



Northern Ireland

Public Services

Ombudsman

Investigation of a complaint against the Southern Health & Social Care Trust

Report Reference: 202004555

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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: Southern Health and Social Care Trust

SUMMARY

This complaint was about care and treatment the Southern Health and Social Care Trust (the Trust) provided to the complainant (the patient) at its Craigavon Area Hospital Maternity Unit (CMU).

The patient's pregnancy was classed as 'high risk'. She was admitted to CMU on 8 October 2021, at almost 34 weeks, with severe abdominal pains. The patient was scheduled for a caesarean section just a few days later. The patient's pain increased during her admission. A junior doctor prescribed pain relief following a review. On the morning of 10 October, a scan showed the patient's daughter sadly died in the womb.

The investigation identified fundamental failings in the CMU staff's care and treatment of the patient and that these failings resulted in catastrophic consequences for the patient and her daughter. If the patient had been escalated and an emergency caesarean carried out on the balance of probabilities the baby would have survived. It established that the midwife did not accurately record the patient's pain score. It also established that midwifery and clinical staff did not escalate the patient's care to a senior doctor for review.

The investigation further identified that the attending midwife made an entry in the patient's record on behalf of one of her colleagues. I considered this did not accord with the NMC Code. The investigation also established that CMU was understaffed on 9 October 2021.

I recommended that the Trust apologise for the failings and injustice identified. I also recommended additional action for the Trust to take to prevent these failures recurring.

Such was my concern for the events that occurred during the patient's admission, and to ensure they do not reoccur, I also recommended the Trust appoint an independent reviewer to carry out a full independent audit of both obstetric and maternity records belonging to high-risk patients who attended the CMU within the past three years, staffing levels including consultant cover and working practices within CMU. The Trust should further share the findings of both audits with my Office.

I wish to pass on my sincere condolences to the patient and her family for the devastating loss of their daughter and sister.

THE COMPLAINT

1. I received a complaint about care and treatment the Trust provided to the patient following her admission to the Craigavon Area Hospital Maternity Unit CMU during the later stages of her pregnancy.

Background

2. This was the patient's fourth pregnancy. She previously underwent two caesarean sections (CS¹) and suffered one miscarriage. The CMU classed the patient's pregnancy as 'high risk'² at the start of her pregnancy and decided her pre-natal care was to be 'consultant led'.
3. The patient attended CMU on eight occasions between July and October 2021 with concerns about the progress of her pregnancy. She experienced abdominal pain and/or cramping on five of those occasions.
4. On 8 October 2021, the patient was 33 weeks and five days pregnant. She self-referred to CMU and was admitted due to experiencing '*severe abdominal pain*'. CMU scheduled her delivery by CS the following week. It started steroid treatment in preparation for the planned delivery. During the evening of 8 October 2021, the patient's pain increased. CMU administered pain relief throughout that evening, night, and the next day.
5. Staffing records indicate that on 9 October 2021, there should have been six midwives on duty. However, only four midwives attended for their shift. Just before 19:00 on 9 October 2021 '*a midwife noticed a significant change in the pain and carried out a CTG [cardiotocography³] to check the baby was okay.*' The midwife was satisfied with the results. The patient asked the midwife '*if there was a possibility she might deliver by caesarean section that night.*' The midwife indicated that '*was a possibility if the pain increased.*'

¹ Caesarean Section - Caesarean section, C-section, or caesarean birth is the surgical delivery of a baby through a cut (incision) made in the birth parent's abdomen and uterus.

² A pregnancy is 'high risk' when the likelihood of an adverse outcome for the woman or the baby is greater than that of the 'normal population'.

³ A cardiotocograph records foetal heart rate and uterine contractions.

6. During the evening and night of 9 October 2021 the pain got increasingly worse. Eventually a midwife asked a junior doctor to assess the patient for pain relief. The doctor prescribed intravenous paracetamol and codeine separately. The patient again asked the doctor and the midwife if they could arrange the CS for that evening. However, the doctor said he preferred to wait until the following morning.
7. The patient said that at approximately 05:30am on 10th October, she told a midwife she had concerns about the baby's movement and requested a CTG. The midwife carried out a CTG and could not find the baby's heartbeat. Another midwife carried out a second scan and found no foetal heartbeat. A doctor carried out a final CTG scan and told the patient the baby had passed away.
8. The Trust carried out a Serious Adverse Incident Report (SAI)⁴ dated November 2022. The SAI investigation found the increase in pain the patient reported, alongside a reduced impact from analgesia prescribed was inaccurately recorded within the obstetric early warning score observations OEWS⁵ chart. It found that if the pain had been accurately recorded within the OEWS chart this would have prompted staff to escalate the patient for a senior medical review, increase observations frequency and potentially undertake a foetal wellbeing check every 15 minutes in keeping with the action protocol within the OEWS chart.
9. The patient was concerned the Trust failed not only her but the '*family's beautiful daughter.*' Also, that the Trust let her and her family down due to both the treatment and care she received.

