Scottish Parliament Region: Lothian

Case 200801828: Lothian NHS Board

Summary of Investigation

Category
Health: Hospital; maternity; out-patient and in-patient clinical treatment

Overview
The complainant (Mr C) complained that his wife (Ms A) had not received appropriate care and treatment when they both attended the Obstetric Triage Department, Simpson's Centre for Reproductive Health (the Centre), prior to the birth of their baby daughter (Baby A), and that Baby A suffered severe medical complications as a result.

Specific complaints and conclusions
The complaints which have been investigated are that:

(a) the Centre failed to detect problems with Ms A's pregnancy and failed to carry out appropriate tests when she attended the Centre on 15 and 16 June 2008 (*upheld*);

(b) the Centre failed to take Mr C and Ms A's concerns and questions into account on 15 and 16 June 2008 (*upheld*);

(c) the Centre failed to give Mr C and Ms A correct advice on 15 and 16 June 2008 or to ensure that adequate follow-up support was in place and offered to Mr C and Ms A on 16 June 2008 *(upheld);* and

(d) on 23 June 2008 there was a time lapse of more than 30 minutes (the recommended practice) from the decision to perform an emergency lower uterine caesarean section to the start of this procedure *(upheld).*

Redress and recommendations
The Ombudsman recommends that Lothian NHS Board (the Board):

(i) inform him of the measures being undertaken to address the issues raised within paragraphs 26, 27 and 28;

(ii) inform him of the measures being undertaken to address the inadequate level of staff interface and communication with Mr C and Ms A at the Centre;

(iii) inform him of the measures they take to ensure that the practice (when presented with a patient with reduced foetal movement) is adhered to, with reference to NICE Antenatal Guidelines 2008;

(iv) inform him of the measures undertaken to ensure that the delay which occurred in this case, from decision to 'knife to skin', does not recur in a similar situation; and

(v) issue Mr C and Ms A with a formal written apology for the inadequate standard of care and treatment Mr C and Ms A received on 15, 16 and 23 June 2008, prior to the birth of Baby A, as identified in heads of complaint (a), (b), (c) and (d).

The Board have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. The Ombudsman received a complaint from the complainant (Mr C) on behalf of his wife (Ms A). Mr C stated that Ms A received inadequate care and treatment before the birth of their baby daughter (Baby A), who was delivered at Simpson's Centre for Reproductive Health (the Centre) by an emergency lower uterine caesarean section on 23 June 2008.

2. On 13 June 2008, when Ms A was around 29 weeks pregnant, she had a show (the mucus plug was passed), however, at that time, Mr C and Ms A had not known what it was or its significance. Mr C stated that, on the afternoon of 15 June 2008, he and Ms A were very concerned as Ms A was bleeding heavily. At the same time, they both considered the foetal movements were greatly reduced and the foetus was not moving as it had been. As a consequence of their heightened concern, Mr C and Ms A attended the Centre on 15 June 2008. According to Mr C, when he and Ms A arrived at the Centre with the mucus plug, they were given the opportunity to witness and admitted to possible foetal movements via the tests that the midwife (Midwife 1) administered, however, they told Midwife 1 they both remained very concerned about the pregnancy as, in their view, the foetal movements were greatly reduced and Ms A felt the foetus was pressing low. Notwithstanding this, Mr C and Ms A were sent home.

3. Mr C and Ms A's concern regarding reduced foetal movements continued through to 16 June 2008, when they again attended the Centre. Ms A stated on that day she still felt the foetus was pressing low and again mentioned this to midwifery staff. However, according to Mr C, he and Ms A were led to believe by the midwifery staff on duty on 16 June 2008 that Ms A's pregnancy was on the right course. Mr C stated that he and Ms A were sent home from the Centre on 16 June 2008 with no follow-up appointment given to them. Mr C and Ms A stated that the only instruction they were given was to return to the Centre if more bleeding occurred. Mr C and Ms A considered they had asked the midwifery staff at the Centre all the right questions and, in good faith, had returned home in the belief that everything with the pregnancy was normal.

