Scottish Parliament Region: Mid Scotland and Fife

Case 200502750: Forth Valley NHS Board

Summary of Investigation

Category

Health: Hospital; Midwifery and Complaint handling

Overview

The complainants raised a number of concerns relating to the cremation of their baby (Baby C) and the subsequent handling and investigation of their complaint by Forth Valley NHS Board (the Board).

Specific complaints and conclusions

The complaints which have been investigated are that the Board:

(a) denied the complainants the opportunity to attend Baby C's cremation (*upheld*);

(b) failed to provide adequate evidence that Baby C was cremated entire (*upheld*);

(c) failed to carry out a thorough investigation of the complaint (*upheld*); and

(d) treated the complainants with disregard for their emotional state (*partially upheld*).

Redress and recommendations

The Ombudsman notes that the Board and Mr and Mrs C have entered into discussion regarding appropriate alternative redress and I am satisfied with this approach. Given the sensitivity and nature of this case, I have decided that the final redress arrangements should remain private to both parties.

Main Investigation Report

Introduction

1. The complainants (Mr and Mrs C) brought their complaint to the Ombudsman on 10 January 2006. The complaint had exhausted the complaints procedure of Forth Valley NHS Board (the Board) and was, therefore, eligible to be investigated by the Ombudsman. Mr and Mrs C's complaint focused on the cremation of their baby (Baby C) without their consent, the Board's failure to provide adequate evidence that Baby C's brain was returned to the body prior to cremation and also the manner in which their complaints were handled by the Board. Mr and Mrs C also claimed they had suffered significant mental and emotional stress as a result of the Board's failing and also from the pursuit of their complaint. A reminder of the abbreviations used here, and other abbreviations, is provided at Annex 1.

2. The complaints from Mr and Mrs C which I have investigated are that the Board:

(a) denied the complainants the opportunity to attend Baby C's cremation;
(b) failed to provide adequate, evidence that Baby C was cremated entire;
(c) failed to carry out a thorough investigation of the complaint; and
(d) treated the complainants with disregard for their emotional state.

Investigation

3. In conducting my investigation, I obtained and reviewed copies of the complaint correspondence between Mr and Mrs C and the Board as well as a copy of Mrs C's medical notes relating to the complaint. I also visited Mr and Mrs C at their home in order to further my own understanding of the complaint. I also identified and reviewed the complaints procedure of the Board.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mr and Mrs C and the Board were given an opportunity to comment on a draft of this report.

(a) The Board denied the complainants the opportunity to attend Baby C's cremation

5. On 28 October 2004 Mrs C underwent a scan of her unborn baby as a result of an earlier test in her pregnancy identifying grossly elevated levels of alphafetoprotein (an antigen level in amniotic fluid which can be used to detect certain fetal abnormalities, including Down's Syndrome and spina bifida). The

scan identified a number of serious abnormalities including significant hydrocephalus (enlargement of the skull) and kyphoscoliosis (backward and lateral curvature of the spinal column). The prognosis for the pregnancy, given by the doctor (Clinician 1) after the scan, was extremely poor. After discussion regarding the pregnancy, Mr and Mrs C, as well as Clinician 1, agreed to what the notes term a therapeutic abortion.

6. On 31 October 2004, Mrs C delivered Baby C as a result of the therapeutic abortion carried out at Stirling Royal Infirmary (the Hospital). Mr C gave written authorisation for a post mortem to be carried out. The reasons for and potential benefits of conducting a post mortem appear to have been communicated to Mr and Mrs C by Clinician 1. In giving this authorisation, Mr C clearly noted that no organs were to be retained and all organs were to be returned to the body prior to cremation. Furthermore, records show Mr and Mrs C also made clear to midwifery staff that they wished to attend the cremation of Baby C.

7. In the week following the delivery of Baby C, midwifery staff had contact with Mr and Mrs C on a number of occasions. The Board's internal investigation of the complaint highlighted that no further confirmation was received during this contact period from Mr and Mrs C regarding their wish to attend the cremation. However, the fact is that Mr and Mrs C had already stated their desire to be present at the cremation and the Board were in possession of this information.