Issues of complaint

10. I accepted the following issue of complaint for investigation:

Whether the care and treatment the Trust provided to the complainant between 8 October 2021 – 10 October 2021 was adequate, appropriate and in

⁴ An SAI is defined as any event or circumstance that led or could have led to unintended or unexpected harm, loss or damage.

⁵ OWES Chart - OWES - Designed to help identify deterioration in the woman and ensure appropriate early intervention.

accordance with guidance and relevant standards.

INVESTIGATION METHODOLOGY

11. 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 complaints process.

Independent Professional Advice Sought

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

- A Registered Midwife with 38 years' experience and specialist knowledge and skills in ensuring midwives are fit to practice through risk management and supervision (MW IPA).
- A Consultant Obstetrician and Gynaecologist MD FRCOG - with 24 years' experience (O IPA).

13. I included the information and advice which informed the findings and conclusions 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

14. To investigate complaints, I must establish a clear understanding of the standards, both of general application and 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 Principles⁶:

- The Principles of Good Administration

⁶ These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

15. The specific standards and guidance referred to are those which 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.
16. The specific standards and guidance relevant to this complaint are:
- The Royal College of Obstetricians and Gynaecologists Green Top Guidelines No 45, published October 2015 (NICE Accredited), (Green Top Guidelines);
 - The Nursing and Midwifery Council's The Code: Professional standards of practice and behaviour for nurses, midwives and Nursing Associates, updated October 2018 (The Code); and
 - The Nursing and Midwifery Council's Standards of proficiency for midwives, published November 2018 (the Standards).
 - The General Medical Council's Good Medical Practice, updated April 2019 (the GMC Guidance).
17. I did not include all information obtained in the course of the investigation in this report. However, I am satisfied I took into account everything I considered relevant and important in reaching my findings.
18. 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. I carefully considered the responses I received.

THE INVESTIGATION

Whether the care and treatment the Trust provided to the complainant between 8 October 2021 – 10 October 2021 was adequate, appropriate and in accordance with guidance and relevant standards.

Detail of the complaint

19. The complainant was concerned that on 9 October 2021, when her pain became increasingly worse, the Midwife or junior doctor did not refer her to a

senior doctor despite her having a 'high risk pregnancy.' She is concerned that despite her requests, the Trust did not carry out scans or deliver her baby daughter.

Evidence Considered

20. I considered the following Guidelines and clinical practice:

- The Green Top Guidelines;
- The Code;
- The Standards; and
- The GMC Guidance

The Trust's response to investigation enquiries

21. The Trust referred my office to the information contained within its SAI report. The report outlined the findings of its own investigation. I enclose the report's findings at Appendix four to this report.

22. The SAI recommendations were:

- Any antenatal in-patient (excluding those in labour at term) should have an individualised plan of care documented that includes frequency of obstetric early warning score (OEWS) observations. As a minimum all antenatal in-patients should have OEWS recorded every 6 hours overnight (suggest midnight and 6 am) with clinical discretion used by the midwife if it is not appropriate to disturb the woman. This practice will be adapted and monitored by Sister in both Maternity In-patient Wards with immediate effect.
- The Practice Development Midwife will reinforce accurate recording of observations when completing the OEWS chart, specifically in women who require analgesia during OEWS training. OEWS training with staff will focus on accurate pain scoring, when to escalate concerns to senior staff and what observations should be carried out, including foetal wellbeing checks. This will be monitored using the OEWS NQI audits⁷ to

⁷ NQI Audits - Social Care Quality Improvement (HSCQI) Northern Ireland is a Quality Improvement (QI) Network whose purpose is to provide a supporting infrastructure for quality, improvement and innovation across the NI HSC system.

include *'is there evidence of an appropriate pain assessment completed'*. This will commence within three months from approval of the SAI report.

- Sharing the learning from this case with relevant staff (Midwives and Obstetricians). Assistant Director to lead on sharing through audit/M+M [morbidity and mortality meetings⁸], within three months of SAI approval.

