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PUBLIC SERVICES OMBUDSMAN FOR WALES
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The investigation of a complaint

By Mrs A

against Hywel Dda

University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 201607619

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Introduction

This report is issued under section 16 of the Public Services Ombudsman (Wales) Act 2005.

In accordance with the provisions of the Act, the report has been anonymised so that, as far as possible, any details which might cause individuals to be identified have been amended or omitted. The report therefore refers to the complainant as Mrs A.

Summary

Mrs A complained about the care and treatment that she and her late son, Baby C, received from the Health Board. Specifically, Mrs A complained that there had been a failure to monitor Baby C's development during her pregnancy and labour, a failure to provide her with a birthing plan and a failure to respond to her concerns about unusual pains during labour. Mrs X also complained that there had been a delay in Baby C seeing a paediatrician, receiving treatment and a failure to conduct necessary tests after birth. Mrs A complained that the Health Board had not only failed to adequately respond to her complaint, but it had failed to conduct a full investigation into the cause of Baby C's death which resulted in her being given different reasons for Baby C's death. Finally, Mrs A complained that Baby C's death was incorrectly registered as a "stillbirth".

The complaint was upheld and it was recommended that the Health Board:

(a) Provides Mr and Mrs A with a meaningful apology for the failings identified in this report

(b) Pays Mrs A the sum of £4500 in recognition of the distress, delay and uncertainty she experienced in this matter, the cost incurred for the private scan and the time and trouble in bringing her complaint to this office.

(c) Identifies the clinicians and midwives responsible for the care of Mrs A and Baby C and discusses the content of this report in their supervision sessions, sharing any lessons learned with colleagues within the department

(d) Ensures compliance with the process for providing information to parents of babies that have been stillborn or neonatal death

(e) Changes Baby C's status from "stillborn" to "neonatal death".

The Complaint

1. Mrs A complained about the care and treatment that she and her late son, Baby C, received from Hywel Dda University Health Board ("the Health Board"). Specifically, Mrs A complained that:

- There had been a failure to monitor Baby C's development during her pregnancy and labour and provide her with a birthing plan
- There had been a failure to respond to her concerns about unusual pains during labour
- Following Baby C's birth, there had been a failure to conduct necessary tests
- There had been a delay in Baby C seeing a paediatrician and receiving treatment
- There was a failure to conduct a full investigation into the cause of Baby C's death which resulted in Mr and Mrs A being given different reasons for Baby C's death and the Health Board failed to adequately respond to this complaint
- Baby C's death was incorrectly registered as a "stillbirth".

Investigation

2. My Investigation Officer obtained comments and copies of relevant documents from the Health Board and considered those in conjunction with the evidence provided by Mrs A. Every detail investigated has not been included in the report, but I am satisfied that nothing of significance has been overlooked.

3. Advice was provided by three of my professional advisers. The Obstetrician Adviser, Dr Nitish N Narvekar, is a Consultant Obstetrician with many years' experience managing women in pregnancy and labour. The Midwifery Adviser, Ms Judith Robbins is a Supervisor of Midwives

with over 23 years' experience. The Neonatal Adviser, Dr J. M. Hawdon, is a Consultant with over 25 years' experience. When making my decision, I have taken into account the Advisers' comments, which I have accepted in full.

4. It is noted that, as a result of Mrs A's complaint to the Health Board, the Health Board undertook an investigation of her concerns including a root cause analysis (a method used to identify the root cause of problems or faults) ("RCA") and a report by the Supervisor of Midwives ("SoM"). Both reports identified lessons to be learned and made recommendations to the Health Board. In response, the Health Board has undertaken work with staff who are caring for parents whose baby has sadly died, to ensure that best practice is maintained and national guidelines are followed.

5. Mrs A and the Health Board were given the opportunity to see and comment on a draft of this report before the final version was issued.