8. On 3 November 2004, Baby C was transferred to Yorkhill[1] Hospital for the post mortem to be carried out. The initial post mortem was completed on 4 November 2004 and this was communicated to midwifery staff at the Hospital by staff at Yorkhill Hospital on the same day. The Yorkhill staff confirmed that, given the deformities of Baby C's brain, a specialist would be required to conduct a neuropathology report and that this could potentially take six to eight weeks to complete. In fact, the neuropathology investigation was carried out relatively quickly on 11 November 2004 at the Southern General Hospital[1] in Glasgow.

9. Baby C was taken from Yorkhill Hospital on 12 November 2004 by undertakers and the cremation of Baby C took place on 17 November 2004. Mr and Mrs C were not present at the cremation. Mr and Mrs C did not receive any confirmation of these arrangements from either midwifery staff or staff at

[1] Please note that neither Yorkhill nor the Southern General Hospital are subject of this investigation.

the undertakers. Mr and Mrs C found out after a consultation regarding the post mortem findings on 7 February 2005, that Baby C had been cremated some two and a half months earlier.

(a) Conclusion

10. In effect, the manner in which Baby C was cremated, that is, without Mr and Mrs C present, was against the wishes of Mr and Mrs C although the Board had been advised previously by Mr and Mrs C that they wished to be present at the cremation. The reason given by the Board, and the undertakers, during the initial handling of the complaint, for the fact that Mr and Mrs C were not advised of these arrangements was that it had been noted that Mr and Mrs C did not wish to have further contact from the midwifery team regarding the cremation. Essentially, it appears that staff interpreted that to mean all aspects of the cremation, including date and time. I believe such an interpretation to be far too wide given the circumstances of the case. I can find no evidence, which satisfies me, as to when the decision to have no further contact regarding the cremation was either taken or communicated to all parties concerned. On the balance of probabilities, I find that this claim is most likely a result of an inaccurate record or an overly literal interpretation.

11. Prior to my involvement in this case, the Board had accepted that Mr and Mrs C were denied the opportunity to attend Baby C's cremation as a result of a communication breakdown between midwifery staff, the undertakers and also perhaps staff at Yorkhill Hospital. It is my conclusion that the midwifery staff at the Hospital had an integral role in the communication process, which they failed to fulfil. This is evident by a number of factors including the statement relating to the failure to clarify or confirm the wishes of Mr and Mrs C regarding further contact about the cremation service, the failure to impress on the undertakers that the parents wished to be present at the cremation service and ultimately the failure to ensure that Mr and Mrs C's stated wish to be present at the cremation was realised.

12. It was this failing which ultimately created a situation for the additional three heads of complaint to arise. It is my considered view that, had the Board made every effort to deal effectively and efficiently with this very serious and tragic mistake, I do not believe Mr and Mrs C's complaint would have escalated to this office and more importantly, the suffering experienced by Mr and Mrs C would have been minimised. I feel that it is important to note that throughout the complaint, the midwifery staff have expressed what I believe to be a

genuine regret for the distress caused by the communication breakdown. I also feel it is important to note that I do not believe that any one individual staff member of the midwifery unit was to blame for the breakdown in communication. The evidence suggests that a number of staff members may not have had adequate knowledge relating to the processes for dealing with the cremation arrangements in this situation. There is evidence which shows confusion on the part of staff in relation to the arrangements for parents to be present at cremation/burial services, for example, a number of handwritten questions made by midwifery staff on the notes querying what may have been possible for the cremation service. I believe that the midwifery staff were effectively ill equipped to identify and deal with the issues raised in relation to the cremation of Baby C due to a lack of adequate training and easily accessible information. The responsibility for this ultimately lies with the Board. I am pleased to note, however, that during the internal investigation of this case, the Board identified this issue and have taken what I consider to be adequate steps, including enhanced training, to address this issue.

13. Mr and Mrs C, as a result of this service failure, suffered significantly from the fact that their wishes were not adhered to in respect of attending Baby C's cremation. It is extremely difficult to quantify the level of suffering this would cause, given the extremely sensitive nature of this experience and in considering the emotional well-being of Mr and Mrs C.

