SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: Glasgow

Case 201302139: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospital; Gynaecology and Obstetrics (Maternity)

Overview

The complainant (Miss C) raised a number of issues about the service she received from Greater Glasgow and Clyde NHS Board (the Board) during 2004. Miss C was admitted to Princess Royal Maternity Hospital on 11 June 2004 to undergo a feticide procedure on medical advice.

Specific complaints and conclusions

The complaints which have been investigated are that the Board unreasonably:

(a) failed to explain Miss C's rights to request a private burial or cremation (*upheld*);

(b) failed to show, or explain, the cremation forms prior to asking Miss C to sign them (*upheld*);

(c) asked Miss C to sign the cremation forms when she was sedated and prior to the delivery (*upheld*); and

(d) failed to provide an accurate explanation, when responding to Miss C's complaint, for the inconsistencies in the dates on the cremation forms (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) apologise to Miss C for the failings identified in this complaint;	17 December 2014
(ii) ensure that staff attending patients after a fetal loss follow the guidance notes;	14 January 2015
(iii) report back to the Ombudsman on how they will ensure that the options for disposal of remains will be published to parents, so that they are aware of the choices that are available to them;	14 January 2015
(iv) report back to the Ombudsman on steps they	14 January 2015

	intend to take to ensure that any form to be completed by a patient after a fetal loss is fully explained to the patient, at a time when they are fully able to understand any explanation given;	
(v)	report back to the Ombudsman on steps they intend to take to ensure that patients, following a fetal loss, are not being asked to give consent while they lack the capacity to fully understand and recall what they are signing; and	14 January 2015
(vi)	formally apologise for the inconsistencies provided in relation to the dates on the cremation forms.	17 December 2014

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

Main Investigation Report

Introduction

1. The complaint relates to the care the complainant (Miss C) received at the Princess Royal Maternity Hospital (PRMH) in 2004; in particular, about the way Greater Glasgow and Clyde NHS Board (the Board) dealt with her daughter's remains following the termination of Miss C's pregnancy in 2004. Miss C's daughter was born at 23 weeks gestation on 13 June 2004, two days after she had a feticide procedure. Miss C explained that she was distraught and had waited weeks before eventually taking the decision, on medical advice, to let her daughter, who was a much-wanted and much-loved baby, go.

2. While the complaint relates to events which occurred in 2004, Miss C only recently discovered that she had signed cremation consent forms in 2004. Miss C stated that she had not previously been aware that she had signed these forms. Miss C accepted that she had been given a number of forms to sign on 11 June 2004 while attending the PRMH but stated that she was advised they were consent forms for the feticide procedure to be carried out that day. Miss C stated that she was sedated to have this procedure and remained in the PRMH until 13 June 2004. He daughter was born at approximately 01:30 on 13 June 2004.

3. Miss C stated that she was told her daughter would be cremated and was asked if she wanted a service. Miss C stated that she was never told she could arrange a private burial or cremation. Miss C maintained that this was wrong and she should have been given a choice. She also stated that, at no point during her stay in the PRMH, was she shown or had explained to her the forms consenting to cremation.

4. Miss C met with clinical staff at the PRMH on 30 July 2013 to discuss the issue of her pregnancy loss in 2004. Following this meeting, Miss C submitted a formal complaint to the Board on 31 July 2013. The Board responded on 20 August 2013. As Miss C remained dissatisfied with the Board's response, she complained to this office.

5. The complaints from Miss C which I have investigated are that the Board unreasonably:

(a) failed to explain Miss C's rights to request a private burial or cremation;

(b) failed to show, or explain, the cremation forms prior to asking Miss C to sign them;

(c) asked Miss C to sign the cremation forms when she was sedated and prior to the delivery; and

(d) failed to provide an accurate explanation, when responding to Miss C's complaint, for the inconsistencies in the dates on the cremation forms.

Investigation

6. The investigation of this complaint involved obtaining and reading all the relevant documentation, including the complaints correspondence and Miss C's health records. Independent advice has been obtained from an experienced general practitioner (the Adviser). I have also taken into account the guidance notes provided by the Board for staff looking after women with a fetal loss.

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

(a) The Board unreasonably failed to explain Miss C's rights to request a private burial or cremation; (b) The Board unreasonably failed to show, or explain, the cremation forms prior to asking Miss C to sign them; and (c) The Board unreasonably asked Miss C to sign the cremation forms when she was sedated and prior to the delivery

8. Miss C's daughter was born in the early hours of 13 June 2004. Following her daughter's birth, Miss C stated that she was asked about the arrangements she would like to make with regard to her daughter's funeral. Miss C stated that she was advised by nursing staff that her daughter would be cremated and was asked if she would like a funeral service. Miss C said that she was not given the option of choosing a burial or cremation. She stated that, had she had been given such a choice, she would have chosen a burial. However, Miss C went on to state that, due to the level of medication she received during the feticide procedure, she was not in a condition to make any decision even if a choice had been given to her.