Relevant legislation, guidance and policies

6. The National Institute for Health and Care Excellence: Intrapartum care for healthy women and babies[1], states that during the first stage of labour intermittent auscultation should be carried out after a contraction for at least one minute, at least every 15 minutes reducing to every five minutes during the second stage of labour. This is repeated in the guidance document Birth Place Decisions: Information for women and their partners on planning where to give birth provided by the Health Board.[2]

7. The Resuscitation Council UK[3] states that "rarely, the heart rate cannot increase because the infant has lost significant blood volume. If this is the case, there is often a clear history of blood loss from the infant, but not always. Use of isotonic crystalloid [a close match to blood plasma] rather than albumin [a protein made by the liver and transports medication and hormones through the blood] is preferred for emergency volume replacement."

[1] Clinical Guideline CG190; December 2014 ("the NICE Guideline")
[2] Kings College London, 2014
[3] www.resus.org.uk/resuscitation-guidelines/resuscitation-and-support-of-transition-of-babies-at-birth/

8. Section 41 of The Births and Deaths Registration Act 1953 (as amended by the Stillbirth (Definition) Act 1992 section 1(1)) defines a neonatal death as a baby "born at any gestation which shows signs of life and subsequently dies".

9. The World Health Organisation ("WHO") defines a stillbirth as a baby born with no signs of life at or after 28-weeks' gestation.

10. The Health Board's policy "Management of Late Intrauterine Foetal Death and Stillbirth" defines a neonatal death as a baby "born at any gestation which shows signs of life and subsequently dies".

11. The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 ("Putting Things Right") outlines the Health Board's statutory duty when responding to concerns.

Relevant background information and events

12. Mrs A experienced a number of difficulties during her first pregnancy. In view of this, Mrs A's second pregnancy was "Consultant led" (when the pregnant person has regular appointments with both a consultant and a midwife to monitor the progress of the pregnancy). The records show that whilst Mrs A's health was monitored throughout the pregnancy, she saw numerous doctors, none of whom discussed a birthing plan with her.

13. Mrs A was concerned about the size of her unborn baby and raised concerns with the clinicians. The records show that Mrs X underwent five scans, during her pregnancy. However, there are radiology records for only three of the scans[4]; the remaining two[5] are referred to in the doctors' notes in the All Wales Maternity Record only. Mrs A said that, as her concerns were dismissed, she paid for a private growth scan. An NHS growth scan was undertaken on 28 April, at 36-weeks and 4 days' gestation. The records show different estimations

[4] 13 November 2015 – Dating scan; 6 January 2015 – Anomaly scan; 28 April 2016 – Growth scan
[5] 24 February 2016; 30 March 2016

of the baby's size and revealed that the baby had stopped growing for a four-week period at the end of the pregnancy, yet no action was taken by the Consultant to investigate this.

14. On 5 May **2016**, Mrs A attended Withybush Hospital Midwife led Unit ("MLU")[6] where she was examined and found to be in the early stages of labour. During the examination, Mrs A complained of an uncomfortable, bruise like pain on the right side of her stomach. Mrs A said the midwife said that it was ligament pain, but this conversation was not documented in the records and during the Health Board's investigation, it was noted that the midwife did not recall Mrs A mentioning this pain. Mrs A declined the invitation to stay and have her baby there stating that, given her previous experience, she wanted to have her baby at Glangwili Hospital where there is a Labour Ward and Special Care Baby Unit.

15. At 8.20pm that day, Mrs A was admitted to the MLU at Glangwili Hospital where she was assessed and found to be in established labour. Mrs A was offered and accepted the use of a birthing pool, it is noted that, whilst there is an unsigned and undated note in the margin of the All Wales Clinical Pathway for Normal Labour document (page 5) stating that a senior midwife had been consulted on whether Mrs A was a suitable candidate to deliver her baby in the MLU, there is no evidence of a risk assessment being undertaken to determine whether it was safe to transfer Mrs A from "Consultant led" to "Midwife led" care. Both maternal and foetal observations were recorded at regular intervals[7] and were within normal limits.

