Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against the South Eastern Health and Social Care Trust

NIPSO Reference: 22353

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The Role of the Ombudsman

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities, and on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

The Ombudsman must also consider whether maladministration has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. A remedy may be recommended where injustice is found as a consequence of the failings identified in a report.

Reporting in the Public Interest

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

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Listed Authority: South Eastern Health and Social Care Trust

SUMMARY

This complaint is about the South Eastern Health and Social Care Trust's (the Trust) care and treatment of the complainant during her pregnancy, labour and post-delivery of her son. The complainant raised concerns about the scheduled date of her induction and the treatment provided to her during her induction and labour. She raised further concerns with the obstetrician's treatment of her, and the insertion of a catheter after her son was born.

The investigation examined the details of the complaint, the Trust's response, and both national and local guidelines. It also considered accounts taken from relevant staff, the complainant, and her husband. I sought independent professional advice from a midwife and an obstetrician. The investigation concluded that the date of the induction was scheduled in accordance with relevant guidance, and that the care and treatment provided to the complainant during her induction and first stage of labour was appropriate.

The investigation found that the second stage of the complainant's labour was prolonged due to the obstetrician's attendance in theatre. However, it established that the decision to prioritise the emergency surgery ahead of the complainant was appropriate. The investigation was unable to conclude whether or not the obstetrician reacted appropriately when the complainant expressed pain during suturing. It found that the attending midwives failed to abandon a procedure to insert a catheter when the complainant became distressed. I considered this a failure in the complainant's care and treatment.

I recommended that the Trust apologise to the complainant for the injustice resulting from the failure identified, and that it provide training to relevant staff to improve communication with complainants who become distressed during post-birth procedures.

THE COMPLAINT

1. I received a complaint about the actions of the South Eastern Health and Social Care Trust (Trust). The complainant said that the Trust failed in its care and treatment of her during the late stages of her pregnancy, labour, and in the minutes after giving birth to her son in the Ulster Hospital (UH) in July 2018.

Background

2. The complainant said that she estimated her due date to be 14 July 2018. She said that the UH recorded her estimated date for delivery (EDD) as 16 July 2018 following her ultrasound scan. She said that staff informed her that due to increased capacity, she would not be induced until 28 July 2018 (term +12 days). However, this was further delayed until 29 July 2018. The complainant attended the hospital on 29 July 2018 and returned home following insertion of a pessary[1]. The complainant said she returned to the UH on the morning of 30 July 2018. She was taken to the labour ward at 15:20 to break her waters[2] and to administer an intravenous[3] hormone drip[4] (first stage of labour[5]). The complainant said that the second stage[6] of her labour lasted more than three hours. Her son was born at 05:16 on 31 July 2018 using forceps[7]. The complainant required sutures (stitches) and the midwives inserted a catheter[8]. The complainant and her son returned home on 1 August 2018.

Issues of complaint

3. The issue of complaint accepted for investigation was:

   Issue 1: Whether the care and treatment the Ulster Hospital provided to the complainant in the late stages of her pregnancy, during her labour, and post-delivery of her son in July 2018, was in accordance with good medical practice

[1] A tablet or gel inserted into the vagina to start contractions.
[2] A procedure used to purposefully break the amniotic sac to induce or speed up labour.
[3] Administered directly into a vein.
[4] The drip contains a drug called Syntocinon, which causes the uterus to contract.
[5] The first stage of labour occurs when the expectant mother experiences regular contractions.
[6] The second stage of labour begins when the cervix is completely dilated and ends with the birth of the baby.
[7] An instrument that can be used to assist in the delivery of a baby.
[8] A soft hollow tube passed into the bladder to drain urine.

INVESTIGATION METHODOLOGY

4. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues the complainant raised. This documentation included information relating to the Trust's handling of the complaint. The Investigating Officer also interviewed the complainant, her husband, and the two midwives and staff nurse who provided care to the complainant during her labour and after her son was born.

Independent Professional Advice Sought

5. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisor(s) (IPA):
    - A Registered Midwife, Registered General Nurse, who has worked within antenatal, intrapartum and postnatal settings.
    - A consultant obstetrician with subspecialist accreditation in Foetal and Maternal Medicine.

6. The information and advice that informed the findings and conclusions are included within the body of this report and its appendices. The IPAs provided 'advice'. However, how I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards

7. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those which are specific to the circumstances of the case. I also make reference to relevant regulatory, professional and statutory guidance.

    The general standards are the Ombudsman's Principles[9]:
    - The Principles of Good Administration
    - The Principles of Good Complaints Handling
    - The Public Services Ombudsmen Principles for Remedy

[9] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

8. The specific standards and guidance referred to are those that applied at the time the events occurred. These governed the exercise of the administrative functions and professional judgement of those individuals whose actions are the subject of this complaint.

The specific standards relevant to this complaint are:

- The General Medical Council's (GMC) Good Medical Practice, as updated April 2014 (the GMC Guidance);
- The Nursing and Midwifery Council's (NMC) The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates, March 2015 (the NMC Code);
- The National Institute for Health and Care Excellence's (NICE) Intrapartum care for healthy women and babies, Clinical Guideline 190, December 2014 (NICE CG190);
- The National Institute for Health and Care Excellence's (NICE) Antenatal care for uncomplicated pregnancies, Clinical Guideline CG62, March 2008 (NICE CG62);
- The National Institute for Health and Care Excellence's (NICE) Inducing labour, Clinical Guideline CG70, July 2008 (NICE CG70);
- The National Institute for Health and Care Excellence's (NICE) Antenatal and postnatal mental health, Quality Standard QS115, February 2016 (NICE QS115);
- The Royal College of Obstetricians and Gynaecologists (RCOG) Assisted Vaginal Birth: Green-top Guideline No.26, 2011 (the RCOG's Guideline);
- The South Eastern Health and Social Care Trust's Care of Low Risk Women in Established Labour, March 2016 (the Trust's policy on Low Risk Women in Established Labour);
- The South Eastern Health and Social Care Trust's Guidelines on the Urinary Bladder in Childbearing Women, May 2017 (the Trust's Urinary Bladder guidelines);
- The South Eastern Health and Social Care Trust's Outpatient Induction of Labour (IOL), May 2018 (the Trust's policy on Outpatient

IOL);

- The South Eastern Health and Social Care Trust's Induction of Labour (IOL), March 2016 (the Trust's policy on IOL); and
- The Guidelines and Audit Implementation Network's (GAIN) Northern Ireland Normal Labour and Birth Care Pathway, January 2016 (the GAIN Guidelines).

9. I did not include all of the information obtained in the course of the investigation in this report. However, I am satisfied that I took into account everything that I consider to be relevant and important in reaching my findings.

10. A draft copy of this report was shared with the complainant and the Trust for comment on factual accuracy, and the reasonableness of the findings and recommendations.

INVESTIGATION

Issue 1: Whether the care and treatment the Ulster Hospital provided to the complainant in the late stages of her pregnancy, during her labour, and post-delivery of her son in July 2018, was in accordance with good medical practice.