4. Throughout the following week, Mr C said that he and Ms A remained anxious as the foetus was still not displaying any great movement, however, they were reassured by their belief that all the checks at the Centre had been

made. On 23 June 2008 Mr C decided to phone their community midwife for advice as there was still very little foetal movement. The community midwife advised Mr C and Ms A to go immediately to the Centre, which they did. After Ms A was examined and had undergone further tests, Baby A was delivered by an emergency lower uterine caesarean section on 23 June 2008.

5. Mr C stated that he and Ms A considered that they both suffered from a series of mistakes made by the Centre; crucially, that the Centre failed to identify on 15 and 16 June 2008 that Ms A's pregnancy was not on the right course. As a consequence, Mr C and Ms A believed that Baby A suffered unnecessary stress in the womb (which went undetected at the Centre) for the duration of a week before her birth on 23 June 2008, and that this resulted in abnormalities developing in Baby A's brain. These abnormalities were revealed through postnatal examinations of Baby A.

6. The complaints from Mr C which I have investigated are that:

(a) the Centre failed to detect problems with Ms A's pregnancy and failed to carry out appropriate tests when she attended the Centre on 15 and 16 June 2008;

(b) the Centre failed to take Mr C and Ms A's concerns and questions into account on 15 and 16 June 2008;

(c) the Centre failed to give Mr C and Ms A correct advice on 15 and 16 June 2008 or to ensure that adequate follow-up support was in place and offered to Mr C and Ms A on 16 June 2008; and

(d) on 23 June 2008 there was a time lapse of more than 30 minutes (the recommended practice) from the decision to perform an emergency lower uterine caesarean section to the start of this procedure.

Investigation

7. The investigation of this complaint involved obtaining and reading all the relevant documentation, including correspondence between Mr C and Lothian NHS Board (the Board). I have had sight of Ms A and Baby A's medical records. As part of my enquiries I wrote to the Board and received a reply from the Nurse Director. Advice was also obtained from the Ombudsman's midwifery adviser, who is a specialist in midwifery and women's health (the Adviser). I met with Mr C and Ms A to discuss their complaint. The Adviser was present at this meeting.

8. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in this report is contained in Annex 1. A glossary of terms can be found at Annex 2. Mr C and the Board were given an opportunity to comment on a draft of this report.

(a) The Centre failed to detect problems with Ms A's pregnancy and failed to carry out appropriate tests when she attended the Centre on 15 and 16 June 2008

9. During the afternoon of 15 June 2008, Mr C said that he and Ms A rushed to the Emergency Unit at the Centre, as Ms C had experienced heavy bleeding and the foetus was not moving as it had done previously. According to Mr C, both he and Ms A were distressed when they arrived at the Centre and explained this situation to the receptionist. Thereafter, Midwife 1 attended to Ms A.

10. According to Mr C, Midwife 1 initially stated that because of the bleeding Ms A would be interned for closer monitoring. Thereafter, Midwife 1 placed a heart monitor on the foetus and left the room. According to Mr C, he and Ms A heard the foetal heart beat slowing down to a near stop then it regained pace. However, when Mr C called Midwife 1 to return to the room, she dismissed what Mr C had described and stated that what Mr C and Ms A were anxious about was the heart monitor picking up Ms A's heart beat. Midwife 1 again left the room and Mr C stated that the foetal heart beat slowed as before. Mr C stated that on her return, Midwife 1 again dismissed his and Ms A's anxiety and explained that everything was normal, including the loss of the mucus plug on 13 June 2008 (see paragraph 2). According to Mr C, Midwife 1 also dismissed Ms A's additional concern when she told her that she felt the foetus was low and pressing down.

11. Mr C said that, following Midwife 1's monitoring of the foetus, she stated it would not be necessary for Ms A to be interned overnight as her bleeding had reduced. Furthermore, an ultrasound scan (the Scan) could only be done on the Monday (16 June 2008) and they should go home and return on 16 June 2008 for Ms A to undergo the Scan.

12. On 16 June 2008, Mr C and Ms A attended the Centre once more and were received for the Scan. According to Mr C, they felt the Scan was rushed through and, thereafter, Ms A waited over three hours for a doctor and midwife

(Midwife 2) to attend Ms A and for the doctor to perform an internal examination. Mr C stated that Ms A told the doctor of her concern about the lack of foetal movement and that she felt the foetus was low and pressing down. After the doctor had completed the internal examination, he stated that he could find no cause for the bleeding and left the room, as did Midwife 2. Midwife 2 returned and stated that everything was normal, that sometimes bleeding happened without consequences, and that Mr C and Ms A should go home and only return if more bleeding occurred (see paragraph 3).