16. Mrs A said that, while she was in the pool, she experienced another very sharp unusual pain which made her cry out. Mrs A described it as "a pain inside as if the baby was kicking back up inside me". Again, Mrs A said she was told it was ligament pain, but this pain was not documented. Again, it is noted in the Health Board's investigation that the midwife did not recall Mrs A mentioning this pain.

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[6] A Labour Ward has doctors, neonatal and anaesthetic care readily available, where a MLU, whilst based in a hospital, is run by midwives and has access to transfer a mother to the Labour Ward in the event of a complication.

[7] The foetal heart rate ("FHR") was recorded at 10-15-minute intervals between 8.30pm and 10.55pm. The final FHR was taken at 10.59pm and recorded as "?FH80bpm". Normal foetal heart rate is between 110-160bpm.

At 10.56pm, Mrs A experienced a bleed and was told that she had lost approximately 250mls of blood. (The post-natal care record notes that Mrs A also lost 200mls post-delivery).

17. At 10.59pm, Mrs A was moved from the birthing pool onto the bed for further assessment. The foetal heart rate had become difficult to detect and by 11.00pm it could no longer be detected. Consideration was given to transferring Mrs A to the Labour Ward for further management. However, vaginal delivery was imminent and there was a significant risk of delivery during transfer to the Labour Ward which was ten minutes away.

18. Baby C was born at 11.09pm. It was noted that Baby C was pale, floppy and that there were no signs of a heart rate or attempts to breathe. The Apgar score (an assessment out of 10 is given based on five aspects of a new-borns health) was 0 at birth. The umbilical cord was double clamped and the midwife cut the cord; there was no blood in the umbilical cord obtainable for analysis.

19. The placenta, when delivered at 11.19pm, was pale and showed evidence of a retroplacental clot (a blood clot between the placenta and the uterus), which suggested a placenta abruption (when the placenta starts to come away from the inner wall of the womb before the baby is born). Placenta abruption is very serious and can deprive the baby of oxygen and nutrients very rapidly.

20. Baby C was moved to the resuscitation table where the Midwifery Team attempted resuscitation. The Paediatric Team (a Registrar and Senior House Officer), who were fast bleeped at 11.10pm and arrived at 11.12pm, continued to actively resuscitate and intubate (passing a breathing tube to enable mechanical ventilation of the lungs) Baby C. Following intubation, Baby C had a heart rate of 30-40 beats per minute (“bpm”) and occasional gasps could be heard.

21. The First Consultant was fast bleeped at 11.15pm and, having been provided with the wrong location information, arrived at 11.27pm. The First Consultant recorded no evidence of spontaneous respiratory effort or movements, a faint heart rate of 30-40bpm, and occasional terminal gasps. Baby C was given two doses of adrenaline (a stress hormone that quickens the heart rate), through the breathing tube, to no effect.

22. At 11.36pm an umbilical venous catheter (this provides access through the umbilical vein for the administration of intravenous fluids and medication in neonatal infants) was inserted. Blood gases were extracted and it was noted that Baby C had severe acidosis (excessive acid in the body's fluids and tissue) and anaemia (inadequate number of red blood cells in the unborn baby's circulatory system, which can cause foetal heart failure).

23. Sadly, at 11.44pm**,** 35 minutes after birth, following a discussion between the clinicians in attendance (multi-disciplinary team), resuscitation was stopped and Baby C was pronounced dead.

24. Having been given time with Baby C, Mrs A was discharged from Hospital.

25. A post mortem was undertaken on 10 May. Baby C was recorded to be significantly smaller than the antenatal growth chart estimations (for example, out of 100 children of the same age and sex, a baby on the 90th centile would be larger than 90% of the babies). The post mortem found no evidence of anomalies or infection and, although there had been blood loss prior to delivery which could indicate placenta abruption, there were no obvious supporting features. The umbilical cord was reported to be attached to the side of the placenta, rather than the centre ("eccentric cord insertion").

