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 ref: 201403840, Greater Glasgow and Clyde NHS Board
Sector: Health
Subject: Hospitals; clinical treatment; diagnosis

Summary
Ms C was assessed as low risk during her pregnancy and it was, therefore, considered suitable for her to deliver her baby at the Community Midwifery Unit at Vale of Leven District General Hospital. After going into labour she was admitted to the maternity unit but her labour was slow to progress. Several hours after admission, an examination found that her baby was in a posterior position (when the back of the baby's skull is in the back of the mother's pelvis). This meant that the delivery would be more complicated and would be likely to need a higher level of care than was available at the maternity unit. Staff called an ambulance to transfer Ms C to the Royal Alexandria Hospital. The ambulance service was particularly busy so the transfer took longer than expected. There was also a delay in the ambulance team accessing the building as they did not know the maternity unit. Ms C was given an episiotomy (a minor surgical cut that widens the opening of the vagina during childbirth) very shortly before she was transferred. Her baby was unwell at birth and she was transferred to another hospital for specialist neo-natal treatment.

Mr and Ms C complained to the board that the maternity unit did not reasonably explain in advance the transfer arrangements to hospital from the unit in case of an emergency; did not provide a reasonable standard of maternity care; delayed making the decision to transfer Ms C to hospital; contributed to delays during the transfer process; and that the board did not handle their complaint in line with the complaints procedure.

The board conducted a Significant Incident Review following the complaint, identifying a number of failings in Ms C's care, and recommending improvements at the maternity unit.

I took independent midwifery advice on this complaint. Regarding the information received about an emergency transfer to hospital from the maternity unit, it was clear that Ms C's understanding of the transport arrangements was not correct. She had also not been given any written information. The board acknowledged that Ms C should have been given clearer information, and they

had amended a leaflet to include the transfer information. However, my adviser noted that the leaflet should be provided to women before they have chosen where to give birth.

We found several failures in the maternity care provided to Ms C in the maternity unit. This included a failure to properly assess her on admission or identify a clear plan of care; lack of monitoring throughout her labour; poor documentation, particularly of care planning and regarding handovers between staff; and also the episiotomy was undertaken inappropriately and possibly unnecessarily. The poor standard of care put Ms C and her baby at unnecessary risk.

As a result of some of the failures above, the decision to transfer Ms C to hospital was delayed. If her labour had been managed properly, she could have been transferred before it was an emergency. I am critical that the board's SIR did not highlight this delay and that they have yet to apologise for it.

The delay in the ambulance arriving at the maternity unit was due to pressures on the ambulance service and therefore out of the board's hands. However, the difficulties the crew experienced getting into the building were avoidable, and I am critical of the lack of action from the maternity unit staff.

The board clearly did not deal with Mr and Ms C's complaints within the timescales of their guidance (Guidance to Staff in Dealing with Complaints). Additionally, the board's final response to their complaints was in the form of notes from meetings, rather than a formal letter clearly stating whether complaints were upheld and providing a meaningful apology.

I upheld all of the complaints.

Redress and recommendations

The Ombudsman recommends that the Board:		*Completion date*
(i)	ensure that the leaflet entitled 'Having your baby at the Vale of Leven CMU' is given to women before they have made a decision about where they would like to give birth, and revise the wording of the leaflet as appropriate;	30 November 2015
(ii)	consider the need to review the NHS Greater	30 November 2015

	Glasgow and Clyde Obstetric Guidelines, in line with National Institute for Health and Care Excellence Guidelines on Intrapartum Care (2014);	
(iii)	reflect on the findings of this case, and consider whether the provision of aromatherapy at the Unit should be offered on a 24 hour basis;	30 November 2015
(iv)	extend the use of the new tool for handover of care, so that it is applied to telephone handovers when transferring care from the Unit to Royal Alexandria Hospital;	30 November 2015
(v)	consider implementing a system for staff rotations from the unit to Royal Alexandria Hospital on an annual basis, if this is not already in place; and	7 January 2016
(vi)	apologise to Ms and Mr C for the failings identified in this report, and the distress this caused them and Baby C.	30 October 2015

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainants are referred to as Mr and Ms C, and their baby is Baby C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Mr and Ms C complained to the Ombudsman about the care and treatment that Ms C received during labour, at the Community Midwifery Unit (the Unit) at the Vale of Leven District General Hospital (Hospital 1), in the hours before Ms C gave birth to their daughter (Baby C). The complaints from Mr and Ms C I have investigated are that Hospital 1:

(a) did not reasonably explain in advance the arrangements for patient transfer in the event of an emergency (*upheld*);
(b) did not provide a reasonable standard of maternity care (*upheld*);
(c) unreasonably delayed making the decision to transfer the patient (*upheld*);
(d) contributed to delays during the hospital transfer process (*upheld*); and
(e) Greater Glasgow and Clyde NHS Board (the Board) did not deal with Mr and Ms C's complaint in accordance with the complaints procedure (*upheld*).