13. Mr C stated that, when he returned to the Centre on 23 June 2008, he and Ms A saw how a Doppler (a baby heart monitor, using sound waves) can help to understand the performance of umbilical blood flow to the placenta in assessing foetal well being. In this regard, Mr C and Ms A asked why a Doppler was not performed on 16 June 2008 and why all their previous comments about the foetal lack of movements were not acted upon (see paragraphs 9, 10, 11 and 12).

14. From the Adviser's review of the clinical records for 15 June 2008, she stated that the assessment and monitoring of Ms A's condition and of the wellbeing of the foetus, was appropriate for a triage unit. From the entries of the clinical investigative procedures which were undertaken, and the follow-up plan for 16 June 2008, the Adviser also considered that these were appropriate for the circumstances in which Mr C and Ms A presented on 15 June 2008.

15. The Adviser stated that the loss of the mucus plug at 29+ weeks could have contributed to the vaginal bleed (see paragraphs 2, 10 and 11). In this regard the Adviser considered that, as the subject of intercourse had been raised with Ms A and Mr C at the Centre on 15 June 2008, it was possible that the episode of bleeding was treated as a post-coital bleed and the more significant issue of the reduced foetal movement was not given closer attention. She went on to state that the loss of the mucus plug was significant and indicative of pending labour. She noted that, although the internal examination on 16 June 2008 confirmed that the neck of the womb was closed, it should have prompted a closer follow-up, by way of a formal appointment. Instead, Ms A had been told to only return to the Centre if further bleeding occurred.

16. The Adviser noted that the Scan (see paragraph 12) confirmed that the placenta (afterbirth) was not low lying, and so not directly implicated in the bleed. In addition, the Adviser stated that the records showed that the foetal

heart rate was noted as being reassuringly reactive and that regular movements were felt on 16 June 2008.

17. According to the Adviser, the internal examination performed on 16 June 2008 (see paragraph 12) confirmed that the neck of the womb was closed (not in early labour) and any blood observed was old, not fresh or recent. The foetal heart rate was noted as 140 beats per minute (BPM) and Ms A's pulse at 90 BPM. The Adviser noted that an electronic foetal monitoring of the foetal heart rate was performed and recorded in the notes as reassuring.

18. The Adviser considered the CTG tracing dated 15 June 2008 (the Trace) and she stated that the half hour Trace was satisfactory. She noted that the foetal heart rate had a baseline of 150 BPM, which is high but not uncommon at 29+ weeks' gestation. The Adviser also noted the brief deceleration at 20:35 to 85 BMP, however, she observed that there was a good recovery to the baseline. The Adviser stated that the maternal tocograph was unreactive and there was no record of maternal movement to account for this dip. In this regard the Adviser stated that, in light of this declaration and Ms A's history on admission, she would have expected the Trace to have run longer than the minimum half hour. Thereafter, the Adviser stated the findings should have been discussed with a senior member of the obstetric team.

19. The Adviser considered that staff appeared focussed with excluding causes of vaginal bleeding in the initial care episodes of 15 and 16 June 2008 (see paragraph 14), nevertheless, she stated that, in the main, the care and investigative procedures were appropriate and reasonable.

20. In the Board's reply to my enquiries, they stated that, when Ms A attended the Centre at 20:20 on 15 June 2008, the case should have been discussed with a more senior obstetrician to consider Ms A's admission to hospital. The Board considered that at that time Ms A was 29+ weeks pregnant, having had a significant amount of vaginal bleeding with reduced foetal movements for six hours (see paragraphs 2, 9 and 10). In this regard, the Board noted that the bleeding had settled; the electronic recording of the foetal heart rate was satisfactory; and foetal movements had been felt by the time Ms A had been seen by the doctor. Nevertheless, they stated that the importance of these symptoms should have been discussed with a senior member of the obstetric team. Furthermore, Ms A also experienced abdominal cramps which settled in

triage, however, the Board stated this symptom should also have been taken into account, as it may have suggested premature labour.