Detail of Complaint

Induction of labour

11. The complainant said in making the decision to delay her induction, the Trust failed to consider how overdue she was, her mental health, and the increased risk to her son. She said that when she was informed of a potential further delay, she '*begged*' staff to let her attend another hospital but she was refused. The complainant also said that she was not monitored at regular intervals during the induction of her labour (IOL).

First stage labour

12. The complainant said that she informed the midwife at approximately 01:00 of her urge to push. She said that the midwife did not assess her until approximately 45 minutes later.

Second stage of labour

13. The complainant said that the obstetrician only attended to her when she had been pushing for three hours, and when her son's heart rate dipped. She said that she remembers '*pleading with the midwives'*. However, they told her that no doctor was available to provide assistance or to assess her.

Post-delivery

14. The complainant said that she told the obstetrician that she felt the sutures. However, he asked her to '*stick it out'* as it '*would not take much longer'*. She also said that after delivery of her son, midwives inserted a catheter without her consent. The complainant said that a midwife '*shouted*' at her for saying no, and held her down so that the catheter could be inserted. She said that this caused her to become distressed. The complainant said that the experience of her son's birth affected her mental health, and she later attended counselling.

Evidence Considered

Legislation/Policies/Guidance

15. I considered the following policies and guidance:

- The GMC Guidance;
- The NMC Code;
- NICE CG190;
- NICE CG62;
- NICE CG70;
- NICE QS115;
- The RCOG's Guideline;
- The Trust's policy on Low Risk Women in Established Labour;
- The Trust's Urinary Bladder guidelines;
- The Trust's policy on Outpatient IOL;
- The Trust's policy on IOL; and
- The GAIN Guidelines.

The Trust's response to investigation enquiries

Induction of labour

16. The Trust explained that '*induction of labour should be offered at Term, Term+10 and before Term+ 15 days…The induction appointment was made for 28 July 2018 and [the complainant] signed the patient consent form for outpatient induction on that date'.* The Trust explained that *'on the morning of 28 July 2018…staff risk assessed the women on [the] list and prioritised the timing of their inductions according to clinical need. As a result, [the complainant] was deferred to the following morning but was given a priority time slot'*. The Trust explained that the complainant's mental state at the time her induction was postponed would not have increased her priority.

17. The Trust was asked if it considered the complainant's request to be induced at a different hospital. It explained, '*if [the complainant] had requested to change hospital, the Trust would have considered her request but would have advised her to remain within the South Eastern HSC Trust…There would also be the risk of experiencing further delays while a bed and transport would be made available to accommodate this request'.*

18. The Trust explained that '*low risk women, who are inpatients, should have their vital signs and a fetal heart rate[10] [FHR] recording carried out 4 hourly. The midwife did a further check on [the complainant's] baby's heart beat at 11:10am'*. The Trust further explained that '*the next check would have been due at 3.10pm but at 3.20pm [the complainant's] care…was transferred into Labour Ward for further management'*.

19. The Trust explained, *'when [the complainant] was transferred to Labour Ward…the need for…interventions would have increased [the complainant's] risk level. This necessitated 1 to 1 care in Labour Ward, which she received, and continuous fetal monitoring (CTG) [cardiotocography[11]], which was commenced at 3.25pm'.* The Trust further explained that at 11:15pm, *'there was a deceleration in the baby's heartbeat. Care was reviewed by the Sister in Charge and the Syntocinon drip was stopped for a short time to allow the*

[10] The baby's heartrate

[11] Cardiotocography (CTG) is a technical means of recording the fetal heartbeat and the uterine contractions during pregnancy.

heartbeat to recover. By 11:30pm, the heart tracing had normalised and [the complainant's] progress in labour was within normal limits'.

First stage of labour

20. The Trust explained that the complainant was *'assessed at 11:00pm…The plan at that time was to perform the next assessment in 4 hours, which would be at 3:00am…The Gain (2016) guideline on normal labour states that full dilation is confirmed when the vertex is visible on the perineum and that in some circumstance it may be necessary to perform a vaginal examination….the Midwife did not feel that there was an indication to perform a vaginal examination at that time'.*

Second stage of labour

21. The Trust explained that there was *'normal [medical] cover between the hours of 9.00pm and 9.00am'.* It further explained that the complainant commenced active pushing at 02:10 and at 02:40 the baby's head was not yet visible. The Trust explained that at 03:15, '*…the Doctor entered the room to review [the complainant's] progress. He signed the baby's heart tracing and confirmed that the tracing was normal. It is documented in the notes that when pushing…[the] baby's head was visible. This indicated that progress had been made in the second stage of labour'.* The Trust explained that '*it would have been reasonable at this stage not to intervene…and it was too early to determine that [the complainant] would require medical attention'.*

22. The Trust explained that the midwife made a referral to the doctor at 04:10. It said that *'the doctor regrets that he could not attend to [the complainant] sooner but he was busy attending the emergency in theatre'*. The Trust explained that *'the doctor…attended [the complainant] at 5.05am…second stage commenced at 1.55am and was completed at 5.16am which is a total of three hours and twenty one minutes*'.

Post-delivery

23. The Trust explained that the obstetrician administered '*Lidocaine 1%...to numb the area. A total of 20mls was administered, which is the standard amount that is used in this situation'.* It said that this pain relief is *'expected to be effective*

for 40 minutes'. The Trust further explained that the suturing was completed 37 minutes after the anaesthetic was administered.

24. The Trust explained that the obstetrician had '*no recollection regarding the need for further local anaesthetic'.* It said that the obstetrician '*apologises that [the complainant] felt that she received insufficient pain relief during this procedure'*. The Trust was asked if the obstetrician agreed that he used the term, '*stick it out'* when the complainant told him that she was in pain. It said that he had *'no recollection of ever saying that to the complainant'.*

25. The Trust explained that '*a catheter should be inserted following an instrumental delivery for six hours'.* It further explained that Midwife A '*obtained verbal consent to insert a catheter at 5:50am'.* It said that Midwife B said that '*although [the complainant] was distressed, she obtained consent for this procedure. She regrets that [the complainant] feels that this was carried out against her consent and on reflection she wishes she had been more receptive to how [the complainant] was feeling…At the time, the Midwife feels that she was acting in [the complainant's] best interests but she regrets that this has added to distress that she experienced at that time'*.

26. The Trust explained that '*if the catheter is not inserted at the time, it increases the risk of it being delayed for a long period. This could result in [the complainant's] bladder becoming over stretched and damaged resulting in bladder problems in the postnatal period'.*

Relevant records

Trust records

27. A summary of the maternity records considered is enclosed at Appendix five to this report.

Community GP records

28. The records document that in September 2018, the GP offered the complainant counselling via the Afterthought service[12] within the Trust, which she later

[12] This service provides mothers with an opportunity, following their birth experience, to have any questions answered that they may not have previously asked.

attended. The records also document that the complainant attempted to attend counselling in September 2019 within the UH. However, she was unable to attend as she experienced a panic attack as she neared the building.