Investigation

2. In order to investigate Mr and Ms C's complaint, my complaints reviewer sought independent midwifery advice (the Adviser), further comments and information from the Board, including an update on the actions they had taken in response to this complaint. In this case, we have decided to issue a public report on Mr and Ms C's complaint because of the significant personal injustice Ms C suffered during labour, and the significant risk caused to Baby C's long term health and wellbeing.

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

Background

4. Ms C attended for regular antenatal check-ups during her pregnancy from April to October 2013 and was assessed as low risk. She was, therefore, considered suitable for delivering Baby C at the Unit. During her antenatal visits she was given information about what to expect when she went into labour, and the services available at the Unit.

5. Ms C went into labour spontaneously on her due date of 21 October 2013 and, when she attended the Unit, she was assessed as being in early labour and was advised to go home until labour was more established. She was

advised to eat and drink, as tests indicated she had low ketones (a measure from a urine test indicating that she was low in sugar/ carbohydrate).

6. Ms C returned a few hours later, at 16:50. She was assessed, and her cervix was found to be almost fully dilated. Her waters had not yet broken and were found to be protruding, so staff artificially ruptured the membrane. Ms C has complained that she was not informed of the intention to do this and did not give consent for it. There was no record of the Baby C's position being diagnosed at this assessment and her ketones were not re-tested. All other standard monitoring measures were found to be normal.

7. Ms C's records indicated that the Baby C's heart was monitored every 15 minutes from her admission, though this does not concur with Ms C's memory of events.

8. After her admission, Ms C's labour was slow to progress. At 20:00 there was a handover of staff, though this was not documented in Ms C's clinical notes.

9. At around 21:00, when Ms C's labour was still not progressing, staff commenced aromatherapy. However, this did not have the desired effect of stimulating a progression in Ms C's labour. At 22:05 an examination found that Ms C was now fully dilated and Baby C was in a 'posterior position' (when the back of the baby's skull is in the back of the mother's pelvis; this is sometimes known as 'back to back'). The decision was made that Ms C should be transferred to hospital for a medical review and an ambulance was called at 22:09.

10. The ambulance was slower to arrive than would normally be anticipated, because the Ambulance Service were particularly busy and had to send an ambulance from Paisley. They arrived on site at 22:23. However, the ambulance crew were unfamiliar with the building and, when they arrived, found they could not initially gain access to the Unit. They arrived in the Unit at 22:33.

11. During the time that Ms C was awaiting the ambulance, staff encouraged her to actively push with contractions, as they were concerned about Baby C's heartbeat. Shortly before the ambulance arrived, they conducted an episiotomy (a surgical cut at the opening of the vagina), with the aim of speeding up

delivery. Ms C has said that she was not given anaesthesia for this procedure. Her records indicated simply that the episiotomy was performed.

12. Mr C had been present with his wife throughout the labour and provided her with encouragement and support. However, when the ambulance was called he was encouraged to leave his wife at the Unit and drive to the Royal Alexandra Hospital (Hospital 2), so that he could be there when she arrived by ambulance. Mr C has disputed the times given by the Board in relation to Ms C's ambulance and transfer to Hospital 2. His own notes suggested that the ambulance was not called until 22:50, and that Ms C arrived at Hospital 2 at 23:30.

13. Ms C's clinical notes indicate that she arrived into Room 1 at Hospital 2 at 23:07, where she was assessed. At 23:20 Ms C went into theatre and she delivered Baby C by forceps at 23:40. Baby C was unwell at birth and Mr and Ms C were warned that she had brain damage and multiple-organ failure. She was rapidly transferred to the Princess Royal Maternity Hospital (Hospital 3), where she received specialist neo-natal treatment.

14. The treatment was successful but, at the time of their complaint to us, Mr and Ms C were still unsure of the long-term damage to Baby C's brain and kidneys.

Findings of the Board's Significant Incident Review

15. Following Baby C's birth, and the complaint brought by Mr and Ms C, the Board conducted a Significant Incident Review (SIR). This identified a number of errors in Ms C's care and made recommendations for improvements in the services at the Unit.

16. The SIR identified a number of failings in Ms C's maternity care and information provision:

- There was insufficient monitoring of contractions, of Baby C's position and of Ms C's behaviour.
- Abdominal palpation (an examination of the abdomen by touch) and vaginal examination were not carried out every four hours, as they should have been when there were no obvious signs of progress in labour. Vaginal examination should have been repeated at the time of staff changes, along with a review of progress and a management plan.