23. The Trust stated it revised the SAI report to include the patient's feedback before it issued the final report. The Maternity Team continue to implement the learning arising from this sad and tragic case. It has been open and honest about the failings in care and have tried to ensure the finalised report reflected this.
24. In a statement to this office, the midwife said *'there is an entry in the notes that have been reviewed by the ombudsman and the IPA at 23:15 on the night of the 9th October which although I wrote I wasn't the midwife involved and had written the notes on behalf of another midwife. I wasn't present with the patient at this time.'*

Relevant Trust Records

25. I enclose the SAI report, which contains extracts from the relevant medical records, at Appendix four to this report.

Relevant Independent Professional Advice

26. I enclose the IPAs' full advice at Appendix two to this report. I have outlined my consideration of the advice in my analysis and findings below.

Analysis and Findings

27. The patient complained that the midwife and junior doctor who reviewed her on 9 October 2021 did not refer her to a more senior doctor despite having a high-risk pregnancy and increased abdominal pain.

⁸ Hospitals make use of these meetings to learn lessons from clinical outcomes and drive improvements in service delivery.

28. I considered the level of midwifery and clinical involvement in the patient's care between 8 and 9 October 2021. The records evidence that following the patient's arrival at the CMU on 8 October 2021, a midwife performed a CTG, which she assessed as '*normal*'. An ST2⁹ doctor reviewed and admitted the patient for pain relief and steroid treatment '*in anticipation of a preterm delivery*'. The records document that the ST2 doctor '*verbally agreed*' the plan with an ST5¹⁰ doctor the same evening.
29. The records further evidence that on the morning of 9 October 2021, a senior registrar doctor assessed the patient during ward rounds. The senior registrar arranged for a CTG twice daily. Both CTGs conducted that day were normal. A FY2¹¹ doctor reviewed the patient in relation to alternative pain relief later that evening. The doctor, nor the midwife, referred the patient to a senior doctor for review.
30. I note that on the evening of 9 October 2021, the patient reported to the midwife that she had green discharge. She also reported increased pain which did not improve with pain relief. The MW IPA advised the patient's description of pain is well documented in the medical notes. However, the report was not in line with the pain score recorded in the patient's OEWS chart (zero).
31. Midwives use OEWS to help identify deterioration in the woman and ensure appropriate early intervention. The guidance that accompanies the OWES charts provides explanation on pain observations. It states that staff should record a score of zero for no pain. I am satisfied the records demonstrate that the patient experienced significant pain at this time. Therefore, I accept the MW IPA's advice that a discrepancy exists between the frequency and type of pain the patient described, and the OEWS recorded. I consider this a failure in care and treatment.
32. The MW IPA advised that at 19.00 on 9 October 2021, when the patient complained of increased pain and a green discharge, the midwife should have

⁹ A doctor in their second year of specialty training.

¹⁰ A doctor in their fifth year of specialty training.

¹¹ A doctor in their second foundation year of training.

highlighted the change in presentation to medical staff. This is because it may have indicated foetal distress despite the normal CTG. The MW IPA also advised there were *'missed opportunities to ensure foetal wellbeing was continually monitored at a time of a change in frequency, intensity or site of pain as experienced by the patient.'*

33. Standard 13 of the NMC Code requires midwives to *'accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care'*. It also requires midwives to *'make a timely referral'* to another practitioner if required. I note the midwife asked a junior doctor to review the patient. However, this was only in relation to pain relief. I accept the MW IPA's advice and consider the midwife should have escalated the patient's symptoms to a senior clinician for review of the risks to the baby and monitoring. I consider this a failure in care and treatment.
34. In relation to clinical care, the SAI review team concluded that the initial medical review and management of the patient was *'appropriate'*. However, I note the O IPA advised that the Trust should have notified a Consultant *'immediately'* following the patient's admission. This was because of the *patient's 'history of repeated admissions with abdominal pain...who has a clearly increased risk of uterine dehiscence'¹² even before the onset of labour.'*
35. The SAI team also considered it would have been *'good practice for a further senior doctor review to have been facilitated given the provisional diagnosis of preterm labour'*. In relation to the evening of 9 October 2021, the O IPA advised that had the junior doctor referred the patient for consultant review, *'on the balance of probability, delivery would have been expedited and intervention before uterine dehiscence may have been possible with avoidance of intrauterine demise'*. I find this both troubling and concerning.
36. I note the patient was admitted on a Friday evening. I appreciate there was likely no consultant on duty in CMU at that time, or the following day. However, I do not consider the absence of a consultant from CMU would have prevented

¹² Uterine dehiscence is a separation of the uterine musculature with intact uterine serosa. Uterine dehiscence can be encountered at the time of caesarean delivery, be suspected on obstetric ultrasound, or be diagnosed in between pregnancies.

the junior doctor or any member of the midwifery team from contacting the consultant on call to escalate the care of the patient.