Interviews

Interview with the complainant

29. The complainant was asked about her experience post-delivery of her son. She explained that when being sutured, she told the obstetrician that she was in pain. She said that the obstetrician did not offer her more anaesthetic or pain relief, but told her he was nearly finished and she should try and '*stick it out'*. The complainant said that she did not ask him again to stop, as she did not want to go against the obstetrician. However, she said that he ought not to have placed her in that position, and he ought to have made the decision to stop.

30. The complainant said that Midwife A called another midwife into the room (Midwife B). She explained that Midwife A asked Midwife B to undertake the procedure. She said that Midwife B told her that she needed the catheter, and she went close to her face and '*shouted*' it at her. The complainant said that she repeatedly said the word '*no*'. She explained that a third person (Staff Nurse) asked her colleagues if they could delay the procedure until the complainant had '*settled*'. However, she said that the midwives '*held her legs down'* and inserted the catheter. The complainant said that she did not understand how it was interpreted that she consented to the procedure.

31. The complainant explained that during this time, she was distressed and she started to hyperventilate. She said that the midwives told her to continue using the Entonox. However, she said that she continued to have a '*panic attack'* and continued saying '*no*'. The complainant questioned why the midwives did not stop the procedure at this stage when she became so distressed. She said it was her view that the midwives did not '*prioritise her as the patient'*.

Interview with the complainant's husband

32. The complainant's husband explained that the complainant started to become distressed during the second stage of her labour when it became apparent that

she needed intervention for her son to be born. He said that his wife remained distressed after the birth of their son including when the obstetrician was suturing. He explained that the complainant told the doctor she could feel '*every stitch'*. He said he could not remember if the doctor responded.

33. The complainant's husband said that the complainant did not consent to the insertion of the catheter. He said she was in pain and could not take any more. He explained that the complainant squeezed his hand, started to cry, and started to have a panic attack. The complainant's husband said that he also became upset. He said that his wife's legs were in stirrups and that the midwives '*could have'* held her legs down. He said it was his view that his wife was forced to have the catheter and that one of the midwives was telling her that she needed it in an '*angry manner'*. However, the complainant's husband was unable to recall if the midwife went close to his wife's face and shouted this at her. When asked if one of the midwives suggested delaying the procedure, he said there was a *'possibility'* it was said.

Interview with Midwife A

34. Midwife A said that she was present when the obstetrician administered 20mls of lidocaine anaesthetic to the complainant. She said she could not recall if the complainant expressed pain when being sutured. She was also asked if she could recall if the obstetrician told the complainant to '*stick it out'* during the procedure. Midwife A said '*not at all'*.

35. Midwife A explained that once he finished suturing, the obstetrician was called to attend another emergency and he asked her to insert the catheter in his absence. She said that she gained consent from the complainant for the procedure. Midwife A said that the complainant was exhausted and sore from a long labour but it was '*no different'* to any other lady going through an induction process. She explained that the complainant asked her if she needed to have the catheter, but she was satisfied that the complainant consented to the procedure.

36. Midwife A explained that she attempted to insert the catheter. However, she had difficulty as the area was tender and swollen. Midwife A said that Midwife B

entered the room and explained to the complainant the need for the catheter. She said that the complainant again provided her consent. Midwife A explained that Midwife B administered Instillagel[13] to ensure the area was numb and inserted the catheter. She said that she did not hear the complainant say 'no', become any more distressed than she was during her labour, or have a panic attack.

37. Midwife A said she did not hear anyone in the room suggest delaying the procedure until the complainant had '*settled*'. She explained that there was no need to stop the procedure, and it would be more painful for the catheter to be inserted later. Midwife A further explained that the complainant would have been at risk of further complications had they not inserted a catheter. Midwife A said she did not witness Midwife B go close to the complainant's face and raise her voice. She said that Midwife B explained the reasons for the catheter when she was approximately one and a half metres away from the bed. Midwife A also denied holding down the complainant's legs while Midwife B inserted the catheter.

Interview with Midwife B

38. Midwife B said that the complainant was '*reluctant*' to have the catheter. She also said that the complainant was distressed and said she could not take anymore. She explained that she took this to mean that the catheter was the '*final straw'* after a long and difficult labour. However, Midwife B said that she explained the reasons for the catheter and the complainant confirmed they could proceed.

39. Midwife B said she did not hear the complainant repeatedly say the word 'no', and did not recognise that she had a panic attack during the procedure. Midwife B explained that the Staff Nurse suggested delaying the procedure because the complainant was distressed. However, Midwife B said that they were unable to wait, and she did not feel there was a need to as the complainant consented to the procedure.

[13] A sterile gel containing a local anaesthetic and antiseptic.

40. Midwife B explained that she was at the end of the bed and she could not recall going close to the complainant's face. She also said that she did not raise her voice. Midwife B said she did not hold the complainant's legs down so she could insert the catheter. She said that she left the room after she inserted the catheter and did not return.

Interview with the Staff Nurse

41. The Staff Nurse explained that she had no recollection of the events that occurred during the complainant's labour. She said that she may have been called away at any time to attend to other patients. The Staff Nurse said that she was unable to recall if the complainant expressed pain at any time when she was sutured, or if the obstetrician made any comment to the complainant.

42. The Staff Nurse said she could not recall if the complainant consented to having a catheter inserted. She explained that she also could not recall if the complainant became distressed at any time, if Midwife B raised her voice to the complainant, or if they held down the complainant's legs when inserting the catheter. The Staff Nurse explained that had she witnessed anything that was outside the standards required as a midwife, she would not have let it go without saying something.

Relevant Independent Professional Advice

Midwife IPA

43. I obtained independent professional advice from a registered midwife (MW IPA). The MW IPA advised that '*the [complainant's] estimated date of delivery (EDD) given was 15 July 2018'*. She further advised that '*the EDD for the [complainant] in accordance with the U/SS [ultrasound] findings was changed and moved back to 1 day later [16 July 2018]'*. The MW IPA referred to NICE CG190 and advised that '*at commencement of the induction of labour I would agree that the [complainant's] pregnancy was 'low – risk 'due to having an uncomplicated pregnancy, and meeting the criteria as defined by NICE [CG190]'*.

Scheduled date for induction of labour

44. The MW IPA advised that '*based upon local guidance and national guidance it was correct to offer the [complainant] an induction of labour date of the 28 July 2018'*. She advised that '*it would not be normal practice at the stage of the induction of labour to reconsider the EDD'*.

45. The MW IPA referred to the acuity of staff for 28 July 2018 and advised that *'it would have been unsafe to commence [the complainant's] induction of labour…therefore it was reasonable to delay the induction of labour'*. She advised that '*the [complainant] was Term+12 and therefore I would not consider that she was high risk'*. The MW IPA reviewed the Trust's acuity records and advised that '*the inpatients all had clinical risk factors and this indicates they were high-risk patients. Therefore it was appropriate to defer the induction of labour until the following day'*.