- Ms C's ketones should have been re-checked when she was admitted, given that concerns had been raised about this earlier in the day.
- There was a lack of a care plan, which should have identified the need to re-examine or re-evaluate the progress of labour approximately three to four hours after admission. The SIR noted that a formal reassessment and plan of care should have been made by, at the latest, four hours after admission.
- The only indicator of the second stage of labour was rectal pressure (the sensation that the baby is pushing on the mother's rectum), which should have been identified as an indicator of a failure of the labour to progress, and this should have been acted on earlier.
- Waiting to use aromatherapy contributed to a delay in assessing the progress of labour. Ms C should have been reassessed prior to the use of aromatherapy, to exclude any reason that was contributing to the lack of progress; such as the baby's position or obstructed labour (when the baby is 'stuck' either due to an obstruction or constriction of the birth passage or due to the condition of the baby), as these would have indicated that aromatherapy was inappropriate.
- Communication with Hospital 2 on the plan to transfer Ms C should have been documented.
- An episiotomy was carried out, but this did not speed up delivery. They also noted that there was no documentation that Ms C was given a local anaesthetic, though the midwives involved confirmed that this was administered.
- Midwives provided information about choices for place of birth when the birth was 'booked', during antenatal classes; and if the mother chose to use the Unit, detailed information would be given at the 37 week review with a midwife. A checklist ensured that all the details were discussed at this review.

17. The SIR concluded that labour appeared to be observed rather than managed, though there was no explanation for this failure. It also highlighted the lack of formal handover when staff changed, and the resultant missed opportunity to recognise the slow progress of Ms C's labour and plan how this would be managed. They acknowledged that this may have facilitated an earlier transfer to Hospital 2.

18. The SIR also noted that the longer than normal wait for the ambulance could not have been predicted. It also noted that, while discussion of choices of where to give birth were not documented, they acknowledged the need to provide clear information to prospective parents, prior to any decision.

19. The SIR outcome was that there were 'major system of care issues', and that if care had been planned and/or delivered differently, it was likely that there would have been a better outcome. It identified several recommendations, including:

- written information on the choice of place of birth to be given when the birth is 'booked', which could be referred to in later discussions;
- consistent information, including ambulance response times in the event a transfer to Hospital 2, given to all prospective parents;
- management review of the practice of the midwives involved in Ms C's care;
- introduction of a formal, documented handover process when there is a change of staff from on duty midwives to those on call; and
- clarification of the process of requesting an ambulance, including response times and information to be included in the request.

(a) Hospital 1 did not reasonably explain in advance the arrangements for patient transfer in the event of an emergency

Concerns raised by Mr and Ms C

20. Ms C has reported that she was told that an ambulance would be waiting at the Unit, on stand-by, while she was in labour. However, this was not standard practice. She was not aware that an ambulance would have to be called and that the target response time, for arrival at the Unit, was 19 minutes. She said that they were told a transfer to hospital would take 15 minutes. Mr and Ms C have said that, if they were aware of potential timescales for a transfer, they would not have chosen to use the Unit for delivering Baby C.

The Board's response

21. In their response to our enquiries, the Board informed us that arrangements for emergency transfers from the Unit to Hospital 2 were usually discussed at least twice during pregnancy. In particular, they said they were discussed at the 37 week antenatal check, where a checklist was completed to confirm that the Unit was a suitable place for the mother to give birth. The Board went on to say that women were informed that, should they need to be

transferred in labour, an emergency ambulance would be ordered, and a midwife escort would be provided.

22. The Board reported that, prior to this incident, no emergency ambulance had taken longer than ten to 15 minutes to arrive. The onward journey to Hospital 2 would then take at least 30 minutes. They said that no midwives had informed women that they would arrive at Hospital 2 in 15 minutes.

23. Following this complaint, staff have confirmed that they will inform women that transfer to hospital is by normal emergency ambulance. The SIR also identified the need to provide women with written information about transfer to hospital. The original leaflet did not make any mention of transfers to hospital. However, the Board also confirmed that this leaflet has been revised, and now includes information about arrangements for transfer of care. The Board have informed us that this leaflet is now in use.

Midwifery advice

24. The Adviser noted that Ms C's records indicated that there had been some level of discussion about transfer to hospital, as this had been ticked in a checklist of issues to discuss with expectant mothers. She also noted that Ms C was under the impression that an ambulance was on stand-by at the Unit, and the transfer time would be 15 minutes. She considered that this suggested that Ms C did not receive clear information about the transfer to hospital during labour.

25. The Adviser went on to say that it would be expected that this information should be delivered consistently by staff and also provided in written format, as well as being clearly documented in the notes that information had been given. She noted that this information was part of the process of making an informed choice about where to have a baby.

(a) Decision

26. We cannot say for certain exactly what information Ms C was given by midwives before she made the decision to have Baby C at the Unit. However, it is clear that she came away from her appointments with an understanding that was incorrect, and that she did not have access to written information. She was under the impression that an ambulance would be waiting on stand-by at the Unit from the time she arrived at the Unit when she was in labour. In the end it took around half an hour for an ambulance to arrive.

27. The leaflet that Ms C received provided advice for when a woman went into labour. I am critical that the Board did not provide Ms C with clear information about what would happen if she needed an emergency transfer and that the oral information she was given was not backed up by written information. I, therefore, uphold this complaint.

28. The Board acknowledged that Ms C should have been given clearer information prior to going into labour, and have amended their leaflet accordingly. The leaflet specifically addresses women who have already chosen to have their baby at the Unit. However, the Adviser noted that this information should be provided ahead of any decision about where to have a baby, as it would be important information for them to consider as part of this decision.