14. It is the normal practice of this office not to uphold a complaint where the authority being complained about have already investigated the complaint, given a detailed explanation of the outcome of that investigation, ensured that action is taken to prevent similar failings and also provided adequate redress to the complainants.

15. It is my view that the Board have adequately investigated this complaint and have also taken action to ensure that, as far as possible, it does not happen again. However, I do not feel that, prior to my investigation beginning, adequate redress or a full explanation, including adequate evidence, had been provided to the complainants. Consequently, I uphold this aspect of complaint.

(b) The Board failed to provide adequate evidence that Baby C was cremated entire

16. Upon discovering that Baby C had been cremated without Mr and Mrs C in attendance, the Board initiated an investigation to ascertain what the cause of

the error had been. The outcome of this investigation was communicated to Mr and Mrs C in a letter on 8 April 2005. The response raised a number of unanswered questions for Mr and Mrs C, in particular, whether or not Baby C had been cremated entire or whether or not the brain had been retained after the neuropathology report was complete. One of the reasons for this being raised as a question by Mr and Mrs C was the timeline of events relating to the post mortem and cremation of Baby C that had been communicated to them by staff.

17. In particular, on 16 December 2004, Mr and Mrs C were advised by the doctor who gave them the post mortem results (Clinician 2) that the neuropathology report process could potentially take six to eight weeks to complete and that they should remain patient. Furthermore, they were advised that an update regarding the outcome of the post mortem, and confirmation regarding the cremation arrangements would be forthcoming. Again this underlines the breakdown in communication between the relevant departments, and the Board's ability to keep Mr and Mrs C informed, as the fact is that Baby C had been cremated almost a full month earlier.

18. Mr and Mrs C questioned whether or not Baby C's brain could have been returned to the body prior to the cremation on 17 November 2004 given that the likely timescale for the completion of the neuropathology report had been communicated to them in early November as six to eight weeks.

19. The Board maintain that during a meeting on 23 September 2005 between staff and Mr and Mrs C, Mr and Mrs C were told that an internal letter from the doctor who carried out the neuropathology report (Clinician 3) to another Clinician outlined the events surrounding the processing of Baby C's brain and body prior to cremation. In the Board's view, this letter, dated 10 February 2005, effectively demonstrated that Baby C's brain had been returned to the body prior to cremation. I am also of the view that the letter provides adequate proof that Baby C's brain was returned. The letter outlines in sufficient detail what examinations were carried out on the brain and also outlines the key events from when the neuropathology investigation began to when the brain was returned to the body. Furthermore, the Board have claimed that a file note taken at the meeting, which was sent to Mr and Mrs C, confirmed this position. The file note read as follows;

> 'Staff were able to confirm from the letter received from [Clinician 3] and the undertakers that the baby had been cremated and the brain had been

returned to the body. Copies of these documents to be provided.'

20. The evidence does not demonstrate sufficiently, however, that the letter from Clinician 3 dated 10 February 2005, was ever provided to Mr and Mrs C prior to my investigation. This view is further reinforced by the fact that on 17 November 2005, Mr C emailed the Board after the meeting had taken place and highlighted that he was still not in possession of documented proof that Baby C's brain had been returned. Furthermore, the evidence shows, from copies of internal emails I have obtained from the Board, that there was confusion as to whether or not the letter from Clinician 3 was ever sent to Mr and Mrs C.

(b) Conclusion

21. In conclusion, I am satisfied that Baby C was cremated entire, however, I do understand Mr and Mrs C's worries in relation to the potential for organ retention given the information that was available to them at the time.

22. I accept that the Board communicated to Mr and Mrs C that the cremation had taken place with the brain returned to the body, however, I have seen no evidence which satisfies me that the letter from Clinician 3 was ever provided to Mr and Mrs C before my involvement with the complaint. Prompt supply of this letter would, I suggest, have provided the reassurance that Mr and Mrs C were seeking. Mr and Mrs C only received a copy of the letter from me during the conduct of my investigation and the Board's failure to provide such a crucial piece of evidence is, in my view, unacceptable. As a result, I uphold this aspect of complaint.