46. The MW IPA advised that at her booking appointment, the complainant reported that she was no longer taking anxiety medication. She further advised that this '*would have indicated that there were no…concerns about the [complainant's] mental health'*. The MW IPA advised that '*there are no documented records during the antenatal period of care to suggest that there [were] any concerns in regards to the [complainant's] mental health which had been identified during the pregnancy'*.

47. The MW IPA advised that she was unable to locate a note of the call informing the complainant that her induction would be postponed until 29 July 2018. The MW IPA advised that '*the midwife should have taken a written record of this telephone conversation and that the cancellation of the planned induction for the 28 July had occurred*'. She advised that she was unable to comment if the midwife took this action due to the absence of a note of the telephone conversation. The MW IPA further advised that she was also unable to determine if the complainant became upset during the telephone call, or if the midwife considered her mental state.

48. In summary for this element of the complaint, the MW IPA advised that '*the concern…is the lack of documented records. When the induction of labour was*

postponed/cancelled, there should [be] detailed records kept of the rationale for delay of the induction of labour and agreed plan thereafter. At a critical point of care, it is very important that any episodes of contact with the [complainant] either in person or by telephone are recorded and this would be an expected standard of care in accordance with the [NMC Code]'.

Induction of labour

49. The MW IPA advised that '*after term +14 days…all women should be considered as high risk. However at this point the [complainant] was an inpatient and the induction of labour had commenced, and therefore the requirement for additional monitoring was in place'*. The MW IPA advised that '*as the [complainant] was reviewed immediately on attendance to the hospital, and there were no further delays with the admission procedures, this would confirm that the staffing levels at this time were safe'*. The MW IPA advised that '*the fetal monitoring that took place on the induction bay was appropriate and in accordance [with] local guidelines*'.

50. The MW IPA advised that she did '*not consider that the [complainant] should have been offered transfer of care to another hospital. I am in agreement with the hospital…which states this would have been unsafe due to different policies, guidance of care. Importantly there would also be the risk of experiencing further delays while a bed and transport would have [been] made available to accommodate this request*'.

51. The MW IPA advised that '*at the point…the meconium liquor was noted, the FHR was within normal range at 140bpm and therefore there were not any signs of fetal hypoxia, it was therefore appropriate to continue as planned with the labour and no further actions were required'*. The MW IPA further advised that '*continuous electronic fetal monitoring was in progress during the ARM and continued thereafter during the whole duration of the labour. As there were no other concerns about the FHR, it was appropriate for the midwife not to have taken any further action'*.

First stage labour

52. The MW IPA advised that '*when the [complainant] experienced rectal pressure it is likely that this was due to the descent of the baby further into the pelvis which can cause pressure on the rectum. This would not be a diagnosis of the second stage of labour'*. She further advised that the '*approximated time for the [complainant] to have reached the second stage of labour would have been considerably after 01.55 hours'*.

53. The MW IPA advised that '*at 23.00 hours, the [complainant] was examined vaginally and so the next vaginal examination would not have been expected to have been performed until 03.00 hours…At the point of involuntary pushing, it was appropriate to bring forward the planned next examination…any sooner than this time was not warranted'*. The MW IPA advised that as the complainant started to push at 02:10, she does not consider that the complainant waited 45 minutes before she was allowed to do so. The MW IPA advised that '*The first stage of labour was appropriately managed and the [complainant] received care in line with national guidelines'*.

Second stage of labour

54. The MW IPA advised that '*it is documented in the [records] at 02.40 hours the vertex (baby's head) was not yet visible. However, at 03.05 hours it is reported that the vertex was now visible. This indicated that progress had been made in the second stage of labour. It would have been reasonable at this stage not to intervene…as reasonable progress had been made…'* The MW IPA advised that '*after two hours of active second stage, the midwife made a referral to the doctor and this is in accordance with national guidance. I do not consider that earlier intervention was required.'*

55. The MW IPA advised that '*from 03.50 hours until the birth of the baby, the CTG demonstrated early decelerations whereby the FHR was dropping from the baseline which coincided with the uterine contractions. It is recognised early decelerations during the second stage of labour are believed to be caused by fetal head compression and do not indicate fetal hypoxia…I would consider…the CTG was again normal'*. The MW IPA advised that '*the action taken by the midwife was appropriate and was in accordance with national*

standards'. The MW IPA was asked if the complainant asked for a doctor to attend to her during the second stage of labour. She advised that there was no record of a request in the maternity records.

56. The MW IPA advised that '*whilst it [second stage labour] was over 3 hours, appropriate escalation had taken place to the obstetrician to request assistance with expediting the birth. However, due to an emergency taking place, the obstetrician was called away. This resulted [in] the second stage of labour becoming prolonged. I consider that the [complainant] was pushing for the correct duration of the second stage of labour'*. The MW IPA advised that '*baby at birth was born in good condition as demonstrated by the normal Apgar score[14] of 9/10, and so this would indicate that the length of the second stage of labour did not impact upon the wellbeing of the baby'*.

Post-delivery (catheter)

57. The MW IPA advised that '*based upon the evidence-based practice, it was the correct decision to insert a catheter post-delivery…as this was to prevent the [complainant] experiencing covert urinary retention'*. She advised that '*the documented record keeping at 05.50 hours informs that midwife A obtained verbal consent from the [complainant]'*. The MW IPA advised that due to the difficulties experienced, Midwife A requested help from a colleague. She advised that the records document that Midwife B also obtained verbal consent for the procedure.

58. The MW IPA advised that *'the [complainant]…was distressed and verbalised that "she could not take anymore". My professional opinion is that this does indicate that the [complainant] was raising concern to the catheterisation'*. She further advised that '*it would seem that in this case, there was a breakdown in communication between the midwifery staff and the [complainant], and there were differing understandings of the anxieties held by the [complainant] and recognition of this concern. In order for communication to be effective then it must result in a shared understanding of the individual's concerns. In this case, despite explanations and exploring the concerns of the [complainant], a*

[14] A test given to newborn babies soon after birth. This test checks a baby's heart rate, muscle tone, and other signs to see if extra medical care is needed.

miscommunication persisted'. The MW IPA added that '*the midwives' actions should have been to take time to listen to the concerns that the [complainant] was verbalising and abandon the procedure until the [complainant] felt able to commence the procedure again'*.

59. The MW IPA advised that the records do not document that the complainant repeated the word 'no' during the procedure. However, she added, '*I would consider that the [complainant] did not want the catheter to be inserted'*. The MW IPA was asked if this had any impact on the issue of consent. She advised that '*I would consider that this verbal consent occurred and initially the woman agreed with the procedure. Once the procedure became painful for the [complainant] to tolerate, this position changed'*.

60. The MW IPA advised that '*there is no documented record keeping from either of the midwives that informs that the [complainant] experienced a panic attack'*. She also advised that she would '*consider that it was unlikely that the [complainant's] legs were held down as this would represent physical force'*. She was also asked if Midwife B went close to the complainant's face and shouted at her. She advised that '*there is no reference within the statement dated 31 July 2018 that Midwife [B] undertook this act'*.