29. I, therefore, remain concerned that this information is not being given to women in enough time for them to make an informed decision about where to give birth. To ensure that this information is provided when women are choosing to give birth at the Unit, I am making the following recommendation.

(a) Recommendation

30. I recommend that the Board:	*Completion date*
(i) ensure that the leaflet entitled 'Having your baby at the Vale of Leven CMU' is given to women before they have made a decision about where they would like to give birth; and revise the wording of the leaflet as appropriate.	30 November 2015

(b) Hospital 1 did not provide a reasonable standard of maternity care

Concerns raised by Mr and Ms C

31. Mr and Ms C have complained that when Ms C was in labour she was not appropriately examined or monitored, and that midwives did not do enough to ensure that her labour was progressing appropriately. They have said that not enough was done when the labour stopped progressing as it should have. They have also complained that staff did not give an appropriate handover when there was a change of staff at 20:00; and that there was an inappropriate delay while they waited for a member of staff trained in aromatherapy to arrive at the Unit.

The Board's response

32. The Board acknowledged that there were failings in Ms C's maternity care, as noted in the findings of their SIR. The Board also met with Mr and Ms C following the SIR, and discussed the findings of the SIR. Differences of opinion remained following this meeting, in relation to exactly what had happened on the evening in question, and what subsequent action should have been taken.

33. In the Board's response to our enquiries they confirmed that action had been taken, including the establishment of a communication tool when transferring care from one health professional to another; for example, handing over between shifts. This was introduced in December 2013. A supervisory investigation had been undertaken and had identified the need for updates on communication and documentation, in February 2014. They also confirmed that management had reviewed the practice of individual midwives involved and appropriate action had been taken.

What should have happened

34. The NHS Quality Improvement Scotland's Pathways for Maternity Care (2009) (the Care Pathways) specified that women who were between 16 and 40 years old, with uncomplicated, singleton pregnancies and with a Body Mass Index between 18 and 35, would be considered low risk and should be offered a midwife led care. These criteria are reiterated in the Board's own Obstetric Guidelines (the Guidelines).

35. The Care Pathways specified that one of the criteria which would indicate the need for maternity team care, rather than midwife led care, would be 'malpresentation' (when the baby is in a position which would make it difficult to deliver naturally, including if it were in a posterior position, as in Ms C's case).

36. The Guidelines specified that, during the active first stage of labour, a woman's cervix should be dilating at least half a centimetre per hour. If this progress were not made, the Guidelines indicated the need to consider a range of clinical considerations including mobilisation to aid optimal foetal positioning, hydration, support, and the use of complementary therapies. It also specified the need for abdominal palpation and urine testing every two hours and vaginal examination every four hours.

37. The Care Pathways and the Guidelines set out the expectation that the baby's heart should be monitored every 15 minutes during the first stage of labour.

38. In relation to the transition to the second stage of labour, the Guidelines stated that this should be identified by a vaginal examination or when the baby's head became visible. If this were followed by expulsive contractions and the head was advancing, the 'active second stage' pathway should be followed. Otherwise, the 'non-active second stage' pathway should be followed. The Guidelines concurred with national guidance; that for a first baby, a non-active, second stage of labour should last no longer than two hours. If the woman has still not moved into the active second stage of labour after two hours, then the Guidelines set out expected measures, such as assessing the vagina and the position of the baby's head, the strength of the contractions, hydration and nutrition, the mother's position and mobilisation, and consideration of an infusion of Syntocinon (a medication which induces stronger contractions). The Guidelines also specified the need to transfer the woman to obstetric led care at this point.

39. The Care Pathways and the Guidelines made limited reference to when to conduct an episiotomy. The Guidelines refer only to an assessment of the perineum (the area between the anus and the vagina) for episiotomy when a woman was in the active second stage of labour for at least 60 to 90 minutes (for a first baby). However, relevant guidance from England (National Institute for Health and Care Excellence (NICE) Guidance on Intrapartum Care (2007)) suggested that an episiotomy should only be performed if there was a clinical need, such as an instrumental delivery or suspected foetal compromise, and that, if performed, there should be tested, effective analgesia before undertaking the procedure.

Midwifery advice

40. The Adviser was satisfied that, given the straightforward nature of Ms C's pregnancy, it was appropriate for her to be considered as 'low risk' and suitable for midwifery led care, such as at the Unit.

41. The Adviser reviewed Ms C's assessments when she arrived at the Unit. She noted that her initial assessment at 14:10 was well documented and met the Guidelines. In relation to Ms C's second assessment, when she returned to the Unit at 16:50, the Adviser noted that no assessment of Baby C's position

was documented. She noted that Ms C's waters were broken and that she was close to being fully dilated.