21. According to the Board, the loss of the mucus plug did not necessarily indicate labour was imminent, however, it was unusual at 30 weeks, particularly if no internal examination had been undertaken. Ms A's notes suggested that the mucus plug was lost on the previous Friday – 13 June 2008. The Board stated that this was probably of less significance compared to the other symptoms experienced by Ms A on 15 June 2008 (see paragraphs 9 and 10).

22. The Board noted that Ms A returned to the Centre on 16 June 2008 and had the Scan, which was satisfactory and which revealed the placenta's position at the top of the uterus. At this time, there had been no further bleeding and the Board stated that the clinical notes indicated that Ms A was feeling regular foetal movements. On that day it was recorded that the foetal heart was listened to, however, given the symptoms from the previous day, the Board stated that an electronic foetal heart rate recording should have been performed 'to confirm that there was no cause for concern'.

23. In the concluding summary of the events of 15 and 16 June 2008, the Board stated that, had Ms A been admitted on the evening of 15 June 2008, she would have received a scan on the following day and also a recording of the foetal heart rate. As Ms A had experienced no further bleeding, it would be anticipated that Ms A would have been discharged home, probably on the afternoon of 16 June 2008. According to the Board, it would not be normal practice to follow up a patient in the antenatal clinic who had experienced bleeding if all tests were satisfactory.

24. The Board stated there was no record in the notes of Ms A having mentioned the foetus being low (see paragraphs 10 and 12). Nevertheless, the Board said that although this should have been recorded, this was a common symptom in healthy pregnancies and would not, on its own, indicate any cause for concern.

25. The Board also stated that there was no indication for Doppler Flow Studies on 15 or 16 June 2008 as the foetal heart rate was satisfactory (see paragraph 13). In view of the appearance of the foetal heart rate on 23 June 2008, they stated that early delivery by caesarean section was required (see paragraph 52).

(a) Conclusion

26. Given all the evidence outlined above, and having carefully reviewed all the relevant documentation, I agree with the Adviser that on 15 June 2008 the recorded entries of the assessment/care and monitoring/investigative procedures of Ms A were appropriate and reasonable for a triage unit, as was the wellbeing of the foetus (see paragraph 14 and 16). Nevertheless, the advice I have received is that the significance of the reduced foetal movements reported by Mr C and Ms A was not given closer attention by the midwifery staff. Furthermore, the loss of the mucus plug was also significant and should have prompted a closer observation (see paragraph 15).

27. I have also received advice that, while the half hour Trace of 15 June 2008 complied with the minimum set by the standard and was adequate, given the admission history Mr C stated and Ms A presented to Midwife 1, the Trace should have run longer than this half hour minimum (see paragraph 18).

28. The Board stated that on 15 June 2008, due to Ms A's presented symptoms, the case should have been discussed with a more senior obstetrician to consider Ms A's admission to hospital and this did not happen (see paragraph 20). Thereafter, on 16 June 2008, given the symptoms Ms A presented on 15 June 2008, the Board stated that an electronic heart rate recording should have been performed and this did not happen (see paragraph 22).

29. Taking into account the collective significance of all the factors outlined in paragraphs 26, 27 and 28, I have decided to uphold this head of complaint.

(a) Recommendation

30. The Ombudsman recommends that the Board inform him of the measures being undertaken to address the issues raised within paragraphs 26, 27 and 28.

(b) The Centre failed to take Mr C and Ms A's concerns and questions into account on 15 and 16 June 2008

31. Mr C stated that when he and Ms A arrived at the Centre on 15 June 2008 they were both distressed (see paragraph 9). According to Mr C, the receptionist who received them was nonchalant, to the extent that both he and Ms A felt uncomfortable. Thereafter, Midwife 1 was in attendance.

32. According to Mr C, after Midwife 1 had placed the heart monitor on the foetus, she left the room. Very soon, Mr C and Ms A heard the foetal heart beat slow down to a near stop and then regain pace. Ms A stated this disturbed them a great deal and, as they felt something abnormal was happening, Mr C rushed to call Midwife 1 to return to the room. Mr C stated that Midwife 1 quickly dismissed what he and Ms A told her and she stated that, in her view, the monitor had picked up Ms A's heart beat. According to Mr C, Midwife 1 again left the room and from that point, the heart monitor started to become unreliable and intermittently showed an 'ERR' sign. Furthermore, Mr C and Ms A could still hear the foetal heart beat slowing. Midwife 1 again entered the room and told Mr C and Ms A the likely cause for the monitor failing to pick up a good signal was probably due to foetal movement. Mr C stated that Ms A told Midwife 1 that she could not feel her baby moving, however, Mr C stated that Midwife 1 touched Ms A's stomach and said that everything was normal.