9. Miss C explained that she was given a number of forms at one time and asked to sign them but at no point during her stay in PRMH was she shown or had explained to her the content of the forms.

Board's response to Miss C's complaint

10. Miss C submitted a formal complaint to the Board on 31 July 2013. The Board responded to Miss C's complaint on 20 August 2013. They explained that her health records from 2004 had been reviewed and that the records included details of discussions which had taken place with Miss C about the cremation arrangements for her daughter.

11. The Board advised Miss C that the health records confirmed that she was provided with clinical and pastoral support at the time of her care in 2004. They stated it was recorded that a discussion had taken place with regard to cremation on 11 June 2004, although no forms were signed at that time. The feticide procedure was carried out on this date, under sedation. The Board stated that Miss C delivered her daughter on 13 June 2004 and the appropriate paperwork was signed and dated on 13 June 2004 (see paragraph 37). They went on to say that Miss C consented for the cremation to be arranged by the PRMH on her behalf.

12. The Board explained it would be normal practice for the midwife during the course of her duties to have full discussion with the patient in terms of what to expect clinically and the processes and paperwork completed as part of post-mortem and funeral arrangements. At the time, this included a discussion on hospital arrangement for cremation. They explained that the application for cremation form was recorded as being completed on 11 June 2004, following discussion about the procedures with the midwife. They went on to say that the consultant had recorded that he talked about perinatal post-mortem benefits and the midwife had recorded that she discussed 'what would happen tomorrow' and that the patient 'would like a post-mortem' and 'would like a hospital cremation'. The Board said that these discussions took place when Miss C was not in established labour and over a period of time before the fetus was delivered, approximately 33 hours.

13. The Board went on to say that, when Miss C attended the labour ward at 16:20 on 11 June 2004, following the feticide procedure, she was not noted by the midwife as being sedated. They stated that Miss C was given the option of going home overnight at 19:45, but she declined and opted to remain in hospital for night sedation. Night sedation was administered at 22:50 and then the following day (12 June 2004) at 12:35. According to Miss C's health records, it was noted that she was sore and had requested further pain relief. Intra-muscular analgesia was administered at 12:35 and a further dose was

administered at 14:00. The Board explained that the health records indicated that Miss C advised that she required further pain relief and a patient controlled analgesia infusion was commenced at 15:00 which Miss C felt benefit from. This was topped up at 20:00 and Miss C's daughter was delivered at 01:47 on 13 June 2004.

Advice received

14. My complaints reviewer asked the Adviser whether there was evidence that Miss C was provided with clinical and pastoral support at the time of her care in 2004. The Adviser said that the health records provided were of good quality and showed that the PRMH had been attentive to Miss C's care, both clinically and pastorally. He went on to say that the health records detailed that attention had been paid to providing mementoes and baby's blessing, etc; attention was paid to arranging a community courtesy midwife visit and informing Miss C's GP. The health records also provided details of the clergy being called and Miss C's daughter being given a blessing. The Adviser also said that the health records detailed the clinical care provided during Miss C's hospital stay, which looked to have been of a good standard.

15. My complaints reviewer also asked the Adviser if there was evidence in the health records that a discussion had taken place with Miss C about the cremation of her daughter and, if there was, was this discussion reasonable. The Adviser said that the health records indicated that the consultant obstetrician (Doctor 1) annotated 'NB Already talked about perinatal autopsy benefit'. The Adviser said that there was also a record of a discussion with Miss C and another healthcare professional, about the proposed cremation. He said that it appeared that Doctor 1 recalled, on 11 June 2004, having previously discussed the post-mortem but there was no record of what was discussed at that time. He said that the healthcare professional who had discussed cremation had simply made a brief annotation, as would be expected.

16. However, the Adviser went on to comment on the matter of consent. He said that to have given informed consent, a competent adult has to have a procedure explained in terms that they understand but also makes them aware of the benefits and risks that are reasonable to disclose. A signed certificate in itself does not confirm informed consent. He said that consent has to be regarded as a fluid situation, where a competent adult is free to change their mind or ask for things to be explained again.

17. The Adviser said that, according to Miss C's health records, the cremation forms were signed on 11 June 2004 and then retrospectively filled in with further details, once Miss C's daughter was delivered on 13 June 2004. From the documentation supplied, it appears that the forms were filled in at 16:20 on 11 June 2004, as Miss C was admitted to the labour ward following the feticide procedure. He said that the anaesthetist had recorded Miss C was given four milligrams plus one milligram plus one milligram of midazolam, also 500 milligrams plus 250 milligrams of alfentanil. The Adviser indicated that the Board had been unable to give the timing of the administration of these drugs, other than they were given prior to 16:20 on 11 June 2004. He said that both these drugs have the potential to render a person 'incapable' of understanding what they were consenting to. In this case, the Adviser was of the view that there was a high probability that Miss C was still subject to the effects of these drugs when she signed the cremation forms. He said that, as such, she potentially lacked the full and proper capacity to be aware of what she was signing. This meant that Miss C was possibly unable to give her full and complete informed consent for her daughter to be cremated.