42. The Adviser was critical that there appeared to be no attempt to diagnose Baby C's position. She considered that this could have helped to formulate an appropriate plan of care for Ms C, based on the criteria in the Guidelines. She noted that, at that time, Baby C's heart was recorded and was normal but also noted that her urine was not checked, when it should have been, given that Ms C had been found to have ketones in her urine earlier in the afternoon. Specifically, the Adviser was critical that there was no plan of care documented following Ms C's assessment on admission. She said that this made it difficult to assess if the plan was appropriate and followed the Guidelines. She noted that best practice would have been to identify a clear plan of care, which would then have been documented, and the information shared with Ms C.

43. During Ms C's admission assessment the midwife broke Ms C's waters, as they were protruding outside the vagina. The Adviser commented that the midwife must have been able to see this was the case before she started the examination and considered that she should have explained to Ms C that she was planning on breaking the waters, and why she wanted to do this. She said that it would not be expected to get written consent to do this, but verbal consent should have been obtained, after an explanation of why it was appropriate. The Adviser noted that the midwife documented that she had gained consent for the vaginal examination, but had not documented that she had provided information as to why she considered the need to break Ms C's waters, or that she had informed consent to do this.

44. In terms of the procedure itself, the Adviser considered that it was clinically reasonable to break Ms C's waters at this point, as Ms C was almost fully dilated and the membranes holding the waters were protruding outside of the vagina, which could have been making vaginal examination difficult. She noted it could also have prevented Baby C's head from descending.

45. The Adviser noted that there was disagreement between the midwifery records, which indicate that Baby C's heart was monitored every 15 minutes, and Ms C's recollection of events, as she was not aware of this monitoring taking place. The Adviser was satisfied that the midwifery records indicated that this monitoring was in line with national and local guidance.

46. In relation to the transfer of care between professionals, the Adviser was critical that there was no documented handover recorded when staff changed at 20:00. She, therefore, found it difficult to assess whether a full handover of care had been provided. If this had occurred appropriately, the Adviser noted that this could have been an opportunity for the whole picture and timeline to have been reviewed, and could have promoted an earlier transfer to Hospital 2. She also noted that there was no documented discussion about the referral to Hospital 2 so, again, it was difficult to establish whether an appropriate handover had occurred.

47. In reference to the timing of Ms C's reassessment, the Adviser noted that, if the Guidelines had been followed, she would have expected an internal examination to have been performed at 18:50 at the latest, to assess if Ms C's cervix was fully dilated and to confirm Baby C's position. She noted that, if an examination had been performed at this stage and Baby C's position had been diagnosed, then a clear plan of care could have been made and an early transfer to Hospital 2 could have been arranged. The Adviser went on to explain that a labour with a baby in a posterior position could result in a slow labour with 'incoordinate' contractions (when contractions are too weak or ineffective in the first stage of labour) and difficulty delivering the baby spontaneously, so instruments are often needed for delivery.

48. The Adviser went on to say that if an examination at 18:50 had found that Ms C was not fully dilated, then a transfer to Hospital 2 should have occurred at that stage. If she was fully dilated, then a second stage of labour pathway should have been followed. The Adviser explained that once the second stage of labour was diagnosed, the nature of the contractions and changes in the cervix should have been used to determine whether Ms C was in an active or a non-active second stage, with different pathways of care indicated for these alternative situations. The Adviser noted that the midwife appeared to follow the non-active second stage pathway, although she did not document this in a plan of care. The Guidelines' requirement for a first baby was that this stage of labour should last no longer than two hours. On this basis, the Adviser considered that a transfer should have occurred at 20:50 at the latest.

49. In relation to the provision of aromatherapy, the Adviser was clear that this can be effective in labour and was identified in the Guidelines. However, she considered that it would have been more appropriate to have started this at 16:50, when Ms C entering the second stage of labour. She went on to say

that, if this was not possible, other actions should have been taken, such as an earlier vaginal examination and transfer. She also said that, if aromatherapy were to be used in a midwifery led unit, then all staff should be trained to use it.

50. The Adviser provided comments on the episiotomy which Ms C had shortly before her transfer to Hospital 2. She noted that there was inadequate documentation about the episiotomy procedure, and there was no explanation of why or how it was carried out. There was no reference to the use of a local anaesthetic.

51. She went on to say that an episiotomy should not be performed if the birth cannot be achieved, and that performing this directly before Ms C's transfer to Hospital 2 without delivery being achievable caused a risk of bleeding from the episiotomy site. She said she found it difficult to justify why the episiotomy was performed and that it was evident that it was not documented appropriately.

52. The Adviser noted that the SIR was, by and large, consistent with her assessment of Ms C's care. She noted that the SIR reviewed whether local anaesthetic was used before Ms C's episiotomy. However, she was critical that the Board did not review whether performing the episiotomy at this stage before transfer was appropriate.

53. In terms of the actions taken following the SIR, the Adviser noted that the handover tool adopted following the SIR was appropriate, but noted that it should also be used for telephone handovers when arranging transfers to Hospital 2, as well as for documenting face to face handovers.

54. The Adviser noted that the Guidelines was last reviewed in 2012, but that since then there had been revised NICE Intrapartum Guidelines, in 2014, and she considered that the Guidelines should be revised to reflect these national guidelines.

