



Northern Ireland

Public Services

Ombudsman

Investigation of a complaint against Belfast Health and Social Care Trust

Report Reference: 202002501

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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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Case Reference: 202002501

Listed Authority: Belfast Health and Social Care Trust

SUMMARY

This complaint is about the Belfast Health and Social Care Trust's (the Trust) care and treatment of the complainant during the induction of labour, labour and delivery of her baby between 1 and 2 September 2010.

The complainant was admitted to the Royal Victoria Hospital (RVH) at 08:45 on 1 September 2010 for a planned Induction of Labour¹ (IOL). The Trust initiated this process at 09:15 with the baby's birth at 00:54 on 2 September 2010. The complainant delivered her baby naturally. During the complainant's labour and delivery process, the Trust administered an epidural and performed an episiotomy.

The complainant said, on 1 September 2010, the Trust informed her that the baby was in a transverse position, which she understood requires a caesarean section; however, the Trust continued with the standard delivery process. The complainant also said the Trust did not inform her about the procedures involved and the potential risks, particularly in relation to an epidural; therefore, she could not give informed consent. The complainant said the Trust did not manage the labour process and its actions were *'neglect[ful]'* and put her and her baby at risk.

The investigation established there were several failings in the complainant's care and treatment related to one of the five elements of the complaint.

The investigation found the Trust failed to record discussions with the complainant, in line with national and local standards, both about the induction of labour process and the progress of her labour. I concluded, because of these failures in care and treatment, the complainant sustained the injustice of the loss of opportunity to be assured she was given complete information about the induction process and the progress of her labour.

¹ Induction of Labour is when a hospital attempts to start labour artificially using a tablet (pessary), gel or other medicines.

The investigation also found maladministration as the Trust did not act in line with the first Principle of Good Administration because it did not update its own guidance in line with national guidance.

I recommended the Trust provide the complainant with a written apology for the injustice caused by the failure in care and treatment. I made further recommendations for the Trust to address under an evidence-supported action plan to instigate service improvement and to prevent further reoccurrence of the failings identified.

I recognise the complainant found her experience distressing. I hope, however, this report provides her with reassurance about her baby's position when labour was induced and the associated decisions about the method of the baby's delivery; how the Trust managed her labour; the epidural consent process; and the Trust's monitoring of the baby throughout the process.

THE COMPLAINT

1. This complaint concerned the actions of the Belfast Health and Social Care Trust (the Trust). This related to the care and treatment provided to the complainant during labour and delivery of her baby from 1 to 2 September 2010.
2. Although the complaint relates to care and treatment provided more than ten years before the investigation, I accepted this complaint for investigation in accordance with the Public Services Ombudsman Act (Northern Ireland) 2016 (NIPSO legislation), Section 26 (2) which states, '*where the complaints handling procedure has been exhausted, the complaint must be made to the Ombudsman within 6 months' of the completion of the body's complaints process*'. The complainant submitted her complaint to the Trust on 18 June 2019, with the Trust's final response and referral to this office on 20 March 2020. The complainant therefore submitted her complaint to this office within the parameters set out in the NIPSO legislation.

Issues of complaint

3. I accepted the following issue of complaint for investigation:
Whether the care and treatment provided to the complainant by the Trust from 1 to 2 September 2010 was appropriate and reasonable and in accordance with relevant standards and guidance.

INVESTIGATION METHODOLOGY

4. To investigate this complaint, the Investigating Officer obtained all relevant documentation from the Trust, together with its comments on the issues the complainant raised. This documentation included information relating to the Trust's complaints process.

Independent Professional Advice Sought

5. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisors (IPA):

- A Midwife (RM RN BSc (Hons) PgCert MA); with more than 27 years' experience; a practising midwife and presently Assistant Director Clinical Quality NHS; previously Regional Maternity Lead with detailed knowledge of contemporary issues relating to midwifery practise and who undertakes 150 hours of clinical practice each year at a local Maternity unit, working in all areas of the service; and
- A Consultant Anaesthetist (MBBS, MD, FRCA, LLM (Medical Law and Ethics)); with more than 19 years' experience as a Consultant Anaesthetist, with specialism in Obstetric Anaesthesia; Clinical Lead for Obstetric Anaesthesia in a large maternity unit for five years.

I enclose the Midwife's (MW IPA) professional advice at Appendices three and four to this report.

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

Relevant Standards and Guidance

7. To investigate complaints, I must establish a clear understanding of the standards, both of general application and of those specific to the circumstances of the case. I also refer to relevant regulatory, professional, and statutory guidance.

The general standards are the Ombudsman's Principles²:

- The Principles of Good Administration.
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.

² These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

The specific standards and guidance relevant to this complaint are:

- The National Institute for Health and Care Excellence (NICE): NICE Clinical Guidance 62 Antenatal care, 2008 (NICE Antenatal Care Guidance);
 - The National Institute for Health and Care Excellence (NICE): NICE Clinical Guidance 70 Inducing labour, 2008, (NICE Inducing Labour Guidance);
 - The National Institute for Health and Care Excellence (NICE): NICE Clinical Guidance 55 Intrapartum Care, Care of Healthy Women and Their Babies During Childbirth, 2007 (NICE Intrapartum Care Guidance);
 - The Nursing and Midwifery Council Midwives Rules and Standards, 2004 (NMC MW Standards);
 - The National Institute for Health and Care Excellence (NICE): NICE Clinical Guidance 37 Postnatal Care up to 8 Weeks After Birth, 2006 (NICE Postnatal Care Guidance); and
 - The Belfast Health and Social Care Trust's Royal Jubilee Maternity Service Guidelines for Induction of Labour, 2002 (Trust Induction of Labour Guidance).
9. I did not include all information obtained during the investigation in this report. However, everything relevant to the investigation has been considered in reaching my findings.
10. I shared a draft copy of this report with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations.