61. The MW IPA advised that '*I do…consider that the procedure should have been abandoned and adequate analgesia should have been provided to enable the procedure to be* recommenced'. She advised that '*the consequences of this experience could have led to the [complainant] experiencing post-traumatic stress disorder which could potentially have been profound, extensive and unforgettable'*. In relation to learnings from the complaint, the MW IPA advised that '*when women are unable to continue with planned induction of labour, despite clinical need, an escalation meeting must be held involving the multidisciplinary team (MDT) to discuss current workload, priorities and solutions'*.

Obstetrician IPA

62. I also obtained independent professional advice from an obstetrician (OB IPA). The OB IPA advised that the number of doctors on shift for 31 July 2018 was '*usual for this size of unit'*.

Second stage labour

63. The OB IPA advised that the obstetrician entered the room at 03:15 and was '*asked to give an opinion on the CTG, not on any other aspects of her [the complainant's] care'*. He further advised that '…*the doctor signed the CTG, which I interpret as considering no further action was needed'*. The OB IPA advised, '*the notes indicate that [the complainant] had been pushing for around one hour, at 03:05 it is documented "vertex visible with pushes" and at 03:10h "[the complainant] continues to push effectively'*. The OB IPA further advised that '*based on the notes, from the information available at the time, there would be a reasonable expectation that [the complainant] would progress to a normal vaginal delivery without the need for medical intervention'*.

64. The OB IPA advised that '*…the [obstetrician] was first informed of the situation at 04:10h on 31/7/18'* because the complainant '*had been pushing for 2 hours'*. He advised that the obstetrician '*agreed to attend as soon as possible'*. The OB IPA further advised, '*there is nothing I have read in the notes that would suggest that it would have been appropriate for the obstetrician to leave an emergency case in theatre to attend to [the complainant*]'. He advised that '*the obstetrician could have considered asking the co-ordinator to call the on-call consultant. In my opinion it would be unusual to call the consultant in this scenario if there were no fetal concerns. However, that decision has to be individualised based on the clinical picture, the anticipated duration of the emergency, and local policies/guidelines. In addition, taking into account travel time, delivery may not have occurred sooner even if this action had been taken'*.

Post-delivery - anaesthetic

65. The OB IPA advised that '*the doctor administered local anaesthetic at 05:08h'*. He further advised, '*I note from the medical notes that 1% lidocaine was recording [sic] as being used'*. The OB IPA also advised that 20mls of

anaesthetic was administered to the complainant, which was in accordance '*with the relevant NICE guideline [CG190]*'. The OB IPA was referred to the Trust's comment that the anaesthetic ought to have lasted for 40 minutes. He advised that he '*could not find any guideline, book chapter or product information that gave a specific duration of action for lidocaine, and it is likely to have some variation between individuals. However, Lidocaine is considered a "moderate acting" (as opposed to short or long) and I consider the response that the anaesthetic should have lasted for 40 minutes to be appropriate'*.

66. The OB IPA advised '*if a complainant experiences pain, then it is appropriate to stop, in line with the relevant NICE guideline [CG190]*'. He further advised that '*it [is] appropriate to offer a top up of local anaesthetic (as long as the maximum dose has not been reached), targeting the areas that are causing pain'*. The OB IPA advised '*it would also be appropriate to discuss the **option** [his emphasis] of tolerating the pain if the complainant felt able, particularly if the suturing was close to completion'*. He advised that 'topping up' the anaesthetic '*would depend on the pain perceived by [the complainant] during suturing'*. He advised that it is not possible to tell from the clinical notes whether the complainant expressed she was in pain. He added that '*it would be in line with established good practice to check that a complainant did not require more pain relief*'.

Post-delivery - catheter

67. The OB IPA advised, '*I cannot see any documentation on the medical record of delivery or suturing…that catheter insertion was requested'*. He further advised '*it would be appropriate for the obstetrician to document the requirement for catheter placement, and instructions for removal'*.

68. The OB IPA advised that '*based on the documentation reviewed, there are areas where record-keeping could have been improved…I have not identified any other failings in the care provided to [the complainant]*'. He added that '*the Trust may wish to review their delivery/repair documentation to include adequacy of pain relief, and catheter placement/instructions'*.

The complainant's response to the draft report

69. In her response, the complainant said that from her first medical appointment, her EDD was confirmed as 14 July 2018. This was due to her having a shorter than normal menstrual cycle. The complainant said that she was not aware that her maternity records documented her EDD as 15 July 2018.

70. The complainant said she did not agree that her son was born *'in good condition'*. She said that he had '*severe bruising, grazing, swelling and burst veins around his eyes'*. She also said that her son regularly attends an orthoptist[15], and an ear, nose and throat (ENT) doctor, who informed her that his health concerns '*could be linked to his birth'*.

71. In relation to the procedure to insert the catheter, the complainant said that while the records documented her verbal consent, '*she never consented to it at any stage'*.

The Trust's response to the draft report

72. In relation to the decision to postpone the complainant's induction, the Trust explained that this '*will involve a discussion with the Consultant on Call for Labour Ward, Labour Ward Sister and the Midwife allocated to work in the induction of labour bay. While the Midwife generally will make the phone call, the Consultant on Call is the individual who will make the overarching decision'*. The Trust explained that the midwife who informed the complainant of the delay was unable to document their telephone conversation in the maternity records as they were in the complainant's possession. However, it further explained that '*staff will review the telephone log book…and improve how any delays of elective care is recorded in the absence of the maternity record'*. The Trust explained that on the day of her induction, the complainant was admitted at 05:50. It said that '*it would be very unusual to admit a woman for induction at that time and this demonstrates that the staff had prioritised [the complainant's] admission on the following day'*.

[15] Orthoptists are the experts in diagnosing and treating defects in eye movement and problems with how the eyes work together.

73. In relation to the second stage of the complainant's labour, the Trust referred to the Registrar Obstetrician's decision not to request the on-call Consultant to attend in his absence. It explained that '*staff agree it would be reasonable to document in the maternity record the reasons why the Consultant was not requested to attend'*.

74. The Trust referred to the Registrar Obstetrician's failure to document whether the complainant reported if the anaesthetic and/or pain relief was adequate during the suturing procedure. It explained that '*staff agree that a review of the…instrument delivery record and training for suturing is required to ensure medical/ midwifery staff clarify with the woman that the pain relief received is adequate during the whole procedure'*.

75. The Trust explained that during the second stage of labour, the complainant '*was using her Remifentanil PCA[16] [patient controlled analgesia] for analgesia'.* It also explained that prior to the insertion of the catheter, the complainant was administered additional analgesia in the form of '*Entonox, intravenous Paracetamol, and a Diclofenac suppository'*. It said that Midwife B '*acknowledged that [the complainant] was distressed. It was for that reason Instillagell was administered to numb the area and [the complainant] was encouraged to breathe Entonox during the procedure'.* The Trust explained that *'staff accept that the catheter could have been inserted at a time that was acceptable to [the complainant]. There was a concern at the time that a delay may have resulted in damage to the bladder'*.