55. She also advised that the Board should ensure that midwives working at the Unit rotate to Hospital 2 annually, to gain and refresh their skills in high risk births. While it was not clear from the records whether such a system were in place, she considered that this could help midwives identify labours like Ms C's, which are slow to progress. If this were not already in place, she noted that this could assist the Board in ensuring that appropriate management plans were made, documented and followed for all labours.

(b) Decision

56. The advice I have received identified several failures in the delivery of maternity care to Ms C while she was at the Unit. This included a failure to appropriately assess Ms C when she was admitted to the Unit; lack of appropriate planning and management of Ms C's labour; lack of appropriate monitoring of the progression of her labour; poor documentation, particularly in relation to care planning and handover of care between professionals; as well as undertaking an episiotomy inappropriately, apparently without anaesthetic and with no identified need for it. This poor standard of care put both Ms C and Baby C at unnecessary risk. On this basis, I uphold this complaint.

57. There were clearly failures, which the Board have acknowledged and have acted on. However, the Adviser identified a range of further measures which could be taken by the Board to further strengthen their practices at the Unit. I am, therefore, making the following recommendations, to ensure that Ms C's experiences are not repeated in future.

(b) Recommendations

58. I recommend that the Board:	*Completion date*
(i) consider the need to review the NHS Greater Glasgow and Clyde Obstetric Guidelines, in line with NICE Guidelines on Intrapartum Care (2014);	30 November 2015
(ii) reflect on the findings of this case, and consider whether the provision of aromatherapy at the Unit should be offered on a 24 hour basis;	30 November 2015
(iii) extend the use of the new tool for handover of care, so that it is applied to telephone handovers when transferring care from the Unit to Hospital 2; and	30 November 2015
(iv) consider implementing a system for staff rotations from the Unit to Hospital 2 on an annual basis, if this is not already in place.	7 January 2016

(c) Hospital 1 unreasonably delayed making the decision to transfer the patient

Concerns raised by Mr and Ms C

59. Mr and Ms C have complained that there was no valid reason for delaying Ms C's transfer to Hospital 2, and that the wait for aromatherapy had been unnecessary. They felt that this had jeopardised her safety and that of Baby C.

The Board's response

60. In their response to our enquiries, and based on the findings of the SIR, the Board acknowledged that there had been a delay in deciding to transfer Ms C to Hospital 2.

Midwifery advice

61. The Adviser noted that there were significant delays in Ms C's transfer to Hospital 2, due to the poor management of labour, and a failure to have a clear plan of care and to identify that labour was progressing slowly. Details of this have been referred to above, in relation to Complaint (b).

(c) Decision

62. It is clear that Ms C should have been transferred to Hospital 2 at an earlier stage of labour although, as there was a lack of vaginal examination and care planning, it is not clear exactly when this transfer should have been initiated. I am aware that, if Ms C's labour had been managed appropriately, she could have been transferred before this became an emergency. This would have been safer for both Ms C and Baby C and would have saved Mr and Ms C significant distress. I am satisfied that poor care management lead to a delayed decision to transfer Ms C to Hospital 2 and I uphold this complaint.

63. I am also critical that the SIR undertaken by the Board did not highlight a delay in transferring Ms C to Hospital 2, nor the impact that had on Ms C and Baby C. Furthermore, there was no reference to this delay, or an apology for it, at the Board's subsequent meetings with Mr and Ms C or in correspondence with them.

(d) Hospital 1 contributed to delays during the hospital transfer process

Concerns raised by Mr and Ms C

64. Mr and Ms C have raised concerns that poor arrangements with the Scottish Ambulance Service contributed further to delays in Ms C's transfer to Hospital 2. They were unhappy that the ambulance crew took longer than normal and that staff did not take action to ensure they could access the building.

65. Mr and Ms C's concerns about the timing of the ambulance have been exacerbated because they disagreed with the timeline provided by the Board. They established a timeline based on email and text correspondence during this

period with other members of their family. Their timeline indicated a much longer period prior to the ambulance being called.

Ambulance timeline

66. Based on the evidence available from Ms C's clinical records from the Unit and Hospital 2, and from the Scottish Ambulance Service (the Service), the sequence of events showed that the ambulance took 14 minutes to arrive at the Unit. (A detailed timeline is provided in Appendix 1.) It took the crew a further ten minutes or so to access the building. This was because the doors were locked. Local ambulance crews were aware of the need to telephone the Unit on arrival, to gain access. However, the crew were not local and were not aware of this protocol.

67. The time taken from when the ambulance was called to Ms C's arrival at Hospital 2 was one hour. Mr C's records indicated that this process took 40 minutes, but that the ambulance did not arrive until 23:30.

The Board's response

68. In the Board's correspondence in relation to this complaint, they noted that the ambulance took 14 minutes to arrive, but that staff normally expected a response time of less than ten minutes, based on previous experience. They noted that staff had telephoned to find out why there was a delay in the ambulance arriving, but it had not become evident at that stage that the crew did not know how to access the building.