THE INVESTIGATION

Detail of Complaint

11. **Whether the care and treatment provided to the complainant by the Trust from 1 to 2 September 2010 was appropriate and reasonable and in accordance with relevant standards and guidance.**

In particular, this considered:

- i. Management of the complainant's labour;
- ii. The position of the baby at induction and during labour on 1-2 September, including what information was provided to the complainant about this at that time;
- iii. The information provided to the complainant about the consequences of the induction process;
- iv. The epidural consent process, including the risks and efficacy of an epidural for the complainant; and
- v. Monitoring of the baby during this period.

12. The complaint included five main elements, as noted above. I addressed each of these elements separately in the report.

Trust's response to investigation enquiries

13. As part of investigation enquiries, the Trust had an opportunity to respond to the complaint.

(i) Management of the complainant's labour

14. The complainant said she had a *'fast scan'* in the labour ward before the Trust transferred her to the delivery suite. The complainant said the presence of two midwives indicated there were issues with the labour and delivery. She also said, *'at no point during labour was she 'content''* but rather she *'was distressed, confused and in agony'*. The complainant said she considered the Trust's failures during her labour *'amount to a neglect in her and her baby's care and that these failures put her and her baby at risk.'*

Evidence Considered

Legislation/Policies/Guidance

15. I considered the NICE Inducing Labour Guidance; the NICE Intrapartum Care Guidance; and the NMC MW Standards.

Relevant Trust Records

16. I reviewed the complainant's medical records for 1 to 2 September 2010.

Relevant Independent Professional Advice

Midwife Advice (MW IPA)

17. The MW IPA provided advice about the complainant's care in the early stages of labour from the initiation of IOL until transfer to the labour ward. This advice is summarised in paragraph 18 below.
18. At 09:15, following a vaginal examination, the complainant's induction of labour (IOL) began. The Trust midwives appropriately employed Cardiotocography³ (CTG) to monitor the labour progress. The CTG records the frequency of contractions. It does not measure the strength of the contractions. At 10:15, a Trust midwife offered the complainant a TENS⁴ machine to help her pain, which the complainant accepted. At 11:00, the complainant requested pain relief and a Trust midwife gave her Pethidine⁵ which takes 20 to 30 minutes to take effect, with each injection lasting two to four hours. Side-effects from this medication include '*wooziness, sickness and forgetfulness*'. Further, many women sleep intermittently after Pethidine, and it may not completely eliminate the pain from contractions. A Trust midwife also gave the complainant anti-sickness medication. At 12:10, the contractions caused the complainant distress; however, records indicate she continued to cope. A Trust midwife performed both an abdominal palpation and vaginal examination to reassure

³ Cardiotocography is a continuous recording of the foetal heart rate obtained via an ultrasound transducer placed on the mother's abdomen. It is widely used in pregnancy as a method of assessing foetal well-being.

⁴ TENS: Transcutaneous Electrical Nerve Stimulation is a method of pain relief involving the use of a mild electrical current. A TENS machine is a small, battery-operated device that has leads connected to sticky pads called electrodes. The pads are attached directly to the skin (the lower back for relief during early labour) and when the machine is switched on, small electrical impulses are delivered to the affected area of the body, which is felt as a tingling sensation. The electrical impulses can reduce the pain signals going to the spinal cord and brain, which may help relieve pain and relax muscles.

⁵ Pethidine: an opioid given as an intramuscular injection to relieve pain and help women relax and is often used during labour.

the complainant but she remained distressed. Therefore, at a Trust midwife's request, a doctor reviewed the complainant. The subsequent plan included administration of medication designed to stop hyperstimulation of the uterus, which can be a side-effect of the gel used to induce labour. Following administration of this medication, contractions settled to a regular 4:10 minutes. The Trust then transferred the complainant to 'Room five'. The Trust performed an ultrasound scan⁶ (USS) to check the baby's heart. Element (v) below includes more detail about the Trust's monitoring of the baby. Following the USS, the Trust arranged for the complainant to transfer to the labour ward, with the complainant considering an epidural. The doctor performed a vaginal examination which identified a dilated cervix of four centimetres with painful contractions 1:4. This indicates established labour, which would initiate transfer to the labour ward.

19. The MW IPA provided advice about staff attendance of the complainant. This advice is summarised in paragraph 20 below.
20. At the point of the baby's birth at 00:54, two midwives attended the complainant. The MW IPA referred to the NICE Intrapartum Care Guidance and advised staff attendance of the complainant throughout the period of care was appropriate in line with this guidance. Specifically, *'there is evidence the complainant received 1:1 care during labour which complied with NICE guidance. It would be normal practice to have two midwives in attendance at the birth, one to care for the mother and delivery of the placenta and one to care for the baby. This would happen even if everything was normal and there were no concerns about either mother or baby. In the complainant's case the same midwife that was in attendance at the birth also carried out the perineal suturing which is good practice'*.
21. The MW IPA provided advice about pain relief provided to the complainant. This advice is summarised in paragraphs 22 and 23 below.

⁶ An ultrasound scan, sometimes called a sonogram, is a procedure that uses high-frequency sound waves to create an image of part of the inside of the body. An ultrasound scan can be used to monitor an unborn baby.