76. Midwife B also provided a response to the draft report. She explained that she *'was concerned at the time that a delay may cause damage to her [the complainant's] bladder. In addition, catheterisation was difficult due to trauma close to the urethra and it was important to determine the extent of this trauma. This meant that the area may have been more sensitive hence Instillagel was used to numb the area. I regret that this experience may have caused [the complainant] undue distress'*.

[16] A method of pain relief that is often used during labour.

Analysis and Findings

The scheduled date for induction of labour

77. I note that the complainant calculated her EDD to be 14 July 2018. However, her maternity records document her EDD to be 15 July 2018, which was based on her last monthly period (LMP). This was put back one day to 16 July 2018 following her anomaly scan in March 2018. I consider that this action was in accordance with the Trust's IOL Policy relevant at that time. While I note that the complainant calculated her EDD to be 14 July 2018, I consider that it was appropriate for the Trust to consider the revised EDD (16 July 2018) when scheduling the complainant's date for induction. I considered the Trust's IOL Policy and NICE CG70. I note that both sets of guidance state that IOL ought to occur before term+15 days. Therefore, I accept the MW IPA's advice that '*it was correct to offer the [complainant] an induction of labour date of the 28 July* 2018 *[term+12 days]*'. I consider that the date scheduled for IOL was in accordance with relevant guidance.

78. I note that the complainant's induction was postponed due to increased capacity in the ward. Having reviewed the relevant records for 28 July 2018, I accept the MW IPA's advice that *'it would have been unsafe to commence [the complainant's] induction of labour'* on that date. I note that the complainant was term+13 on 29 July 2018. Therefore, the rescheduled date was still within the period for induction allowed for by the Trust's IOL Policy and NICE CG70. I accept the MW IPA's advice that '*it was appropriate to defer the induction of labour until the following day'*. I consider that the care and treatment provided to the complainant was appropriate and in accordance with relevant guidelines. I do not uphold this element of the complaint. However, this is not to diminish the complainant's real concern, who for good reason wanted an earlier IOL.

79. The complainant said that the Trust failed to consider her mental health when it made the decision to delay her induction. I note that the complainant said that she became upset when the Trust informed her that her induction would be delayed. The records do not contain a note of this phone call. In the absence of this record, I am unable to determine what information the Trust obtained from the complainant, and what consideration it gave to this or to her mental health. I

am also unable to determine if the Trust explained the rationale for its decision to delay the induction, or if the complainant agreed with the plan of care.

80. It is clear from my consideration that the complainant had deeply held concerns about how far she was passed her due date, and that this ought to have been identified by those looking after her. I accepted that the IOL was scheduled in accordance with standards, and I note that the Trust demonstrated that it prioritised the complainant by asking her to attend earlier than usual that morning. However, this does not mean that I do not consider that staff should have done all they could to reassure the complainant and sought, if possible, to meet her requests. The absence of this record makes it difficult to determine if this was the approach staff who contacted the complainant took. While I accept that the midwife did not have access to the complainant's maternity records at the time, I would have expected her to record a note of the phone call elsewhere, and for it to be retained centrally. I consider the absence of this record a service failure. I note that in response to a draft copy of this report, the Trust said that in future '*staff will review the telephone log book…and improve how any delays of elective care is recorded in the absence of the maternity record'*. I welcome this learning.

Induction of labour

81. The complainant said that upon hearing of a potential delay of her progression to the labour ward, she requested a transfer to a different hospital. However, her request was refused. I note that this request is not documented in the complainant's clinical records. Therefore, I am unable to conclude whether or not she made this request. Nevertheless, I accept the MW IPA's advice that a transfer would likely have resulted in the '*risk of experiencing further delays while a bed and transport would have been made available to accommodate this request'*.

82. The complainant also said that she was not monitored at regular intervals during her induction of labour and that the midwives were too busy to speak with her. I note that there was one midwife on duty in the induction ward on the morning of 30 July 2018, which was normal for the ward. I also note the MW IPA's advice that *'as the [complainant] was reviewed immediately on*

attendance to the hospital, and there were no further delays with the admission procedures, this would confirm that the staffing levels at this time were safe'.

83. I note that paragraph 20.4 of the Trust's Policy for IOL states that if transfer to the labour ward is not immediately possible, '*a CTG should be performed to assess fetal wellbeing every 4 hours'*. I note from the records that the baby's heartrate was monitored at 06.55 until 08:15, and again at 11:10. I accept the MW IPA's advice that *'the fetal monitoring that took place on the induction bay was appropriate and in accordance [with] local guidelines'.*

84. I note that an artificial rupture of the membranes (ARM) at 15:25 detected light meconium. The records document that a CTG was commenced soon afterwards. I note the MW IPA's advice that a CTG '*was in progress during the ARM and continued thereafter during the whole duration of the labour. As there were no other concerns about the FHR, it was appropriate for the midwife not to have taken any further action'*. I accept this advice and consider that the complainant was monitored appropriately during the induction of her labour. I consider that the care and treatment provided to the complainant during the induction of her labour was appropriate and in accordance with relevant guidelines. I do not uphold this element of the complaint. However, I consider that there is learning in the complainant's experience that the Trust should consider in order to assist with improving the experience of expectant mothers.

First stage of labour

85. The complainant said that she informed the midwife at approximately 01:00 of her urge to push (onset of second stage labour). However, the midwife did not assess her until approximately 45 minutes later. NICE CG190 states that the active second stage of labour is identified as '*expulsive contractions with a finding of full dilatation of the cervix or other signs of full dilatation of the cervix, [or] active maternal effort following confirmation of full dilatation of the cervix in the absence of expulsive contractions'*. I note that the complainant experienced rectal pressure with her contractions from 01:10. I accept the MW IPA's advice that '*this would not be a diagnosis of the second stage of labour'*. There is no indication in the notes that the complainant was involuntarily pushing or experiencing expulsive contractions at that time. While I understand the

complainant's concerns, and better communication at the time may have alleviated these concerns, on balance, I consider that there was no indication at that time to examine the complainant.

86. The records document that the complainant started to push involuntarily at 01:50, and an examination was undertaken. I note active pushing commenced at 02:10. Therefore, I do not consider that there was a period of 45 minutes between the complainant entering the second stage, and when she was instructed to push. However, I accept that as the complainant felt she was ready to push earlier, she would have perceived this period to have lasted longer than recorded. I consider that the care and treatment provided to the complainant during the first stage of her labour was appropriate and in accordance with relevant guidelines. While I do not uphold this element of the complaint, as I have indicated above, better communication with the complainant to explain the situation would have been beneficial and may have helped to alleviate her concerns.