26. On 19 August, Mrs A wrote to the Health Board complaining about the care and treatment she and Baby C had received. Mrs A wrote to the Health Board on a number of occasions to add further concerns about record keeping and the behaviour of the Second Consultant during their meeting to discuss the cause of Baby C's death.

27. On 24 August, Mr and Mrs A met with the Midwifery Service Delivery Manager, the Third Consultant and a Patient Support Facilitator to discuss her concerns. During the meeting, Mr and Mrs A were informed that the likely cause of Baby C's death was a placenta abruption. The Third Consultant confirmed that, in her view, Baby C had not been stillborn, rather he should be classified as a neonatal death. Mrs A was informed that the Health Board was undertaking a RCA.

28. The RCA found that there was no evidence of antenatal care planning and that the scan measurements had not been plotted on the growth chart. The RCA also found that there had been no foetal heart rate monitoring for nine minutes prior to delivery and, that the documentation relating to Baby C's birth was conflicting. Finally, the RCA noted that Mrs A had not been screened prior to discharge home. An action plan was created to address the identified issues.

29. On 11 January **2017**, Mrs A wrote to the Health Board outlining her concerns about the RCA.

30. On 23 January, the SoM completed a report on this matter. The SoM raised numerous concerns about record keeping. In particular, the failure to risk assess the transfer Mrs A from "Consultant led" to "Midwife led" care. It was also noted that there had been a failure to evidence Mrs A's referral to an appropriate professional, when problems were detected during labour.

31. On 20 February, the Health Board responded to Mrs A's complaint.

32. On 7 June, the Health Board published an investigation report on Mr and Mrs A's concern about the designation of Baby C's death. The report found that the designation of the death as a stillbirth was reasonable and accurate as, at no time following birth, did Baby C show any signs of spontaneous life.

Mrs A's evidence

33. Mrs A said that the place of birth had not been discussed with her before she went into labour. However, given that she was receiving consultant led care because she had experienced problems when giving birth to her first child, she believed that her only option was to give birth on the Labour Ward. Furthermore, had she been aware of the lower level of foetal monitoring in the MLU, she would not have agreed to deliver there.

34. Mrs A said that, while she was in the pool, Mr A noticed a pool of water near where she had been changing. Mr A showed the midwife the fluid and was told that, if Mrs A's waters did not break again, she would note it in the medical record as Mrs A's waters breaking; there is no reference to the fluid in the records.

35. Mrs A said that the monitoring on the MLU was ad hoc and the midwives did not keep the heart monitor on for the recommended one minute. Mrs A said that the midwife could not have taken a one-minute heart beat recording at 10:55pm, because the midwife was not in the room a minute later when she experienced a heavy bleed in the pool (this has been disputed by the Health Board – see paragraph 46). Mrs A said that, in her view, she should have been transferred to the Maternity Ward at that point.

36. Mr and Mrs A said that, after Baby C was born, they both heard him making a noise while the midwives were working on him. Mr and Mrs A said that one of the paediatricians attending Baby C had been unable to find the intubation equipment he needed and was shouting at people to find the right size tube. Additionally, the attending clinicians were waiting for the First Consultant to arrive so that they could insert an umbilical venous catheter.

37. Mr and Mrs A said that the First Consultant had decided to stop resuscitation without discussing the decision with them first (This has been disputed by the Health Board – see paragraph 50).

38. Mr and Mrs A asked to hold Baby C and the nurses removed the tubes before passing him to them. Mrs A said that, for approximately 10 minutes, Baby C would gasp periodically. Mrs A said the midwife told her that it was a reflex from the spine.

39. Mrs A said that, prior to leaving the Hospital, she told the midwife that she had been anaemic during pregnancy so, knowing that she had had a bleed, she asked if she required any extra iron. Mrs A said that, despite not checking her iron levels, the midwife said "no", because she had not lost enough blood. It was noted that the blood test results in Mrs A's records for this period had come from a blood test undertaken over two weeks earlier.