33. On 16 June 2008 Mr C and Ms A returned to the Centre. Mr C stated that both he and Ms A felt the subsequent Scan had been rushed through. Mr C and Ms A waited in the waiting room. According to Mr C, he asked the receptionist three times what was happening, however, only at Mr C's third request, some three hours later, did the receptionist go to check with the doctor. Thereafter, the doctor and Midwife 2 attended to perform an internal examination (see paragraph 12). As the doctor entered the room, Mr C said that he asked him about the Trace taken on 15 June 2009. However, Mr C said that he felt as if he was disturbing someone else's conversation, so much so that he felt he had to pause and ask, 'is it ok doctor if I speak with you?'.

34. Following the internal examination, the doctor left the room. Midwife 2 also left the room, however, before she did so she told Mr C and Ms A that the doctor would return and give them his conclusions. However, the doctor did not return. Midwife 2 returned and, according to Mr C, she told him and Ms A that both she and the doctor felt that everything was normal and that they should return home (see paragraph 12).

35. According to the Adviser, maternal recognition of decreased foetal movements has long been used during antenatal care in an attempt to identify the possibility of a jeopardised foetus and intervene to prevent death. The literature suggests that, given the low prevalence of foetal compromise and the high percentage of certainty required, the possible predictive value of the maternal perception of reduced foetal movement for foetal compromise is low.

However, in this regard, and following National Institute For Clinical Excellence (NICE) Antenatal Guidelines 2008 (see Annex 3), women's concerns should be heeded and the Adviser stated that, in this instance, Ms A's care seemed less than optimal.

36. The Adviser noted that, from her examination of the records for 15 and 16 June 2008, she had seen that the Centre was operating at a high activity level, however, she considered this was no mitigation for distressed prospective parents being treated with dismissal and disregard. In the Adviser's view, she stated it was evident from her review of this issue that Mr C and Ms A's emotional and communication needs were not wholly met by staff at the Centre and that Mr C and Ms A's concerns were dismissed. She considered these were oversights by busy clinicians and contributed to the poor perception of care held by Mr C and Ms A. Furthermore, the Adviser stated that the dismissive attitudes and seeming disregard for Mr C and Ms A's concerns and feelings were inadequately acknowledged in the Board's response to their complaint, and also in the case record which the Adviser examined.

37. The Adviser considered it was fitting for health care professionals to be mindful of the wider emotional needs of prospective parents; to listen to them; to value and hear what they say; to act with professional courtesy; and to instigate appropriate care in good time.

38. In their reply to my enquiries, the Board stated that, while their initial complaint response of September 2008 had addressed Mr C's midwifery complaint regarding the lack of care and treatment provided by the Centre, on reflection, the Clinical Management Team had acknowledged that it did not address Mr C and Ms A's medical concerns in sufficient detail (see paragraph 36). The Board apologised for this shortcoming.

(b) Conclusion

39. Given the evidence outlined above, and having listened to Mr C and Ms A's personal account of their visits to the Centre on 15 and 16 June 2008, I consider that their feelings and questions were not appropriately responded to by the Centre. Given the set of circumstances which led to Mr C and Ms A's urgent attendance at the Centre on those days, I support the Adviser's view that Mr C and Ms A's needs were not met and their concerns were dismissed by the staff they came into contact with at the Centre on 15 and 16 June 2008.

40. In particular with reference to NICE Antenatal Guidelines 2008 (see paragraph 34), I have not seen evidence that Mr C and Ms A's concerns regarding reduced foetal movement, combined with Ms A's heavy bleeding, were heeded. In this regard, I consider that maternal concerns of reduced foetal movements may represent a warning sign that a foetus could be at risk, in other words, deserving of closer attention and, according to the advice I have received and the paperwork I have examined, Ms A did not receive this (see paragraphs 15 and 18). Taking all these factors into account, I uphold this complaint.