69. Since this issue came to light, the Board have put a laminated notice on the door, with instruction on how to gain entry out of hours. This issue was also discussed with the Service at the time of the SIR.

What should have happened

70. The Guidelines specified that all emergency transfers to an obstetrics hospital (Hospital 2 in this case) should be by emergency ambulance. Births in the Unit are considered in the same way as home births, and if an emergency patient transfer is needed, the Unit should dial 999 for an emergency ambulance.

71. The Guidelines also stated that the midwives should also have telephoned the labour ward co-ordinator and given details of the transfer. If this were not

possible, ambulance control should have been requested to pass on information.

(d) Decision

72. I have reviewed the documentation in relation to the Board's timeline, including information given to the Board by the Service. It is clear that it took longer than expected for an ambulance to arrive, due to other demands on the service that evening, which were beyond the Board's control.

73. However, the ambulance did arrive within the Service's target response time of 19 minutes so, while it was unfortunate that the ambulance took longer to arrive than normal, the Board's actions in relation to calling for an ambulance and the anticipated response of the Service were in line with the Guidelines.

74. The delay that subsequently took place at the Unit, due to the difficulties the crew had in accessing the building, were not covered by the Guidelines, and were clearly regrettable. I am critical that, while staff thought to telephone the ambulance service when the ambulance had not arrived after eight minutes, they did not take any further action and another 18 minutes elapsed without any further action to find out why the ambulance had not arrived. This additional delay during the hospital transfer process could reasonably have been avoided, and on this basis, I uphold this complaint.

75. I am satisfied that the Board have taken steps to avoid this situation from occurring again, but consider that this failure also warrants an apology from the Board.

(e) The Board did not deal with Mr and Ms C's complaint in accordance with the complaints procedure

Concerns raised by Mr and Ms C

76. Mr and Ms C have complained that the Board did not respond to their complaint within the specified timescales. They said that the response took months and that, during this time, there were several months where nobody contacted them. Mr and Ms C met with staff from the Board, in response to their complaint, and received a copy of the notes from this meeting. However, they were not happy that these notes were an accurate representation of the meeting and provided their own comments on these notes. The Board responded to these comments. However, Mr and Ms C still felt that some

issues had not been fully investigated and that the Board had not taken the issues sufficiently seriously.

What did happen

77. Mr and Ms C wrote to the Board on 21 November 2013 to complain about what had happened during Ms C's labour. They included a detailed timeline, based on records they had kept at the time. This was acknowledged by the Board on 22 November 2013. They received more details of the complaints procedure and timescales in a letter sent on 4 December 2013. However, they did not hear anything further from the Board, despite several enquiries, until May 2014, when they arranged to meet with clinical staff to review the SIR investigation and report findings (which was prepared in February 2014).

78. Mr and Ms C met with clinical staff on 28 May 2014, to review the SIR, but remained dissatisfied and wrote to the Board on 30 May 2014. The Board responded on 9 June 2014, apologising for the poor complaints handling and noting the significant concerns which remained. They extended the offer for Mr and Ms C to meet with complaints handling staff.

79. Mr and Ms C met with clinical staff and the complaints manager on 25 June 2014, to discuss their complaints in detail. A follow-up letter of 18 July 2014 included notes from the meeting. It was noted that these should accurately reflect the main content of the points which Mr and Ms C raised; the response from staff; and the action plan which was agreed. This letter referred Mr and Ms C on to the SPSO if they had further concerns.

80. On 25 July 2014 Mr C responded to the meeting minutes, by noting his comments and concerns about what was discussed; comments he felt were missing from the notes; and his concerns that the notes were one-sided. He said that he would be bringing his complaint to the SPSO.

81. The Board responded on the same day, and offered to review his complaints further. An email sent on 21 August confirmed that the staff had met to discuss their comments and would provide a final response. On 24 September the Board sent a letter to Mr and Ms C, along with further comments on the meeting notes. The letter acknowledged the lack of detail in the original notes, and the additions to the notes included acknowledgements of failings and apologies for these, as well as a range of other actions to be taken

forward by the Board in relation to service improvements and staff supervision. The letter signposted Mr and Ms C to our office.

What should have happened

82. The Board's Guidance to Staff in Dealing with Complaints (the Guidance) provided detailed information on complaint handling, to supplement the Board's complaints procedure. It noted the requirement to provide a final response letter within 20 working days, or to inform the complainant of why there was a delay and when they could expect a response.

83. In terms of content of this final response, the Guidance noted that this should include clear statements of whether a complaint is upheld or not; a meaningful apology when things have gone wrong; action taken to prevent issues from recurring; and a full explanation of any areas of disagreement. The final response should also signpost complainants to the SPSO if they remained dissatisfied. The Guidance also allowed for staff to clarify any areas of concern which remained, and to give consideration to further points raised by the complainant. This could include re-opening the complaint. Any review of the complaint at this stage should be carried out by a director.