40. Mrs A said that when she returned home she received support from the Community Midwife because the Bereavement Midwife was very difficult to get hold of and failed to offer any support. Mrs A said that it was a "nightmare" to get hold of the pictures and the measurements the Health Board had arranged of Baby C. (This has been disputed by the Health Board – see paragraph 54)

41. Mr and Mrs A said that, in view of the noises that Baby C made during resuscitation, the recorded heart rate and the subsequent gasps he made when being held, he should not have been registered as "stillborn".

42. Mrs A said that the process to get any answers about what happened to her son was so difficult that she has lost all confidence in the Health Board and its clinicians. Mrs A said that, given the sensitivity of the matter, communication from the Health Board was poor, the timeframes provided, particularly in relation to the RCA, were unrealistic and its responses could only be described as obstructive and inaccurate.

43. In response to the draft report, Mr and Mrs A said that they felt misled by the clinicians about the noises Baby C was making while they were holding him in their arms and that it brings small comfort to them to know that they did hear their son cry.

44. Mr and Mrs A said that the Health Board's decision to classify Baby C as stillborn denied them the opportunity to discuss the possibility of organ donation.

The Health Board's evidence

45. The Health Board said that, in its view, the antenatal care provided to Mrs A and Baby C was exemplary and there were no suggestion of concerns at that time. The Health Board said that it had acknowledged and apologised to Mrs A for its failure to provide her with a birth plan and the information she required to make an informed choice. That said, the Health Board said that, in its view, given her uneventful antenatal progress, it had been clinically reasonable for Mrs A to have delivered her baby on the MLU.

46. The Health Board said that all monitoring of the labour was appropriately undertaken on the MLU with the midwife recording the foetal heart rate for one minute as per the All Wales Midwifery Care Guidelines. The Health Board said that the midwife was also present when Mrs A experienced the loss of blood. The Health Board said that up until 10.56pm, 13 minutes prior to delivery, all relevant tests and observations were conducted and found to be within normal ranges, and the midwives sought appropriate assistance once Mrs A's progress in labour had been assessed and a plan of care determined. Unfortunately, Mrs A's labour progressed to delivery rapidly.

47. The Health Board said that, during the second stage of labour, whilst experiencing expulsive contractions, it would be difficult to differentiate between uterine contractions and another causative factor, particularly placental abruption pain, which is normally a sustained continual pain without a uterine contraction.

48. The Health Board said that, whilst Mrs A had experienced blood loss in the pool, the retro-placental clot was only evident after the delivery of Baby C, when the midwives routinely checked the placenta and membranes. It was also noted that the umbilical cord was completely white and empty, so there was no blood available for samples.

49. The Health Board said that, in its view, there were no unnecessary delays in the attempts to resuscitate Baby C, as the midwives in attendance had been trained in neonatal resuscitation. The Health Board said that Baby C's heart rate could not be increased because he had lost a significant amount of blood. That said, at delivery, there was no clear history of blood loss from Baby C so the initial resuscitation priority had been the effective expansion of the lungs and cardiac output. The Health Board said that the Registrar and the First Consultant were both competent in the insertion of an umbilical venous catheter and that, whilst it was sited 27 minutes after birth, it was not clear if this delay had been the result of technical issues or difficulties caused by Baby C's reduced circulating blood volume. The Heath Board said that effective expansion of the lungs and adequate cardiac compressions are, typically, all that is required in over 99% of resuscitation interventions in new-born infants. The Health Board said that, whilst it accepted that lessons could be learned, it did not believe that resuscitation attempts fell below an acceptable standard.

50. The Health Board said that the records show that the First Consultant discussed the decision to stop resuscitation with Mr and Mrs A and the multi-disciplinary team in attendance. This was also supported by the attending midwife who also recalled the First Consultant explaining the likelihood that Baby C would have occasional gasps.