22. The complainant was admitted to the RVH for IOL at 08:45 on 1 September 2010, with gel applied at 09:15 to initiate the induction. The Trust provided the complainant with a TENS machine at 10:15 for pain relief, and at 10:30, the Trust offered the complainant further pain relief but which she declined. At 11:00, in response to the complainant's request for further pain relief, the Trust administered Pethidine. At 12:10, because the Pethidine provided little relief for the complainant's contractions, the Trust midwife requested doctor review which was appropriate. At 14:05, the complainant transferred to 'Room five' where she received Entonox⁷ and, at 15:00, because of stronger contractions, the Trust discussed further pain relief options with her. At 15:20, the complainant decided to have an epidural. The Trust midwife performed a vaginal examination which indicated a cervix dilation of three to four centimetres. This indicated '*established labour*' but with potentially another six to eight hours of labour remaining. The Trust informed the complainant of these findings. The complainant then requested an epidural, which the Trust subsequently arranged. The complainant continued to use Entonox throughout her labour.
23. The MW IPA referred to the NICE Intrapartum Care Guidance and advised the Trust provided appropriate pain relief care and treatment to the complainant throughout her labour. Specifically, '*there is evidence that the midwives responded appropriately to the complainant's pain and discomfort and pain relief was given as needed*'. She also advised, '*a small number of epidurals do not provide the level of relief required to alleviate some women's pain and it is unfortunate that this appeared to be the case for this complainant*'.
24. The MW IPA provided advice about the overall management of the complainant's labour. She advised, except for the failure to discuss what was happening with the complainant, which issue is addressed within element (iii) below, '*overall the midwives managed the [induction], labour and birth appropriately according to*' both NICE Intrapartum Care and NICE Inducing

⁷ Entonox is a well-established quick-acting pain-relieving gas mix, consisting of 50% nitrous oxide and 50% oxygen. It is commonly known as gas and air.

Labour Guidance and which the MW IPA advised '*were the standards at the time*'.

Responses to the Draft Investigation Report

25. Both the complainant and the Trust were given an opportunity to provide comments on the Draft Investigation Report. Where appropriate, comments have been either reflected in changes to the report or are outlined in paragraphs 26 and 45 to 47, under element (iii) below.

The Complainant's Response

26. In relation to all the elements of the complaint, the complainant reiterated her belief that the records of the period of care did not accurately reflect her experience and therefore should not be relied upon as evidence.

Analysis and Findings

27. I refer to the MW IPA's advice above, with specific consideration of the following. The Trust used a CTG to monitor labour progress which was appropriate. In compliance with NICE Intrapartum Care Guidance, staff attendance of the complainant throughout the period of care was appropriate. Further, the attendance of two midwives at the baby's birth was '*normal practice*'. When the contractions caused distress to the complainant, but the Pethidine gave little relief, the Trust midwives '*appropriately*' requested doctor review. The Trust provided appropriate pain relief care and treatment to the complainant throughout her labour in line with NICE Intrapartum Care Guidance and '*the midwives responded appropriately to the complainant's pain and discomfort and pain relief was given as needed*'. I note the MW IPA's advice, '*overall the midwives managed the [induction], labour and birth appropriately according to*' the relevant standards. The Trust performed an USS to check the baby's heart; however, I refer to element (v) below which includes consideration of the issue of monitoring of the baby.

28. I note the Trust stated it provided one-to-one midwifery care during the complainant's labour in line with common practice. The Trust further stated, a second midwife attended the birth, in keeping with standard good practice. I

consider these statements accord with the MW IPA's advice about staff attendance.

29. I accept the MW IPA's advice and am satisfied the Trust appropriately managed the complainant's labour. Therefore, I do not uphold this element of the complaint.

Detail of Complaint

(ii) *The position of the baby at induction and during labour on 1-2 September, including what information was provided to the complainant about this at that time*

30. The complainant said the Trust induced her labour without checking the position of her baby. She said, after the IOL process began, the Trust told her that the baby was in a transverse position, yet the Trust did not record this. The complainant said, she understands, because of the risks associated with a baby in this position, the Trust should have performed a Caesarean section immediately. The complainant said these risks include a risk to the baby. The complainant said, after the 'fast scan', the midwives told her about this problem in detail, after which the Trust transferred her to the delivery room where she spent 14 hours in labour.

Evidence Considered

Legislation/Policies/Guidance

31. I considered the NICE Inducing Labour Guidance; the NICE Intrapartum Care Guidance; and the NMC MW Standards.

Relevant Trust Records

32. I considered the complainant's medical records for 1 to 2 September 2010.

Relevant Independent Professional Advice

MW IPA advice

33. The MW IPA provided advice about the baby's position during her pregnancy, and at the onset of the IOL, as well as the Trust's actions in relation to this. This advice is summarised in paragraphs 34 to 36 below.
34. During the complainant's antenatal period, the Trust managed the complainant according to the NICE Antenatal Care Guidance. At 32 weeks, the baby was in a breech position⁸, which is *'the baby's bottom is presenting first rather than the baby's head'*. This is not unusual at 32 weeks in a first pregnancy; however, the baby remained in a breech position at 36+ weeks. The Trust then offered the complainant an External Cephalic Version⁹ (ECV), which is a technique designed to turn the baby, so the baby lies head-first. ECV increases the likelihood of having a vaginal birth. Before the Trust performed the ECV, however, the baby *'spontaneously turned'* to become *'cephalic'* which is head-down. At an antenatal review on 23 Aug 2010, at 40 + 1 weeks, a vaginal examination identified the baby was in a vertex position, which is head-first.
35. At 08:45 on 1 September 2010, the complainant was admitted to the RVH for IOL, during which the Trust carried out a full assessment. This assessment included an abdominal palpation in line with NICE Inducing Labour Guidance. During this examination, the baby was *'longitudinal (lying top to bottom of the uterus) ... head first'* and a vaginal examination at 09:15 confirmed this. The MW IPA advised, *'it would be almost impossible for the baby to turn into a transverse position (lying left to right across the mother's uterus) at this point'*. Further, the Trust explained this to the complainant during the meeting on 28 January 2022. The MW IPA referred to the NMC MW Standards and advised, if the baby was in a transverse position, the Trust *'would have been required to refer to a doctor as this would be outside of a midwife's sphere of practice'*.