(e) Decision

84. It is clear that the complaints brought by Mr and Ms C were not responded to within the timescales identified in the Guidance. It is unclear why the Board took so long to respond to Mr and Ms C's complaints. The SIR reported in February 2014, yet no significant action was taken to respond to their complaints until late May 2014. There also appeared to have been a lack of coordination between the clinical and complaints teams in their contact with Mr and Ms C and this led to confusing messages about complaints handling.

85. The lack of contact from November to May 2014 caused significant concern, and led Mr and Ms C to conclude that staff were not taking their concerns seriously. Despite more significant efforts to respond to their concerns in June and July, this was too little, too late. I understand that there were reasonable disagreements between the two parties on some elements of the complaint, particularly in relation to the timing of events. I am also aware that the Board did acknowledge significant clinical failings. However, the protracted correspondence around the content of meeting notes did not provide Mr and Ms C with the reassurance they needed that significant failures had been identified and were being addressed.

86. The Guidance allowed for further explanation and information to be given to complainants after the Board's final response. It also potentially allowed the Board to re-investigate a complaint at this stage, if new information came to light. So the Board were well within the remit of the Guidance when they responded to Mr and Ms C's comments on the meeting notes. However, the Board should guard against slipping into protracted correspondence which may not serve to resolve the complaint, and which may further entrench views.

87. I also note that, while Mr and Ms C did receive letters from the Board, the substantive responses to their complaints were in the form of notes from meetings. This did not facilitate an effective response to the serious issues which Mr and Ms C raised. The Guidance indicated the need to provide clear statements on whether a complaint was upheld or not. The meeting minutes did acknowledge failings and identified the need for improvements, but they did not clearly state which complaints the Board had upheld and which they had not. They also included apologies for failings, but these did not meet the requirements in the Guidance for a meaningful apology, which was important in this case.

88. Overall, the Board did not deal with Mr and Ms C's complaints within the timescales or in the manner required by the Guidance and the Board's complaints procedure and, on this basis, I uphold this complaint.

General Recommendation

90.	I recommend that the Board:	*Completion date*
(i)	apologise to Ms and Mr C for the failings identified in this report, and the distress this caused them and Baby C.	30 October 2015

89. The Board have accepted the recommendations and will act on them accordingly. We will follow-up on these recommendations. The Board are asked to inform us of the steps that have been taken to implement these recommendations by the date specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mr and Ms C	the complaints in this case, and parents of Baby C
the Unit	Vale of Leven Community Midwifery Unit
Hospital 1	Vale of Leven District General Hospital
Baby C	Mr and Ms C's baby
the Board	Greater Glasgow and Clyde NHS Board
the Adviser	Midwifery adviser
Hospital 2	Royal Alexandra Hospital
Hospital 3	Princess Royal Maternity Hospital
SIR	Significant Incident Review
the Care Pathways	NHS Quality Improvement Scotland's Pathways for Maternity Care (2009)
the Guidelines	Greater Glasgow and Clyde NHS Board's Obstetric Guidelines
NICE	National Institute for Health and Care Excellence
the Service	The Scottish Ambulance Service
the Guidance	NHS Greater Glasgow and Clyde Guidance to Staff in Dealing with

Annex 2

Glossary of terms

abdominal palpation	an examination of the abdomen by touch
episiotomy	a surgical cut at the opening of the vagina, to aid a difficult delivery and prevent rupture of tissues
incoordinate contractions	when contractions are too weak or ineffective in the first stage of labour
ketones	a measure from a urine test indicating that the patient is low in sugar/carbohydrate
malpresentation	when the baby is in a position which would make it difficult to deliver naturally, including if it were in a posterior position
obstructed labour	when the baby is 'stuck', either due to an obstruction or constriction of the birth passage or due to the condition of the baby
perineum	the area between the anus and the vagina
Syntocinon	a medication which induces stronger contractions

Annex 3

Timeline of events during Ms C's transfer to Hospital 2

Time	Source of information	Action
22:07	Clinical notes (the Unit)	Midwives call for an emergency ambulance
22:09	the Service	Midwives call for an emergency ambulance
22:15	Clinical notes (the Unit)	Midwives call ambulance control again to enquire about ambulance
22:23	the Service	Ambulance crew arrive on site
22:33	Clinical notes (the Unit)	Ambulance crew gain access to the building
22:35	Clinical notes (the Unit)	Ambulance left the Unit with midwife escort
22:41	the Service	Ambulance left the Unit
23:04	the Service	Ambulance arrived at Hospital 2
23:07	Clinical notes (Hospital 2)	Ms C arrived into room at Hospital 2
23:20	Clinical notes (Hospital 2)	Ms C transferred to theatre

Annex 4

List of legislation and policies considered

NHS Quality Improvement Scotland's Pathways for Maternity Care (2009)

NHS Greater Glasgow and Clyde Obstetric Guidelines

National Institute for Health and Care Excellence Guidance on Intrapartum Care (2007)

NHS Greater Glasgow and Clyde Guidance to Staff in Dealing with Complaints