18. The Adviser explained that he could find no evidence in the health records to indicate that Miss C had the opportunity to discuss any option other than cremation. However, he said that, if Miss C lacked capacity to understand what was being discussed at 16:20 on 11 June 2004 because of the sedating effects of the medication she had been given, then she would have been unable to give her opinion regarding the means of disposing of her daughter's remains. As indicated above, Miss C stated that had she been given an option she would not have chosen cremation. The Adviser said that the health records did not show if the option of burial was given to Miss C but he said that this was irrelevant if the papers for cremation were signed when Miss C was still under sedation and so lacked capacity to give her informed consent at 16:20 on 11 June 2004.

19. The Adviser said that, in his view, Miss C should not have been asked to decide at a time when she potentially lacked the ability to fully understand what was being asked.

20. The Adviser also said that the majority of the guidance contained in the guidance note provided by the Board for staff looking after women with a fetal loss had not been followed in this case. He said that the guide suggests there should be:

- the options for funeral arrangements/disposal;

- what parents would like done with ashes (if any remain); and
- physiotherapy leaflet supplied.

21. The Adviser concluded that, based on Miss C's health records, it was highly likely that she was not capable of giving her informed consent at 16:20 on 11 June 2004. This was because of the persisting effects of the sedating drugs Miss C had been given for the feticide procedure prior to her transfer to the labour ward. As such, the Adviser was also of the view that Miss C was also unable to give her reasoned opinion about how she wanted her daughter's remains disposed of. He said that the health records were not clear if a family arranged burial was offered (as should have been done) but even if it was, it was likely that Miss C was unfit to make a decision about it at that time.

22. As this complaint related to events which occurred in 2004, my complaints reviewer asked the Board whether there had been any changes to their practice around when to ask a patient undergoing a feticide procedure to sign cremation forms. The Board explained that there is no specific guideline in place now or in 2004 which would indicate when discussion about the post-mortem or funeral arrangements would or should take place, however, consent would be required for both. They went on to explain that when and where this discussion would take place can be patient led but can be medically/midwifery led, depending on each individual situation.

(a) Conclusion

23. I recognise that this would have been an extremely difficult and traumatic experience for Miss C and her family and that it remains an upsetting and stressful situation. I accept the advice I have received that the Board were attentive to Miss C's care both clinically and pastorally during her stay in the PRMH in 2004.

24. However, I consider that the crucial factor in this case is whether Miss C was able to give her informed consent. From the health records, it appears that the cremation forms were filled in on 11 June 2004 at 16:20, as Miss C was admitted to the labour ward following the feticide procedure. The advice I have received and accept is that during this procedure Miss C received medication which has the potential to render a patient 'incapable' of understanding what they are consenting to. I also accept the advice I have received that it is highly probable that Miss C was still subject to the effects of the sedating medication at 16:20 on 11 June 2004 and, as such, she was not capable of giving her

informed consent at that time. Furthermore, I also accept the advice I have received that Miss C lacked the capacity to understand what was being discussed; was unable to give her reasoned opinion about how she wanted her daughter's remains disposed of; and potentially lacked the full and proper capacity to be aware of what she was signing.

25. I recognise that the Board state that the health records confirm there was discussion about cremation with Miss C on 11 June 2004. In line with the Board's guidance for staff looking after women in Miss C's situation, parents have the choice of burial or cremation. I am extremely concerned that there is no evidence in the health records that Miss C was given the opportunity to discuss any option other than cremation. While I consider this is a serious failing, even if there had been a discussion on the options available to Miss C, given the persisting effects of the sedating medication Miss C would have been unable to give her opinion regarding the means of disposing of her daughter's remains. It is also of concern to me that Miss C was asked to make such a decision when she may have been unable to understand what was being discussed.

26. Furthermore, there is no evidence that all the guidance detailed in the guidance note for staff looking after women in Miss C's situation was followed in this case. In particular, options for funeral arrangements/disposal and what parents would like done with ashes (if any remain).

27. Given the sensitivity around early pregnancy loss, I am extremely concerned that there is no evidence that the Board discussed with Miss C her right to request a private burial or cremation. It is clear that had the option of burial been given to Miss C she would have chosen that, rather than cremation. While I am critical of this failing, the advice I have received and accept is that even had such a discussion taken place, there is no evidence that Miss C was fully able to understand what she was being asked at the time. I consider these were serious failings in the care provided to Miss C and I uphold the complaint.