⁸ Breech position is when the baby is lying bottom or feet first, rather than head-first.

⁹ If your baby is in a breech position at 36 weeks, the mother will usually be offered an external cephalic version (ECV). This is when a healthcare professional, such as an obstetrician, tries to turn the baby into a head-down position by applying pressure on the abdomen. This is a safe procedure, although it can be a bit uncomfortable. Around 50% of breech babies can be turned using ECV, allowing a vaginal birth.

36. Following the abdominal palpation and vaginal examination, the records did not document the information the Trust shared with the complainant; however, the MW IPA advised, *'there was equally no indication at this time that there was anything abnormal about the baby's position and therefore there was nothing to convey.'* The Trust acted appropriately because the baby's position was normal. The MW IPA also advised, *'there was no indication at any point that the midwife was concerned about the baby's position and the records indicate that the complainant's labour was progressing normally'* and, therefore, *'there was no risk to either the complainant or her baby as everything was normal'*.

Analysis and Findings

37. I refer to the MW IPA's advice at paragraphs 34 to 36 above, with specific consideration of the following. At all the complainant's examinations, from 23 August 2010 until the baby was born, the baby was not in the breech position. Following this *'it would be almost impossible for the baby to turn into a transverse position'* and, if this had been the case, the Trust midwives would have had to refer the complainant to a doctor. I note the MW IPA's advice the Trust acted appropriately; *'everything was normal'*; *'there was no risk to either the complainant or her baby'*; and there is no indication the Trust gave the complainant any information to the contrary. I accept the MW IPA's advice and am satisfied at the time of the complainant's care, the baby was in a normal delivery position; therefore, the baby was not in a transverse position or in any position for which a Caesarean Section would be required. Therefore, I do not uphold this element of the complaint.

Detail of Complaint

- (iii) *The information provided to the complainant about the consequences of the induction process*
38. The complainant said the Trust did not fully inform her about the various procedures which happened during her labour.

Evidence Considered

Legislation/Policies/Guidance

39. I considered the NICE Intrapartum Care Guidance; the NMC MW Standards; the NICE Postnatal Care Guidance; and the Trust Induction of Labour Guidance.

Relevant Trust records

40. I reviewed the complainant's records for 1 to 2 September 2010 and her postnatal care records for the period of 3 September to 31 October 2010.

Relevant Independent Professional Advice

MW IPA advice

41. The MW IPA provided advice about the Trust's provision of information to and discussion with the complainant about the induction of labour process and the progress of her labour and how the Trust documented this. This advice is summarised in paragraphs 42 and 43 below.
42. The MW IPA referred to the NICE Intrapartum Care Guidance about communication to enable women '*to reach informed decisions about their care*' and advised '*there is no indication in the records that there was any discussion with the complainant about what was happening prior to her transfer to room 5 on the labour ward.*' She advised the Trust should have discussed with the complainant '*what was going to happen to her ... staff should have provided reassurance to the complainant that everything was within normal limits and this should have been documented in the records.*'
43. The MW IPA also referred to the NICE Postnatal Care Guidance and provided advice about the complainant's postnatal care, related to the period of up to eight weeks after birth but which period is outside the scope of the complaint. She advised women, '*should be offered an opportunity to talk about their birth experiences and to ask questions about the care they received during labour*'; however, the records did not indicate '*this happened for the complainant. If this had happened there may have been an opportunity to clarify exactly what*

happened during her labour and birth and to allay any misconceptions that she may have held.'

Third-Party Information

44. The MW IPA's particular observation about women being given the opportunity for a postnatal care debrief lay outside the scope of the complaint, both in terms of timelines and because it related to care provided by a body other than the Trust. However, in consideration of the potential impact of providing reassurance and information to the complainant about her experience during labour and delivery offered by this debrief opportunity, I sought the complainant's postnatal care records for the period of approximately eight weeks after the birth from 3 September to 31 October 2010. I identified the complainant's General Practitioner (GP) and the South Eastern Health and Social Care Trust Community Midwifery Unit (SE Trust Midwifery) provided the complainant's post-natal care. The Trust did not provide this care.

Responses to the Draft Investigation Report

The Trust's Response

45. The Trust referred to the Ombudsman's finding in the Draft Investigation Report related to element (iii); specifically, the Trust failed to record discussions with the complainant about the progress of her labour. The Trust contended this is *'factually inaccurate'*. The Trust referred to the records of the complainant's labour. It stated, at 13:10, the records document, because of the complainant's distress, a *'doctor'* reviewed the complainant with *'the plan ... to transfer from room 15 (induction room) to the main labour ward'*, with the complainant considering an epidural. Further, at 14:40, a midwife *'reassured'* the complainant; at 15:00, the midwives discussed pain relief options; and at 15:25, the complainant consented to a vaginal examination, after which the *'findings [were] discussed with'* the complainant who decided to have an epidural. The Trust also referred to the *'evidence'* of the completed partogram, which it stated is *'a half hourly record of all care administered'*.
46. The Trust stated it *'would not normally be appropriate'* to discuss the progress of labour in the intrapartum period until labour is *'clearly established'*. The Trust

stated, *'progress during the induction / early labour phase is difficult to predict'*; therefore, *'discussions tend to be limited to the woman's immediate comfort and the next possible steps'*. The Trust stated, in the complainant's case, this occurred with appropriate documentation. The Trust further stated the complainant's records *'indicate appropriate planning, reassurance, consent and discussion of progress (vaginal examination)'* with the complainant. The Trust reiterated the complainant's labour progress *'was within the expected normal range'* with progression from four centimetres to full dilation in less than ten hours. The Trust stated the second stage of labour *'was also as expected'*, lasting 24 minutes.