51. Further to Mrs A's concerns about anaemia, the Health Board said that all pregnant women routinely have their iron levels tested when booking into maternity services and again at 28 weeks.[8] The Health Board said that each test had found Mrs A's haemoglobin level (this enables the body to transport oxygen to the body's vital organs) was within normal parameters for midwifery led care at birth. The Health Board said that it is routine practice to use the last recorded haemoglobin level to support clinical decisions on haemoglobin management during labour. The Health Board said that, had Mrs A had sustained significant blood loss, more than 500mls, during delivery, it would have been noted as a post-partum haemorrhage (heavy bleeding

[8] Antenatal Screening Wales Standards; NHS Wales

after birth) warranting further analysis for anaemia. The Health Board apologised if that information had not been clearly communicated to Mrs A and that she had not received the appropriate assurances.

52. The Health Board said that it also recognised that there had been a failure to undertake a number of tests, including a TORCH screen (TORCH stands for Toxoplasmosis (a parasitic disease caught from animal faeces which can affect an unborn baby), Other diseases, including HIV, syphilis, and measles, Rubella, Cytomegalovirus (a common virus that is part of the herpes family and can affect unborn babies) and Herpes simplex), on both Mrs A and Baby C after delivery and said that it had apologised to Mrs A for those failings. The Health Board said this failing was not the result of a lack of awareness of required practice, rather an unfortunate consequence of the staff attempting to accommodate Mrs A's strong desire to return home. The Health Board said that, on reflection, it should have articulated, more clearly, the need for the tests and should have explained the implications of them not being performed to Mrs A.

53. The Health Board recognised that there are different perspectives on the recording of a stillbirth and a neonatal death. In Baby C's case, on delivery, he showed no sign of a heartbeat or muscle response; subsequent gasps were the signs of terminal apnoea (breath pattern leading up to death). The Health Board said that, whilst it can never be sure when Baby C died, it is of the view that it was more likely, given the clinical signs and presentation, that he was stillborn.

54. The Health Board said that it was saddened to learn that Mrs A had not felt like she had received appropriate support from the bereavement midwife and experienced difficulty contacting her. The Health Board record shows that between 9 May and 1 September, there were eight occasions when Mrs A spoke to the Bereavement Midwife on the telephone (these calls related to the access of information) and that, on 17 June, the Bereavement Midwife undertook a home visit with Mrs A, where they discussed support provided by the SANDS[9] charity.

[9] Stillbirth & neonatal death

55. The Health Board said that, in its view, the obstetric RCA undertaken after the event had been thorough and had informed the Health Board's response to Mrs A's complaints. The Health Board acknowledged that, whilst the obstetric RCA had not identified the cause and time of Baby C's death, it did identify a number of shortfalls in the process which resulted in an action plan. The Health Board said that it had undertaken the identified actions and that lessons have been learned.

Professional Advice

The Obstetrician Adviser

56. The Adviser said that Mrs A had attended a sufficient number of antenatal visits and that the records showed no cause for concern about Baby C's growth and development. However, the failure to record the scans undertaken during the antenatal clinic visits provided scope for confusion and doubt.

57. The Adviser said that, particularly in view of the previous problems Mrs A experienced during the birth of her first child, the Consultant should have discussed a birthing plan with her and failing to do so put her and Baby C at risk. The Adviser said that Mrs A's history meant that delivery at a MLU would not be the best option and she should have been made aware of the associated risks. That said, as the events progressed Mrs A developed an unrelated risk.

58. The Adviser said that, whilst a placenta abruption had been recorded in the labour notes and eccentric cord insertion in the post mortem report, the proximity of both in relation to each other is not documented; this was a serious omission in understanding the cause of Baby C's death, because close proximity would have suggested that the bleed was from Baby C. Unlike a full abruption, a marginal abruption does not leave a mark, so the post-mortem examiner would not have known where, on the placenta, the bleed occurred. The Adviser said that the responsibility for recording both the site of the cord insertion and the bleed was with the clinical staff involved in the delivery.

59. The Adviser said that, whilst the Health Board's complaint response addressed all areas of obstetric care, there appeared to be an inappropriate emphasis on abruption as the cause of Baby C's death rather than the consideration of alternative reasons, such as occult hypoxia (lower than normal concentration of oxygen in the blood that is hidden).