(b) Recommendation

41. The Ombudsman recommends that the Board inform him of the measures being undertaken to address the inadequate level of staff interface and communication with Mr C and Ms A at the Centre.

(c) The Centre failed to give Mr C and Ms A correct advice on 15 and 16 June 2008 or to ensure that adequate follow-up support was in place and offered to Mr C and Ms A on 16 June 2008

42. In Mr C's view, he and Ms A attended the Centre on 15 and 16 June 2008 and clearly presented Ms A's symptoms which had caused them great distress. However, according to Mr C, he and Ms A were not given correct advice or follow-up support from the staff on duty at the Centre on these days.

43. The Adviser considered that, based on the overall evidence she has seen, Mr C and Ms A were not correctly advised or supported on 15 and 16 June 2008 by the midwifery staff at the Centre. For example, she noted in the letter from the Director of Operations, Women's and Children's Services and Clinical Neurosciences dated 1 September 2008 to Mr C, she apologised for and stated that advice on normal (or reduced) patterns of foetal movements should have been given to Mr C and Ms A at the time they had discussed their concerns with staff. Furthermore, the Adviser considered Ms A should have received a follow-up appointment on 16 June 2008 (see paragraph 15). However, she noted that there was no midwifery record of a follow-up appointment having been made for Ms A following her attendance at the Centre on 16 June 2008.

44. In the Board's reply to my enquiries, they stated that it would be usual practice for staff in the Centre, who had seen a patient with reduced foetal movements, to give advice on recording movements and offer guidance on how

to seek advice if foetal movements became reduced. However, the Board had advised that it appeared from the notes that this had not been discussed with Ms A (see paragraph 43).

(c) Conclusion

45. I have considered the evidence outlined above and reviewed very carefully all the relevant documentation and the advice received. I consider that neither Mr C nor Ms A was correctly advised by the midwifery staff at the Centre on 15 and 16 June 2008, given the specific set of circumstances which led to Mr C and Ms A's urgent attendance at the Centre on these days. I have also considered that the Board outlined their usual practice when presented with a patient with reduced foetal movement. However, Mr C and Ms A did not receive this advice, neither were they offered a follow-up appointment during their attendance at the Centre on 16 June 2008. Taking all these factors into account, I uphold this complaint.

(c) Recommendation

46. The Ombudsman recommends that the Board inform him of the measures they take to ensure that the practice (when presented with a patient with reduced foetal movement) is adhered to, with reference to NICE Antenatal Guidelines 2008.

(d) On 23 June 2008 there was a time lapse of more than 30 minutes (the recommended practice) from the decision to perform an emergency lower uterine caesarean section to the start of this procedure

47. Mr C stated that when he and Ms A arrived at the Centre on 23 June 2008, Ms A was again put on the heart monitor, as had happened on 15 June 2008 and again left alone (see paragraph 10). According to Mr C, very soon he and Ms A again witnessed the two events - where the foetal heart beat slowed down and came to a near stop. When the midwife (Midwife 3) returned to the room, she dismissed what was recorded on the paper and said this was the machine picking up Ms A's heart beat. Mr C said that it was only when Midwife 3 stayed and checked the Trace that she acknowledged something was not right and recognised that the first part of the Trace was not normal.

48. The Adviser stated that the evidence she viewed from the ultrasound scan of 23 June 2008 suggested placental dysfunction and an increased risk of perinatal death. She noted that the maternal case record indicated that Ms A was received on the labour ward at 11:45 on 23 June 2008 and the decision to

perform an emergency lower uterine caesarean section was made in an entry at 12:00. According to the Adviser, it was not clear from the records if this entry was made by a consultant obstetrician or an experienced registrar. The Adviser noted that an entry at 12:40 indicated that the labour ward was very busy and a theatre and an anaesthetist were not yet available and free.

49. The Adviser stated that the continuous monitoring of the foetal heart throughout this episode showed reduced beat to beat variability and unprompted decelerations occurring, which is further evidence of foetal compromise. Entry to theatre was at 13:00. 'Knife to skin' was at 13:35. A total of 95 minutes elapsed from 'decision' to 'section' to 'knife to skin'. The Adviser stated that this time lapse fell short of the recommended practice of no more that 30 minutes from 'decision' to 'knife to skin'.