47. The Trust stated it considered it took appropriate actions in relation to this and previously apologised to the complainant in writing for any distress caused by poor communication. The Trust stated, therefore, it could not identify either the necessity for a further apology or an appropriate scope or approach associated with a sample audit, as recommended in the Draft Investigation Report.

Further Independent Professional Advice Following Receipt of Draft Investigation Report Responses

48. In consideration of the Trust's comments in response to the Draft Investigation Report, the MW IPA provided further independent professional advice. The additional advice relates to the recording of discussions with, and information provided to, the complainant about the induction and progress of her labour.

Analysis and Findings

49. I refer to the MW IPA's original advice. She advised the NICE Intrapartum Care Guidance requires communication with complainants *'to reach informed decisions about their care'*. I note the MW IPA advised the records did not indicate *'there was any discussion with the complainant about what was happening prior to her transfer to room 5 on the labour ward'*. The MW IPA further advised, staff should have discussed what was happening with the complainant, reassured her *'everything was within normal limits'* and documented the discussion.

50. I refer to the MW IPA's further advice. The MW IPA advised, at an antenatal appointment on 23 August 2010, the Trust scheduled the IOL with the complainant. The MW IPA advised, at this time, the Trust did not document any discussion about either what the IOL involved or other options available to the complainant. The MW IPA referred to the NICE Inducing labour Guidance and advised '*there is no documented evidence in the records of any discussion*' of specific aspects stipulated in this guidance, particularly those related to other options available to the complainant. Further, she referred to the Trust Induction of Labour Guidance that IOL '*should always be discussed at the Antenatal Clinic ... and fully documented in the Antenatal notes*'. I note the MW IPA advised '*there is no indication ... discussion was undertaken to comply with both local and national guidelines*'. The MW IPA referred again to the NICE Inducing Labour Guidance and advised, '*there is no indication in the records that the complainant was given documented information about IOL at the time this was booked or on admission for IOL*'. The MW IPA also referred to the Trust's statement about its introduction in 2013 of the issue of information about epidurals to women, to support informed choice and decision making. She advised '*there is no indication that such information around IOL was available for women in 2010 or subsequently*'.
51. The MW IPA explained, at 09:15 on 1 September 2010, the Trust administered a drug for inducing labour. This was in the form of a gel. I note she referred again to the NICE Inducing Labour Guidance and advised, '*there is no documented evidence that the midwife discussed the risk of uterine hyperstimulation with [the complainant] prior to the insertion*' of the gel. She further advised, this risk did materialise as '*the complainant experienced "uterine hyperstimulation"*' and the Trust then administered a drug to slow/stop contractions at 13:10.
52. The MW IPA referred to the records which the Trust stated provided evidence of discussion with the complainant about her labour. In relation to the record of 13:10, the MW IPA advised, '*there is no documented evidence that the causes of the uterine hyperstimulation, the associated risks or the plan for continued care in labour in relation to the IOL were discussed with the complainant*'. In

relation to the record of 14:40, the MW IPA advised, *'there is no documented evidence of the nature of what the midwife 'reassured' the complainant about'*. I note, in reference to the record of 15.00, related to the discussion of pain relief options, the MW IPA advised, *'the nature of the options discussed should be documented'* to demonstrate the woman could *'make an informed decision'*. She explained the definition of informed choice as giving the individual *'all the information about what the treatment involves, including the benefits and risks, whether there are reasonable alternative treatments and what will happen if the treatment does not go ahead'*. In relation to the record of 15:25, the MW IPA advised, although the Trust *'informed'* the complainant of the vaginal examination findings, *'there is no indication that there was any discussion about what her options, other than epidural might be'*. The MW IPA also provided advice about the partogram records. She advised that this is a tool which records maternal and foetal wellbeing and progress in labour; however, it *'does not provide evidence of discussions about what was happening to the complainant or information to help her make an informed choice about her care.'*

53. The MW IPA also provided advice about the nature of *'discussion'*. She advised, this is the process of *'talking about something to then reach a decision or exchange ideas'*. The MW IPA advised, to make an informed choice about care, a woman should receive an explanation of what she can expect in the process, what is happening to her and her possible options. Within healthcare, valid, informed and voluntary consent requires communication of all information related to what the treatment involves, the benefits and risks and other reasonable alternatives, including the consequences if the treatment does not go ahead. The MW IPA advised the complainant's antenatal records include a section, *'Parent Education Sessions'* but which is blank. She advised, the complainant signed her birth plan but *'there is no evidence'* the complainant discussed her birth plan with a health professional. I note the MW IPA further advised, *'there is no documented evidence'* the Trust discussed either the complainant's birth plan or planned interventions during either the IOL process or transfer to the delivery suite. The MW IPA referred to the NICE Intrapartum Care Guidance and advised, although the requirements of this guidance which

are related to communications *'may have taken place during the complainant's care there is little / no evidence in the documentation' this occurred.*