(c) The Board failed to carry out a thorough investigation of the complaint

23. Mr and Mrs C complained that the internal investigation of their complaints, conducted by the Board, was not sufficiently robust. I have seen documented evidence which outlines the steps taken by the Board in investigating Mr and Mrs C's complaint, which included obtaining statements from relevant staff members, reviewing all relevant communication and medical notes as well as meeting with Mr and Mrs C. I believe the investigation of Mr and Mrs C's complaint was adequate and the Board did take Mr and Mrs C's complaints very seriously. I am also satisfied that the Board conducted a root cause analysis in relation to the circumstances involved in the complaints and I believe the Board should be credited for this work. I also accept that the Board

carried out a thorough investigation and were able to obtain all the evidence which, had it been presented adequately and promptly to Mr and Mrs C, would have deflected further complaint and brought reassurance for Mr and Mrs C.

(c) Conclusion

24. While I accept that the initial stages of the investigation were carried out to a high and detailed standard, I believe that the subsequent failure to communicate the result of that thorough investigation to Mr and Mrs C was a failing on the Board's part and led Mr and Mrs C to conclude the investigation was not thorough. This, in effect, represented an incomplete investigation. I believe the investigative work of gathering and assessing the relevant information was carried out to a high standard, and for this the Board should be commended. However, I have concluded that the Board failed to provide a prompt answer to Mr and Mrs C's question regarding the cremation of Baby C. This failure to provide evidence supporting a vital conclusion of the Board's investigation effectively undermined the entire investigation process for Mr and Mrs C. The complainants remained uncertain of a central aspect of their complaint upon the completion of the investigation, and still did not receive the evidence that they requested until the complaint had been pursued through the Ombudsman's office. The failure to adequately conclude the investigation leads me to uphold this aspect of complaint.

(d) The Board treated the complainants with disregard for their emotional state

25. Mr and Mrs C have claimed that the Board, in handling the complaint and also allowing the cremation of Baby C to proceed without them, treated them with disregard for their emotional state. In coming to a conclusion on this aspect of complaint, I have very carefully considered the evidence which documented the manner in which the Board managed and dealt with Mr and Mrs C.

26. The Board have denied that they treated Mr and Mrs C with disregard for their emotional state, whereas the complainants have cited a number of incidents of what they view as evidence of the Board's disregard for their emotional state.

27. Mr and Mrs C claim that the manner in which staff communicated with them, for example, leaving voicemail messages and the wording contained within certain letters to them, demonstrated that staff had treated them with

disregard for their emotional state. Although there are certain aspects of the points put forward by Mr and Mrs C, which I agree with, there are certain aspects that I do not, due to the evidence supplied by the Board. I do not believe that detailing such aspects of the complaint will further the understanding of the complaint, and the situation can be best surmised by concluding there are strong opposing views held by the Board and Mr and Mrs C with regards to this point of complaint.

28. I believe, based on the evidence supplied by the Board, that staff members had a genuine concern for Mr and Mrs C's welfare while they were in contact with them, however, I can also appreciate that certain aspects of the management of the complaint and communication with Mr and Mrs C would lead Mr and Mrs C to feel aggrieved in respect of their treatment by the Board.

29. I note that great care was taken by the Board to select an appropriate staff member to meet with Mr and Mrs C regarding the complaint. I am satisfied that the Board did tend to have consideration for Mr and Mrs C's welfare. However, there are examples of poor treatment by the Board. I believe that the Board's failure to appoint an individual point of contact for Mr and Mrs C when pursuing their complaint demonstrates a poor service. Given the number of staff members that were involved in the complaint, including staff from other NHS Boards, I believe that nominating an individual point of contact to manage the flow of information between the Board and Mr and Mrs C would have been a more appropriate course of action and would have allowed a better relationship to develop between the Board and Mr and Mrs C.