(a) Recommendations

28.	I recommend that the Board:	*Completion date*
(i)	apologise to Miss C for the failings identified in this complaint;	17 December 2014
(ii)	ensure that staff attending patients after a fetal loss	14 January 2015

	follow the guidance notes; and	
(iii)	report back to the Ombudsman on how they will ensure that the options for disposal of remains will be published to parents, so that they are aware of the choices that are available to them.	14 January 2015

(b) Conclusion

29. Miss C states that she was given a number of forms to sign on 11 June 2004 and that the Board failed to explain these forms to her. As a result, Miss C was unaware that she had signed cremation forms until some years later, when she requested copies of the forms. I recognise that the Board explained that the normal practice was for the midwife to have full discussion with the patient in terms of the paperwork to be completed and that, in this case, the application for cremation form was recorded as being completed following these discussions. However, regardless of whether any explanation about the forms was given, I consider that it is likely, given the sedating effects of the medication Miss C had received, she would not have been able to fully understand any explanation given to her. I consider that this was unreasonable.

30. In view of the failings I have identified, I uphold the complaint.

(b) Recommendation

31.	I recommend that the Board:	*Completion date*
(i)	report back to the Ombudsman on steps they intend to take to ensure that any form to be completed by a patient after a fetal loss is fully explained to a patient, at a time when they are fully able to understand any explanation given.	14 January 2015

(c) Conclusion

32. As detailed above, Miss C states that she was unaware she had signed cremation forms in 2004. I accept that the health records indicate that there was discussion about the cremation of Miss C's daughter at the time. However, I am satisfied that Miss C lacked the full and proper capacity to be aware of what she was signing. As such, I consider that Miss C was likely to be unable to give her full and complete informed consent for her daughter to be cremated.

33. It is of serious concern to me that it is highly likely that Miss C was unable to give her informed consent for the cremation of her daughter because of the

persisting effects of the sedating medication she had received. As such, I consider that Miss C should not have been asked to sign any forms when there was a possibility that she was unable to fully understand what she was being asked to sign. I am extremely critical of these failings. Given my criticism on this matter, it is of concern to me that it appears that the Board have not, since 2004, changed their practice around when to ask a patient undergoing a feticide procedure to sign cremation forms.

34. I am also greatly concerned that Miss C was asked to sign forms at such an upsetting time. I have seen no evidence which persuades me that there was a clinical need for Miss C to sign these forms at such a distressing time. I uphold the complaint.

(c) Recommendation

35.	I recommend that the Board:	*Completion date*
(i)	report back to the Ombudsman on steps they intend to take to ensure that patients, following a fetal loss, are not being asked to give consent while they lack the capacity to fully understand and recall what they are signing.	14 January 2015

(d) The Board unreasonably failed to provide an accurate explanation, when responding to Miss C's complaint, for the inconsistencies in the dates on the cremation forms

36. Miss C was aggrieved that when she complained to the Board she was advised that it was recorded that discussion had taken place with regard to cremation on 11 June 2004 but that no forms were signed at that time. The Board went on to say that the appropriate paperwork was signed and dated on 13 June 2004. However, copies of the forms obtained by Miss C clearly indicated that the forms had been signed on 11 June 2004.

37. The Board subsequently accepted, having investigated this matter further, that the cremation forms were signed on 11 June 2004 and not 13 June 2004. The Board indicated that they would wish to offer their sincere apologies to Miss C for this error and for any distress it may have caused her.

(d) Conclusion

38. The crux of Miss C's complaint was that she was not aware that she had signed the cremation forms on 11 June 2004 and that she should not have been

asked to sign these forms while sedated. The Board accepted that, due to an error, they incorrectly advised Miss C when responding to her complaint on 20 August 2013 that she had signed the cremation forms on 13 June 2004, two days after the feticide procedure. I recognise that this caused Miss C to question whether this mistake had been deliberate.

39. I am mindful that the Board explained that this was an error on their part; however, I am concerned, given how pivotal the matter of when the cremation forms were signed, that incorrect information was given to Miss C. I uphold the complaint.

(d) Recommendation

40.	I recommend that the Board:	*Completion date*
(i)	formally apologise for the inconsistencies provided in relation to the dates on the cremation forms.	17 December 2014

41. 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

Miss C	the complainant
PRMH	Princess Royal Maternity Hospital
the Board	Greater Glasgow and Clyde NHS Board
the Adviser	general practitioner
Doctor 1	consultant obstetrician

Annex 2

Glossary of terms

feticide	an act that causes the death of a fetus
competent	able to understand what is being explained, understand the implications of it and retain and repeat the information at a later date
midazolam	a powerful valium like drug that causes relaxation, reduced awareness of what is going on and amnesia – forgetting what has happened while under its effect
alfentanil	a synthetic morphine like drug which also reduces awareness and kills pain