Second stage of labour

87. The complainant said that it was 'obvious' that she required medical intervention after one hour of active pushing, and that the obstetrician briefly entered the room at this stage but did not assess her. I referred to NICE CG190, which states, '*suspect delay if progress (in terms of rotation and/or descent of the presenting part) is inadequate after 1 hour of active second stage'*. The maternity records document at 02:40, '*nothing visible…in terms of vertex'*. They document at 03:05, '*vertex visible with maternal pushes'*. As progress '*in terms of…the presenting part'* was made one hour after the start of the second stage, I accept the OB IPA's advice that '*there would be a reasonable expectation that [the complainant] would progress to a normal vaginal delivery without the need for medical intervention'*. Therefore, I do not consider there was a need for the obstetrician to assess the complainant when he entered the room at 03:15.

88. The complainant said that during the second stage of her labour, she pleaded with the midwives for the obstetrician to attend, but to no avail. She said that the obstetrician only attended after three hours of active pushing, and after her

son's heartrate dipped. NICE CG190 states, '*diagnose delay in the active second stage when it has lasted 2 hours and refer the woman to a healthcare professional…*' I note that the maternity records document at 04:10, '*Has been actively pushing for 2 hours… [obstetrician] currently in theatre – aware of situation – will attend asap'*. I accept the MW IPA's advice that '*the action taken by the midwife was appropriate'*. I consider that the midwifery staff acted in accordance with NICE CG190, and that the subsequent delay experienced was out-with their control.

89. I note that despite the referral to the obstetrician at 04:10, he did not attend until 05:05. The records document that by the time her son was born, the complainant was actively pushing for three hours 21 minutes. I note that this is outside the time NICE CG190 recommends for the second stage (three hours). The records document that the obstetrician was delayed due to his attendance at an emergency in theatre. I note the OB IPA's advice that '*there is nothing I have read in the notes that would suggest that it would have been appropriate for the obstetrician to leave an emergency case in theatre to attend to [the complainant*]'. I accept this advice. I have no reason to doubt that the obstetrician would have attended the complainant earlier had he not been attending to an emergency in theatre.

90. I also note the MW IPA's advice that '*the length of the second stage of labour did not impact upon the wellbeing of the baby'*. I note that the complainant disagreed with this view. However, I note that the MW IPA based her advice on the Apgar score documented in the records. Furthermore, there is no evidence within the records that would lead the MW IPA to conclude that the delay in the second stage is in any way linked to the complainant's son's later health concerns. Based on the evidence available, I consider that the care and treatment provided to the complainant during the second stage of her labour was appropriate. While there was a delay in the attendance of the obstetrician, this appears to have been based on clinical prioritisation and therefore was appropriate. I appreciate that by the time the obstetrician attended to her, the complainant had endured a long and difficult labour. I also appreciate that as time progressed without medical intervention, it would likely have caused the

complainant concern. While I do not uphold this element of the complaint, it does not diminish the concern the complainant experienced while she awaited medical intervention.

91. I note that the records do not document that staff made an effort to contact the on-call Consultant while the obstetrician was in theatre. I accept the OB IPA's advice that '*the obstetrician could have considered asking the co-ordinator to call the on-call consultant…taking into account travel time, delivery may not have occurred sooner even if this action had been taken'*. However, there is no evidence within the records to suggest that the obstetrician considered this option, or that he documented his rationale for not contacting the on-call Consultant. I would have expected that due to the length of delay in attending to the complainant, and that it resulted in the second stage continuing for more than the expected three hour period, the obstetrician ought to have recorded the rationale for this decision. I consider the absence of this record a service failure. I note that in its response to a draft copy of this report, the Trust agreed that it was reasonable to document the rationale for this decision.

Post-delivery – anaesthetic

92. The complainant said that when the obstetrician was suturing, she could '*feel every stitch'*. I note from the records that the obstetrician administered 20mls of 1% lidocaine at 05:08, which is in accordance with NICE CG190. I note that the Trust explained that the anaesthetic ought to have lasted for 40 minutes. However, the OB IPA advised that he was unable to find reference to this timeline in any guidance. I also note the OB IPA's advice that although this was a reasonable estimation, the effect of the anaesthetic can vary. Therefore, I do not consider it reasonable for the Trust to assume that the anaesthetic would still have been effective when the obstetrician finished suturing after 37 minutes.

93. The complainant said that she informed the obstetrician that she was in pain. She also said that in response to her concerns, the obstetrician told her to '*stick it out'* and that it would '*not take much longer'*. NICE CG190 states that if a woman reports inadequate pain relief, it ought to be addressed immediately. To have continued suturing in circumstances where a patient was complaining of

pain, and did not agree to the continuation without further administration of anaesthetic or pain relief, would in my view be concerning. However, there is nothing within the maternity or medical records to suggest that the complainant reported these concerns to the obstetrician. I note that both the complainant and her husband said that she informed the doctor that she was in pain. However, the staff present at the time could not recall whether or not the complainant raised this concern at the time. Furthermore, those present in the room could not recall the obstetrician making the comments stated above. I have no reason to doubt the complainant's account. However, on the balance of probabilities, I cannot conclude that the complainant informed the obstetrician that she was in pain or that he responded in the way she reported.

94. In relation to the records for this procedure, I note that the OB IPA advised, '*It would not be standard practice to record such checks specifically within the notes'*. However, I note that the records also fail to document that the anaesthetic and/or pain relief administered was effective for the duration of the procedure. I refer the Trust to the OB IPA's advice to '*review their delivery/repair documentation to include adequacy of pain relief…'* and ask it to consider recording this information for future similar procedures.

Post-delivery – catheter

95. The complainant said that after her son was delivered, the midwives inserted a catheter without her consent. I accept that there was a clinical reason for the insertion of the catheter, and note that the obstetrician asked Midwife A to conduct the procedure. I note that both Midwife A and Midwife B said that they obtained oral consent from the complainant prior to insertion, and the maternity records support their verbal accounts. However, the complainant and her husband disagreed with the records and maintain that she did not consent to the procedure. I acknowledge the conflict in views regarding this issue. In the absence of any additional evidence to support either view, I am unable to conclude whether or not the complainant consented to the procedure to insert a catheter after her son was born. I acknowledge that it is not appropriate for staff to obtain written consent for such procedures. However, I wish to stress the

importance of staff being sure that clear verbal consent is obtained before proceeding.

96. The complainant said that she became distressed and repeatedly said the word 'no' during the procedure. She also said that she had a panic attack and that her husband became upset. While the evidence does not substantiate the complainant's full account, I am satisfied that there is sufficient evidence to suggest that the complainant raised concerns about the procedure, and became distressed. I note the MW IPA's advice that when the complainant became distressed, the procedure '*should have been abandoned and adequate analgesia should have been provided to enable the procedure to be recommenced'*. I note that in response to a draft copy of this report, the Trust explained that the midwives already administered analgesia prior to the procedure. However, I consider that had the procedure been abandoned, it is likely that further analgesia would have been required at a later time so that it could be recommenced.