30. I note that there are a number of examples which the Board have provided as evidence of their consideration for Mr and Mrs C's welfare, however, the same examples were cited by Mr and Mrs C as examples of the Board's failure to take into account their welfare. For example, the evidence shows that staff put forward various suggestions for communicating with, and managing, Mr and Mrs C. A staff member made a suggestion that although Baby C had already been cremated, the Board should arrange for a memorial service for Mr and Mrs C to attend. I believe that such an act would have contributed significantly to resolving this complaint, however, the suggestion was never followed up by the Board. Essentially, this demonstrates that the Board were actively considering what action to take in terms of dealing with Mr and Mrs C, however, the fact that such a sound suggestion was not followed up or at least discussed with Mr and Mrs C, does show a lack of consideration of Mr and Mrs C's

emotional state in my view. I believe that this example highlights why a single point of contact, working closely with Mr and Mrs C and developing a good relationship with them, may have been a more sound approach for the Board to take in this case.

(d) Conclusion

31. I have considered the evidence very carefully relating to this point of complaint as both sides give directly contradictory arguments. I am aware that a large proportion of this aspect of complaint rests on individual interpretation of events. I am of the view that there is evidence both for and against the argument that the Board failed to treat Mr and Mrs C with due consideration given to their emotional well-being and given the extremely sensitive nature of the case. The Board have accepted that the treatment of Mr and Mrs C was not perfect, but did not constitute a disregard for their emotional welfare. I believe, however, that given the nature of this complaint and the fact that the Board's failings in cremating Baby C led to the initial complaint, the Board should have managed the complaint more effectively.

32. I believe that the failures were unintentional on the part of staff, but a result of the extremely difficult and sensitive nature of this very rare type of case. I believe that aspects of the case outlined previously in this report demonstrate why it would be understandable for Mr and Mrs C to feel that their emotional welfare had been disregarded. I conclude that the emotional welfare of Mr and Mrs C had been unintentionally disregarded to a significant extent, however, I do not accept that there was total disregard for their emotional welfare. For this reason, I partially uphold this aspect of complaint.

33. Considering all heads of complaint and the circumstances surrounding the entire complaint, I believe I must highlight my general views on this case. I must draw attention to the fact that the Board have, in my view, taken effective and efficient measures in their work to identify what went wrong and have taken steps to ensure, to the best of their ability, that this kind of situation does not arise again. The Board's management and response to the process issues involved in this case have been, in my view, excellent. However, the management of, and communication with, Mr and Mrs C during the complaint was on the whole unacceptable. The nature of this complaint, given that Baby C had been cremated without their knowledge, demanded the highest level of service be provided to Mr and Mrs C. This was not achieved and for that I have been critical of the Board.

General Recommendations

34. I believe that the Board's apology which they submitted with their evidence is adequate redress for point (d) of the complaint. I have considered whether or not the Board should contact Mr and Mrs C directly with an apology, however, Mr and Mrs C have expressed to me that they do not feel they could interpret any further apologies as sincere given their experiences regarding this case.

35. The Board and Mr and Mrs C have entered into discussion regarding appropriate alternative redress and I am satisfied with this approach. Given the sensitivity and nature of this case, I have decided that the final redress arrangements should remain private to both parties.

22 August 2007

Annex 1

Explanation of abbreviations used

Mr and Mrs C	The complainants
Baby C	Mr and Mrs C's baby
The Board	Forth Valley NHS Board
The Hospital	Stirling Royal Infirmary
Clinician 1	The Clinician who conducted the therapeutic abortion
Clinician 2	The Clinician who communicated the outcome of the post mortem findings and dealt with Mr and Mrs C at various points throughout the complaint
Clinician 3	The Clinician responsible for carrying out the neuropathology report

Annex 2

Glossary of terms

Alphafetoprotein	An antigen produced in the fetal liver that can appear in certain diseases of adults, such as liver cancer, and whose level in amniotic fluid can be used to detect certain fetal abnormalities, including Downs Syndrome and spina bifida
Hydrocephalus	A usually congenital condition in which an abnormal accumulation of fluid in the cerebral ventricles causes enlargement of the skull and compression of the brain, destroying much of the neural tissue
Kyphoscoliosis	A condition in which the spinal disorders of kyphosis and scoliosis occur together