54. The MW IPA referred to the Trust's comments that the patient's records evidence the Trust provided appropriate reassurance and discussion of progress. She advised the patient's records are detailed under *'observations and findings'* and *'action and evaluation'*. I note the MW IPA referred to the NICE Intrapartum Care Guidance and advised there is a *'very limited record of observations and findings with the associated action and limited record of evaluation'*. The MW IPA referred to specific examples and highlighted details which these records should have contained; for example, at 14:40, she advised there was no *'evaluation following action'*; at 15:00, there was no record of the frequency or strength of the contractions and there were no details of the pain relief options discussed.
55. I note the MW IPA concluded the *'provision of information to enable women to make informed choices for their care is fundamental to everything'*. She suggested, certainly at the time of the complainant's care, the Trust did not understand *'what informed choice and appropriate discussion is in relation to care for women the documentation provided in this case does not reflect local or national guidelines of the time and has clearly impacted on the complainant and her family for some considerable time'*.
56. I note the MW IPA referred to the Trust Induction of Labour Guidance and advised, at the time of the complainant's care, this guidance, dated 2002, *'was significantly out of date'*. She advised the appropriate guidance, introduced in 2008 was the NICE Inducing Labour Guidance. The MW IPA advised, the Trust should ensure its internal guidelines reflect current national guidance.
57. I refer to the MW IPA's original advice in which she also referred to the NICE Postnatal Care Guidance which stipulates that women are given the *'opportunity to talk about their birth experiences and to ask questions about the care they received during labour'*. I note she advised this may have allowed the

complainant to *'clarify exactly what happened during her labour and birth and to allay any misconceptions that she may have held.'*

58. I refer to the records obtained from third parties as detailed in paragraph 44. During the period of 3 to 14 September 2010, the SE Trust Midwifery reviewed the complainant was reviewed on seven occasions, after which it discharged her from its care. I note the record of the first visit by the SE Trust Midwifery on 3 September 2010, the day after the complainant's discharge following the birth states, *'[complainant] had long labour baby od¹⁰ was happy with care'*. During the first eight weeks of the complainant's postnatal care, the complainant attended her GP Practice on five occasions, two of which were specific postnatal reviews at 18 days, on 20 September 2010 and at six weeks, on 11 October 2010. These records do not specifically reference a discussion about the birth experience but evidence the complainant's GP provided her with specific postnatal review and care.
59. I accept the MW IPA's advice. I consider the Trust's failure to record discussions with the complainant about the IOL process does not accord with either the NICE Inducing Labour Guidance or the Trust Induction of Labour Guidance. Further, the Trust's failure to record discussions about the progress of the complainant's labour with her does not accord with the NICE Intrapartum Care Guidance. I consider these constitute failures in care and treatment and therefore uphold this element of the complaint.

Injustice

60. I considered carefully whether the failures caused an injustice to the complainant and her family. I consider, because of the failures, the complainant sustained the injustice of the loss of opportunity to be assured she was given complete information about both the IOL process and the progress of her labour.
61. I refer to the MW IPA's advice about the complainant's postnatal care and the opportunity to discuss the birth experience. I consider the complainant's

¹⁰ Ordinary Delivery

postnatal care did not lie within the Trust's area of responsibility. Further, I consider the SE Trust Midwifery record of the first visit to the complainant, after the birth on 3 September 2010, indicates the SE Trust Midwifery discussed the complainant's labour experience with her; and the complainant indicated she '*was happy with [her] care*'. I consider this contemporaneous record evidences the SE Trust Midwifery gave the complainant an opportunity to discuss her experience in line with NICE Postnatal Care Guidance. Therefore, I did not identify any required learning or improvement related to the relevant aspect of the MW IPA's advice.

62. I also refer to the MW IPA's further advice that, at the time of the complainant's care, the Trust Induction of Labour Guidance dated from 2002; however, the Trust did not update this in line with the NICE Inducing Labour Guidance, amended in 2008 and adopted by the Northern Ireland Department of Health during 2009/10 year and, therefore, prior to the complainant's period of care. I accept the MW IPA's advice and am satisfied the Trust did not update its guidance to reflect national guidance. I consider this does not align with the first Principle of Good Administration, '*Getting it right*'. I consider this constitutes maladministration.

Detail of Complaint

(iv) The information provided to the complainant about the risks and efficacy of an epidural and the epidural consent process

63. The complainant said the Trust did not fully inform her of the potential risks of the epidural and, therefore, she could not give informed consent. Specifically, the complainant said the Trust did not tell her about: - the risks of back pain from the epidural; the issues associated with successful epidural siting; or epidural efficacy. She also said she did not request an epidural, as her notes show she planned a natural birth throughout her pregnancy; however, the Ward Sister coerced her into agreeing to an epidural.

Evidence Considered

Legislation/Policies/Guidance

64. I considered the NICE Intrapartum Care Guidance.

Relevant Trust records

65. I reviewed the complainant's records for 1 to 2 September 2010.

Relevant Independent Professional Advice

Anaesthetist Independent Professional Advisor (AN IPA) advice

66. The AN IPA advised, at 15:00, the Trust midwife discussed pain relief options with the complainant, following which the complainant decided to have an epidural. The AN IPA advised, following this request, the Trust midwife contacted a Trust anaesthetist, who then came to attend the complainant. The AN IPA advised the Trust acted appropriately. The AN IPA further advised, often complainants change their mind from the pre-decided birth plan as their *'expectation of labour pain is quite different ... it is difficult to plan for coping with pain that you have no experience or knowledge of'*. The AN IPA advised, the Trust midwife appropriately discussed pain relief options at this point, and which is *'standard practice'*. The AN IPA advised, *'women in labour are often quite distressed due to the pain. Epidural is thought to be the gold standard for pain relief in labour and in most cases provides extremely good pain relief. It is then up to the woman what form of analgesia, if any, she wishes to have'*.
67. The AN IPA advised *'as complainants need to be positioned either sitting or lying with the back arched out, this would have to be explained. They need to remain still during critical parts of the procedure and that requires explanation and co-operation'*. The AN IPA advised the Trust anaesthetist documented the complainant's verbal consent for the epidural. The AN IPA further advised, the Trust anaesthetist's discussion on *"time to onset' and risks associated with an epidural, including failure, post Dural puncture headache, infection, bleeding, and temporary and permanent nerve damage'* is documented. The AN IPA advised the appropriate discussion of *'time to onset'* and *'failure'* would include the possibility of re-siting the epidural as standard. The AN IPA advised the

Trust anaesthetist also appropriately outlined figures for the incidence of these risks to the complainant. The AN IPA advised '*there is no evidence to suggest that epidurals cause back pain*' and therefore this would not be a risk. The AN IPA advised '*pregnancy and the ensuing childbirth are however, known to cause back pain*'.

