between units. While she does not consider there to have been any problem arising from the omissions in this case, she commented that the number of times Ms C was moved from unit to unit illustrates the clear need for a Scotland-wide Unified Maternity Record, which moves with the woman wherever her care is provided and extends to the postnatal period.

59. Such an initiative has recently been launched by the Scottish Executive Health Department and NHS Quality Improvement Scotland and is referred to as the Scottish Woman Held Maternity Record (SWHMR).

Maternity notes for women transferring during pregnancy/labour: conclusion

60. I believe that a number of the issues raised by Ms C in pursuing this complaint would have been addressed (or avoided) had the SWHMR been adopted by the health boards concerned at the time of the events of this complaint. The Ombudsman recommends the Board consider adopting the SWMHR. The Ombudsman also asks that the Board inform her of the action they have taken in this regard.

Additional observations

61. I acknowledge that, for Ms C, the fact that I have identified that there were some elements of suboptimal care would give her cause to question whether earlier recognition of her labour would have made a difference for Baby C. I have stated below the view of both the obstetric and midwifery advisers that there is no evidence to suggest earlier recognition or intervention would have made a significant difference for Baby C. I hope this information is of some reassurance to Ms C.

62. The midwifery adviser commented that, while she believed there was evidence of suboptimal care associated with being unable to provide one-to-one midwifery care for a period in the early hours of 25 September 2001, she did not believe that there was definitive evidence that this would have altered the outcome.

63. The obstetric adviser also indicated that survival of babies born at such an early stage is marginal. He did not find any evidence that earlier intervention or recognition of Ms C's labour would have changed matters.

Summary of recommendations

64. Following the investigation of all aspects of this complaint the Ombudsman recommends that the Board:

i. review their current practice regarding communication with and documentation of discussions with patients by medical staff and produce internal guidance to meet the GMC standard;

ii. undertake to monitor and evaluate the quality of their maternity records, in line with the *Clinical Standard for Maternity Services 1C.7* and provide her with the plan for and results of such monitoring and evaluation;

iii. review their guidelines for transfer into the community and post-transfer care and consider how guidelines might best ensure that the relevant primary care staff are aware of any possible significant complications following discharge of the patient;

iv. consider adopting the Scottish Women Held Maternity Record and inform her of the outcome of the action it is taking in this regard.

Summary of further information requested

65. In addition, the Ombudsman requests that the Board:

i. inform her of their plan to achieve the staffing levels identified by the *Birth Rate Plus* report and that the Board keep her appraised of their progress towards achieving this level of staffing;

ii. provide her with details of the action they have taken to fulfil the action statement of the *Framework for Maternity Services in Scotland* with regard to neonatal resuscitation training and to consider using the SMMDP to achieve this goal. The Ombudsman would ask that the Board again advise her of the outcome of this consideration.

Further action

66. As noted in paragraph 5, the Board have been given an opportunity to comment on the draft of this report. They have said that they accept the recommendations. The Ombudsman has asked the Board to notify her when and how the recommendations are implemented.

20 December 2005

Appendix 1

Explanation of abbreviations used

Ms C	The complainant
Baby C	Ms C's baby daughter who died
GMC	General Medical Council
PRI	The Perth Royal Infirmary
QMH	Queen Mother's Hospital, Glasgow
SGH	Southern General Hospital, Glasgow
SMMDP	Scottish Multi-professional Maternity Development Programme
SWHMR	Scottish Women Held Maternity Record

Appendix 2

Glossary of medical terms

CTG/ Cardiotocography	Monitoring of a baby's heart rate frequency before birth by electronic means.
Hypoxia	A shortage of oxygen in the body.
Intubate	To place a tube in the windpipe to assist with breathing.
Perinatal	The time immediately following birth.
Placenta praevia	Placenta wholly or partially covering the cervix.