50. The Adviser noted from the discharge summary on Baby A's notes that Baby A sustained a widespread brain haemorrhage and had an increased risk of long term disability yet to be determined and stated 'One can only speculate that this occurred during the period from 16 to 23 June 2008'.

51. The Adviser noted that the Board had provided the audit results of emergency caesarean sections in various categories, from 'decision' to 'incision', in response to my enquiries, however, these related to a period from 8 August to 12 September 2005. The Adviser stated that a more recent audit report would be more reassuring and appropriate, given the issues of medical and midwifery workload capacity, demands and availability of both anaesthetic staff and operating theatres, at the time the Board acknowledged. According to the Adviser, this was occurring against a backdrop of a significant increase in the birth rate experienced by the Board.

52. In their response to my enquiries, the Board stated that on 23 June 2008, when Ms A presented at the Centre with reduced foetal movements, the recording of the foetal heart was a cause for concern (see paragraph 25). This should have led to an urgent review by senior medical staff and subsequently arrangements made for an immediate caesarean section.

53. However, according to the Board, following the review by the consultant, at 12:00 a decision for an emergency caesarean section was made and at that time the labour ward was extremely busy. It was, therefore, necessary to wait for a theatre to become available. Anaesthetic backup was also requested. In

this regard, the Board referred to the results of the audits of emergency caesarean section times from 'decision' to 'incision' (see paragraph 51).

(d) Conclusion

54. Given all the evidence outlined above, and having carefully reviewed all the relevant documentation, I share the Adviser's conclusion that the time lapse for carrying out the emergency caesarean section fell short of the recommended practice of no more that 30 minutes from 'decision' to 'knife to skin'. Taking all these factors into account, I uphold this complaint.

(d) Recommendation

55. The Ombudsman recommends that the Board inform him of the measures undertaken to ensure that the delay which occurred in this case, from decision to 'knife to skin', does not recur in a similar situation; and

General recommendation

56. The Ombudsman also recommends that the Board issue Mr C and Ms A with a formal written apology for the inadequate standards of care and treatment Mr C and Ms A received on 15, 16 and 23 June 2008, prior to the birth of Baby A, as identified in heads of complaint (a), (b), (c) and (d).

57. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mr C	The complainant, the husband of Ms A and the father of Baby A
Ms A	The aggrieved, Mr C's wife, the mother of Baby A
Baby A	The baby daughter of Mr C and Ms A
The Centre	Obstetric Triage Department, Simpson's Centre for Reproductive Health
The Board	Lothian NHS Board
The Adviser	The Ombudsman's midwifery adviser, a specialist in midwifery and women's health
Midwife 1	The midwife at the Centre who attended to Ms A on 15 June 2008
Midwife 2	The midwife at the Centre who attended to Ms A on 16 June 2008
Midwife 3	The midwife at the Centre who attended to Ms A on 23 June 2008
The Scan	Ultrasound scan carried out on 16 June 2008
BPM	Beats per minute

Annex 2

Glossary of terms

Absent end diastolic flow	An abnormality in blood flow associated with foetal growth retardation and an increased risk of perinatal death
Amniotic fluid	The nourishing and protecting liquid contained by the amniotic sac of a pregnant woman
CTG Tracing	Electronic foetal monitoring
Doppler	Baby heart monitor, using sound waves
Foetus / foetal	Term applied to an embryo and describes the stage before birth
Lower uterine caesarean section	Delivery of the baby through an abdominal incision
Maternal tocograph	Record of contractions
Mucus plug	The mucous plug (sometimes call the blood show) which plugs the cervix to protect the womb and baby from infection and disease
Obstetric	Branch of medicine concerning pregnancy, labour and the period immediately following childbirth
Perinatal	The period around the time of birth
Placental dysfunction	Can result in placental insufficiency, resulting in damage to the foetus
Post-coital	After intercourse

Triage unit	Medical assessment centre
Ultrasound scan	Test which uses sound waves to create images of organs and structures inside the body

Annex 3

List of legislation and policies considered

NICE Antenatal Guidelines: National Institute For Clinical Excellence; NICE Clinical Guideline 62; Section 12. 6.2