37. Standard 15 of the GMC Guidance requires doctors to '*refer a patient to another practitioner when this serves the patient's needs*'. Given the Patient's complex history, including repeated admission with abdominal pain, I agree with both the O IPA and the SAI review team that on 9 October 2021, the junior doctor should have referred the patient's care to a senior doctor. I consider this a failure in the care and treatment.
38. Based on the evidence available, I consider the patient's report at 19.00 on 9 October 2021 represented a turning point in her care. It is concerning the CMU staff did not escalate the patient's care when her presentation changed on the evening of 9 October 2021. I consider the failure to escalate the patient for a senior medical review following her admission, and on the evening of 9 October 2021, a **fundamental** failing in the care and treatment provided. I uphold the complaint.
39. I accept the O IPA's advice and note with sadness that had these failings not occurred, it is likely staff would have expedited delivery. Instead, the actions had **catastrophic consequences** for the outcome of the patient's pregnancy. I consider the failures caused the complainant and her family to sustain the injustice of distress, upset, uncertainty, and a loss of opportunity to deliver her daughter when her presentation changed on the evening of 9 October 2021.
40. I wish to comment on the attending midwife's statement to my office in which she explained that she was not with the patient at 23:15 on 9 October 2021, and instead, she entered the record on behalf of another midwife. This causes me great concern. Standard 10 of the Code requires midwives to '*Keep clear and accurate records relevant to **your practice***'. It also requires midwives to '*complete records accurately and **without any falsification***'. In making this record on behalf of her colleague, I consider the midwife failed to act in accordance with the NMC Code. I consider this a service failure.

41. I also wish to comment on the SAI review panel's determination that the medical record was an '*error*'. I am disappointed that the panel did not identify the seriousness of this falsification of a patient record. I would ask the Trust to share my concerns with the panel for future learning.
42. In relation to the reduction in expected staffing levels in CMU on 9 October 2021, I do not consider it acceptable for such a critical service to be so understaffed. Regardless, I do not doubt that had the midwifery team been fully staffed, such was the nature of the failures identified, they still would have occurred.

CONCLUSION

43. I received a complaint about care and treatment the Trust provided to the patient in October 2021. I uphold the complaint. I identified fundamental failings in the care and treatment CMU provided to the patient. I consider these failings resulted in catastrophic consequences for the patient. They also led to the complainant and her family to sustain the injustice of distress, upset, uncertainty, and loss of opportunity.

Recommendations

44. I note the Trust carried out an SAI and made a number of recommendations following its investigation. I welcome this action.
45. In addition to those the Trust already identified, I further recommend:
 - i. Within **one** month of the date of this report, the Trust provides the complainant with a written apology in accordance with NIPSO's 'Guidance on issuing an apology' (August 2019) for the injustice caused as a result of the failures and injustice identified.
 - ii. The Trust should appoint a suitably qualified independent reviewer to conduct a full obstetric audit of records belonging to all high-risk patients who have attended the CMU within the past three years. This review should include staffing levels including consultant cover and working practices within the CMU.

- iii. The Trust should appoint a suitably qualified independent reviewer to conduct a full midwifery audit of records belonging to all high-risk patients who have attended the CMU within the past three years. This review should include staffing levels and working practices within the CMU.
- iv. The Trust should share the outcomes of both audits with my office.
- v. Shares the finding of this report with relevant staff to allow them to reflect on the failings identified.
- vi. Provides training to relevant staff on the management and responsibilities of high-risk pregnancy including when staff should escalate the patient to a senior doctor.
- vii. Provides training to relevant midwifery staff on the recording of accurate pain scores for patients' OEWS charts, in line with guidance.
- viii. The Trust should share my concerns with the relevant staff and remind them of the importance of making their own accurate medical records.

46. I recognise the devastating impact the Trust's actions had on the patient and her family. I appreciate this report will never make up for the loss of their daughter and sister. However, I hope it provides the patient with further answers and helps take away any uncertainty that remains. I wish to pass on my sincere condolences to the patient and her family.

MARGARET KELLY
Ombudsman

September 2024

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and relevant guidance, 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.