68. The AN IPA advised '*there is no evidence that the complainant was coerced or pressured into having an epidural. The complainant would have been positioned for the epidural and would have had to remain still for the procedure. There is no evidence to suggest that she was pressured to do so.*'
69. The AN IPA advised both epidurals provided '*demonstrable sensory block*' which indicates '*successful [insertion] in the correct place both times*'. The AN IPA advised, there was no indication of '*any difficulties encountered during the procedure*'. The AN IPA advised, although epidurals are inserted correctly, sometimes these do not work for unknown reasons. She also advised certain positions of the baby's head can lead to low back pain in labour and which is very difficult to treat. The AN IPA concluded the Trust provided appropriate care.

MW IPA advice

70. The MW IPA advised, at 12:10, because the complainant's contractions caused her distress, despite the administration of Pethidine at 11:00, the Trust midwife asked a doctor to review the complainant. The MW IPA advised, at this time, the doctor documented the complainant's consideration of an epidural. At 15:00, as the complainant had stronger contractions, the Trust midwife discussed pain relief options with her, in accordance with the NICE Intrapartum Care Guidance. The MW IPA advised, the Trust midwife conducted a vaginal examination and informed the complainant she was in established labour but there could be a further six to eight hours of labour. '*The complainant decided to have an epidural*' which was then arranged. The MW IPA advised the Trust acted appropriately in line with the NICE Intrapartum Care Guidance.

Analysis and Findings

71. The AN IPA and the MW IPA both advised the Trust midwife discussed pain relief options with the complainant, following which the complainant *'decided to have an epidural'*. The AN IPA advised the Trust midwife appropriately discussed pain relief options at this point which reflected *'standard practice'*. I note the MW IPA advised the Trust took appropriate actions in line with the NICE Intrapartum Care Guidance.
72. The AN IPA advised, because complainants need to remain still during critical parts of the epidural procedure, this *'requires explanation and co-operation'*. I note the AN IPA advised the Trust anaesthetist appropriately documented the complainant's verbal consent for the epidural and the discussion of the risks and efficacy of an epidural. The AN IPA advised *'there is no evidence that the complainant was coerced or pressured into having an epidural'*. The AN IPA advised *'there is no evidence to suggest that epidurals cause back pain'* and, therefore, this would not be a risk; however, *'pregnancy and the ensuing childbirth are ... known to cause back pain'*. The AN IPA advised both epidurals provided *'demonstrable sensory block'* indicating successful insertion *'in the correct place both times'*. The AN IPA advised epidurals do not always work, even when inserted correctly. The AN IPA concluded the Trust provided appropriate care.
73. I accept the AN and MW IPAs' advice. I am satisfied the Trust provided appropriate information to the complainant about the risks and efficacy of the epidural; the epidural consent process was undertaken appropriately; and the Trust did not coerce the complainant into having an epidural. Therefore, I do not uphold this element of the complaint.
74. I recognise the integrity of complainant's perceptions of her experience but I refer to the AN IPA's advice, the pain of labour can *'alter [complainants'] perception and recollection of events. This can be exacerbated if they have received Entonox and opiates as well. Pain and all these medications do alter the capacity to think, perception and most importantly memory.'*

75. I also refer to the Trust's information leaflet about epidurals for labour pain, which, since August 2013, the Trust gives to women, and which facilitates and supports informed choice and decision-making.

Detail of Complaint

(v) Monitoring of the baby

76. The complainant said the Trust did not take appropriate steps to ensure the wellbeing of her baby. This included concerns about monitoring of the baby during labour.

Evidence Considered

Legislation/Policies/Guidance

77. I considered the NICE Intrapartum Care Guidance.

Relevant Trust records

78. I reviewed the complainant's records for 1 to 2 September 2010.

Relevant Independent Professional Advice

MW IPA advice

79. The MW IPA advised, in addition to monitoring labour progress, the CTG also monitors foetal wellbeing through electronic tracing of the baby's heart rate. The MW IPA advised this is appropriate. The MW IPA advised, at 13:10 during the doctor's review, the CTG was very difficult to interpret due to loss of contact and which is usually caused by either the mother's movement or the position of the baby. The MW IPA advised, the doctor, therefore, conducted an USS to check there the baby's heart. She advised the USS showed a regular heartbeat of 135 beats per minute throughout a contraction, and which is within normal limits. The MW IPA referred to the NICE Intrapartum Care Guidance and advised the use of USS is recommended when there is an abnormal foetal heart trace.
80. The MW IPA referred to the NICE Intrapartum Care Guidance and advised the Trust appropriately monitored the baby throughout the period of care. She

further advised there *'is clear documentation in the records of regular recording of the foetal heart throughout labour and birth. Regular abdominal palpations were undertaken prior to vaginal examination. The complainant was having continuous foetal monitoring throughout her labour and the midwives appropriately called for doctor review when they were concerned about the baby's heart rate at 12.50, 15.55 and 16.45'*.