97. I note that the Trust explained that Midwife B recognised the complainant's distress and it was for this reason that she administered further pain relief including Instillagel. However, despite her recognition, it is clear that the midwives failed to abandon the procedure to allow the complainant to recover from her distress. While I acknowledge the reasons why the midwives felt it necessary to continue the procedure, I do not consider that they responded appropriately to the situation. I am satisfied that the midwives' actions were not in accordance with good midwifery practice as outlined in the NMC Code. I consider that this represents a failure in the complainant's care and treatment. I uphold this element of the complaint.

98. The complainant also raised concerns that Midwife B 'shouted' at her and that the midwives held her legs down so they could insert the catheter. I note that these actions are not documented in the maternity records. I also note that no other person present in the room at the time substantiated the complainant's account. Therefore, on the balance of probabilities, I cannot conclude that Midwife B shouted at the complainant, or that any of the midwives held her legs down. Such practices, if they were to have occurred, would have been

extremely distressing for the complainant who had just been through a traumatic birth and clearly would not be acceptable.

Summary of findings

99. Although I have not upheld all of the complainant's concerns, I identified that midwifery staff failed to respond appropriately when she became distressed during the procedure to insert a catheter post-delivery of her son. I note the MW IPA's advice that the experience '*could have led to the [complainant] experiencing post-traumatic stress disorder which could potentially have been profound, extensive and unforgettable'.* I also note that the complainant's community GP reported that she attended counselling after the event. It is clear from my review of the records that the complainant found the delay in her IOL stressful and the labour difficult. It is also clear that the slow progress of her labour, the delay in the obstetrician attending, the suturing, and insertion of a catheter post-delivery added to her stress. While I cannot be certain that the failure I identified was the sole cause of the complainant's need for support post discharge, I am satisfied that the failure caused the complainant to experience the injustice of distress.

CONCLUSION

100. I received a complaint about the Trust's care and treatment of the complainant during her pregnancy, labour and post-delivery of her son. The complainant said that the Trust failed to consider the increased risks to her and her son when arranging the date for her induction. She also raised concerns with the Trust's care and treatment of her during the first two stages of her labour. The complainant raised further concerns with the obstetrician's treatment of her, and the midwives' actions when inserting a catheter after her son was born.

101. My investigation established that the date for the complainant's induction was arranged in accordance with relevant guidelines. It also established that the decision to postpone the induction date for one day was appropriate. My investigation did not establish if the Trust considered the complainant's mental health when rescheduling her induction. This was due to the lack of a record of the midwife's telephone conversation with the complainant. I consider this a service failure.

102. My investigation established that the care and treatment provided to the complainant during her induction and first stage of her labour in the UH was appropriate and in accordance with relevant guidelines. It also identified that the midwives appropriately referred the delay of the second stage to the obstetrician. The investigation established that although it resulted in a delay in the obstetrician's attendance to the complainant, it was appropriate for him to prioritise the emergency surgery ahead of the complainant. However, it identified that the rationale for the decision not to refer the matter to the on-call Consultant obstetrician was not recorded. I consider this a service failure. I was unable to conclude if the complainant informed the obstetrician that she was in pain during suturing, or if he told the complainant to '*stick it out'*, due to insufficient evidence.

103. The investigation found that the midwives failed to respond appropriately when the complainant raised concerns and became distressed during a procedure to insert a catheter. I am satisfied that this represents a failure in the complainant's care and treatment. I consider that this failure caused the complainant to experience the injustice of distress.

Recommendations

104. I recommend that the Trust provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016) within **one month** of the date of this report, for the injustice caused as a result of the failure identified.

105. I also recommend that the Trust discusses the findings of this report with the staff involved in the complainant's care within **one month** of the date of this report. Furthermore, I recommend that the issues identified within this report ought to be raised with the midwives and the obstetrician involved in the complainant's care at their next staff appraisal.

106. I further recommend that the Trust implements an action plan to incorporate the following recommendation and should provide me with an update within **three months** of the date of my final report. That action plan is to be supported by

evidence to confirm that appropriate action has been taken (including, where appropriate, records of any relevant meetings) to:

i. Provide training to relevant staff to improve communication with complainants who become distressed during post-birth procedures. The content of the training ought to be in accordance with the NMC Code.

MARGARET KELLY
Ombudsman **February 2021**

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and with regard for the rights of those concerned.
- Acting in accordance with the public body's policy and guidance (published or internal).
- Taking proper account of established good practice.
- Providing effective services, using appropriately trained and competent staff.
- Taking reasonable decisions, based on all relevant considerations.

2. Being customer focused

- Ensuring people can access services easily.
- Informing customers what they can expect and what the public body expects of them.
- Keeping to its commitments, including any published service standards.
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances
- Responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

3. Being open and accountable

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately.
- Keeping proper and appropriate records.
- Taking responsibility for its actions.

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.
- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Putting mistakes right quickly and effectively.
- Providing clear and timely information on how and when to appeal or complain.
- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

6. Seeking continuous improvement

- Reviewing policies and procedures regularly to ensure they are effective.
- Asking for feedback and using it to improve services and performance.
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.

Appendix 2

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

Getting it right

- Acting in accordance with the law and relevant guidance, and with regard for the rights of those concerned.
- Ensuring that those at the top of the public body provide leadership to support good complaint management and develop an organisational culture that values complaints.
- Having clear governance arrangements, which set out roles and responsibilities, and ensure lessons are learnt from complaints.
- Including complaint management as an integral part of service design.
- Ensuring that staff are equipped and empowered to act decisively to resolve complaints.
- Focusing on the outcomes for the complainant and the public body.
- Signposting to the next stage of the complaints procedure, in the right way and at the right time.

Being Customer focused

- Having clear and simple procedures.
- Ensuring that complainants can easily access the service dealing with complaints, and informing them about advice and advocacy services where appropriate.
- Dealing with complainants promptly and sensitively, bearing in mind their individual circumstances.
- Listening to complainants to understand the complaint and the outcome they are seeking.
- Responding flexibly, including co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

Being open and accountable

- Publishing clear, accurate and complete information about how to complain, and how and when to take complaints further.
- Publishing service standards for handling complaints.

- Providing honest, evidence-based explanations and giving reasons for decisions.
- Keeping full and accurate records.

Acting fairly and proportionately

- Treating the complainant impartially, and without unlawful discrimination or prejudice.
- Ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.
- Ensuring that decisions are proportionate, appropriate and fair.
- Ensuring that complaints are reviewed by someone not involved in the events leading to the complaint.
- Acting fairly towards staff complained about as well as towards complainants.

Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Providing prompt, appropriate and proportionate remedies.
- Considering all the relevant factors of the case when offering remedies.
- Taking account of any injustice or hardship that results from pursuing the complaint as well as from the original dispute.

Seeking continuous improvement

- Using all feedback and the lessons learnt from complaints to improve service design and delivery.
- Having systems in place to record, analyse and report on the learning from complaints.
- Regularly reviewing the lessons to be learnt from complaints.
- Where appropriate, telling the complainant about the lessons learnt and changes made to services, guidance or policy.