Analysis and Findings

81. The MW IPA advised the use of the CTG to monitor the baby's wellbeing was appropriate. I note the MW PA advised the use of the USS is recommended under the NICE Intrapartum Care Guidance for monitoring the baby's heart. The MW IPA also advised the Trust appropriately monitored the baby throughout the care and the baby's heart was regular and within normal limits. I accept the MW IPA's advice and am satisfied the Trust took appropriate actions in monitoring the baby. Therefore, I do not uphold this element of the complaint.

Records

82. The complainant said the records did not reflect her experience and women should be asked to sign their records. The investigation, therefore, also considered whether the complainant's records for the period of care were appropriate.

Relevant Independent Professional Advice

MW IPA advice

83. The MW IPA advised, *'the records appear to be an accurate and consistent reflection of the care provided'*. She referred to the NMC MW Standards and advised, *'there is no indication of retrospective record keeping or inappropriate additions being added after the event.'* The MW IPA advised, *'there is no standard that I am aware of that indicates women should sign their records'* and *'to be asked to sign their records during labour seems impractical and somewhat unfeeling as women may perceive that staff were trying to 'cover their backs''*.

AN IPA advice

84. The AN IPA advised, *'the records appear to be a standard format and nature of complainants in labour'*. She also advised, *'Women in labour are generally in a significant amount of pain and the pain can alter their perception and recollection of events. This can be exacerbated if they have received Entonox and opiates as well. Pain and all these medications do alter the capacity to think, perception and most importantly memory.'* The AN IPA advised it is not currently *'standard practice for complainants to read and sign their medical records. Additionally, when in labour with significant pain and distress, I am not sure if many complainants would consider this as an appropriate action.'* The AN IPA also advised, whilst not specifically required, an anaesthetist's debrief with women might be beneficial to reassure them.

Analysis and Findings

85. I note the MW IPA advised, in line with the NMC MW Standards, *'there is no indication of retrospective record keeping or inappropriate additions being added after the event'*. Further, the AN IPA's advised the records are standard.
86. I note both the MW and AN IPAs advised it is not currently standard for women to sign their records and, given the pain and distress of labour, such an action would not be appropriate.
87. I accept the MW and AN IPAs' advice. Except for the failures I identified at paragraph 59, which relates to the failure to record specific discussions with the complainant during labour, I am satisfied both that the Trust maintained appropriate records and it acted appropriately in not asking the complainant to sign her records.

CONCLUSION

88. I received a complaint about the care and treatment the Trust provided the complainant from 1 to 2 September 2010. I upheld one of the five elements of the complaint.

89. The Trust failed to act in accordance with the NICE Inducing Labour Guidance and the Trust Induction of Labour Guidance because it did not record discussions with the complainant about the IOL.
- I recognise this failing caused the complainant to sustain the injustice of the loss of opportunity to be assured she was given complete information about the IOL process.
90. The Trust failed to act in accordance with the NICE Intrapartum Care Guidance because it did not record adequate discussions about the progress of the complainant's labour with her.
- I recognise this failing caused the complainant to sustain the injustice of the loss of opportunity to be assured she was given complete information about the progress of her labour.
91. The Trust did not update its Induction of Labour Guidance in line with the amended NICE Inducing Labour Guidance of 2008. This constitutes maladministration because the Trust did not act in accordance with the first Principle of Good Administration, '*Getting it right*' as it failed to take appropriate account of the amended guidance.
92. The investigation concluded the Trust appropriately managed: - the complainant's labour, including those actions related to the baby's presenting position at the IOL; the epidural consent process; and the monitoring of the baby.
93. I welcome the Trust's acceptance of the recommendation at paragraph 96 below. The Trust stated it will share with relevant staff, those aspects related to communication and discussion with women which are stipulated in the current version of the NICE Intrapartum Care Guidance (now the NICE CG190 Intrapartum Care for Healthy Women and Babies, December 2022). The Trust also stated it will share relevant aspects of the *NICE CG138 Patient Experience in Adult NHS services, Improving the Experience of Care for People Using*

Adult NHS Services. The Trust stated these will be shared through safety briefs and team meetings. I welcome this commitment to improvement.

94. I recognise the complainant found her experience distressing. I hope, however, this report provides her with reassurance about her baby's position during IOL; the Trust's management of her labour; the epidural consent process; and how the Trust monitored her baby throughout the process.

Recommendations

95. I recommend the Trust provides the complainant with a written apology in accordance with NIPSO's 'Guidance on issuing an apology' (July 2019), for the injustices caused because of the failures identified (within **one month** of the date of this report).
96. I further recommend the Trust should remind relevant staff of the importance of the present versions of the NICE Intrapartum Care Guidance (now NICE CG190, December 2022); the NICE Inducing Labour Guidance (now NICE NG27, November 2021); and the Trust Inducing Labour Guidance. The Trust should evidence this through records of information sharing and/or training records to be provided within **six months** of the date of this report.
97. I also recommend the Trust should undertake a sample audit of women's records in this area in relation to the recording of communication and discussion with them about the IOL process and the progress of labour. The Trust should take action to address any identified trends or shortcomings and provide this Office with an update of findings and corrective actions as appropriate. This should be provided within **six months** of the date of this report.
98. I recommend the Trust also undertakes a sample audit of its internal policies and guidance in this area in relation to the timeliness of updates to these in line with national standards. The Trust should take action to address any identified trends or shortcomings and provide this Office with an update of findings and

corrective actions as appropriate. This should be provided within **six months** of the date of this report.

MARGARET KELLY
Ombudsman

16 October 2023

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.

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.