60. The Adviser also highlighted further discrepancies in the complaint response. This included the Health Board incorrectly stating that the post-mortem reported a retroplacental clot which confirmed the diagnosis of abruption, when evidence of the clot was not visible at post-mortem stage. Additionally, it was suggested that Baby C had been severely anaemic at birth, but, given that the blood sample had been taken 27 minutes after birth, in a baby declared stillborn, with severe cardiorespiratory failure, the result may not be a true reflection of his condition at birth.

The Midwifery Adviser

61. The Adviser said that the midwives had appropriately measured the overall growth of Mrs A's baby and the measurements were within normal range. The placenta could be seen and was found to have no abnormalities and there was good blood flow to and from the cord.

62. The Adviser said that, contrary to NICE guidelines, there was insufficient discussion with Mrs A about her birth plan and it would not have been possible for Mrs A to have made an informed decision about where she wanted to deliver her baby.

63. The Adviser said that good practice states that midwives should record any concerns, including unusual pain, in the maternity notes so that they can be followed up during any subsequent appointments.[10]

[10] The Code; Professional standards of practice and behaviour for nurses and midwives; 31 March 2015 ("the NMC Code")

64. The Adviser said that, when Mrs A was assessed by the midwives to see if she met the criteria for delivery in the MLU, appropriate consideration was given to her previous pregnancy and labour and senior advice was sought. The Adviser said that, as Mrs A was considered to be of low risk, it was appropriate and responsive to offer the option of pain relief, using the birth pool.

65. The Adviser said that the decision to transfer Mrs A to the Delivery Suite was a difficult call to make because of the risk of Mrs A delivering her baby in the middle of a ten-minute transfer. In view of this, the midwives requested that help attend the MLU. The Adviser believed, on balance, this was the most appropriate course of action by the midwives.

66. The Adviser said that a placental abruption could not have been predicted and is often sudden. The Adviser said it was likely that the second pain Mrs A described was the abruption, especially as it was at that time the blood loss became visible in the birthing pool.

67. The Adviser said that the Neonatal Team should have been fast bleeped when the blood had been noted in the pool and they were unable to hear the baby's heart, so that preparations could have been made to attend the imminent birth. Instead the Neonatal Team were fast bleeped one minute after the head had been delivered and they arrived over two minutes later. Having reviewed the umbilical cord gas results, the Adviser said that it was unlikely that, even if the Neonatal Team, including the First Consultant who was last to attend, had been present for the birth, it would have made any difference to the sad outcome.

68. The Adviser said that no cord blood was taken for testing cord gases despite double clamping of the cord. This is essential and recommended as good practice when a baby is born requiring resuscitation.

69. The Adviser said that the documents provided show that Baby C's haemoglobin level was low at birth which indicated that the blood loss in the pool was likely to have been foetal blood loss. The Adviser said that low haemoglobin would have reduced Baby C's ability to survive, as he was born after this blood loss and was already anaemic.

70. The Adviser said that, after the delivery of her son, Mrs A's blood should have been tested to see whether she needed a blood transfusion. The Adviser said that using a previous haemoglobin result from before the birth in the discharge summary was not good practice.

71. The Adviser said that a mother can pass infections to a baby during pregnancy or delivery. Early detection and treatment of those infections is crucial for preventing complications but also for detecting whether any form of infection may have contributed to a baby's death. In the absence of any newer tests, a TORCH screen is still best practice when a baby has died and it should have been undertaken in this case.

72. The Adviser said that, whilst the midwives kept contemporaneous records of the labour and delivery, it would have been good practice to have recorded the discussion about delivery on the MLU and the explanation as to why Mrs A left one MLU to attend another. Additionally, there should be a record of the risk assessment, the complaints of unusual pain and the fluid loss, including the 'show' of blood which Mrs A said was not documented. The failure to document this information was not in line with best practice.

73. The Adviser concluded that better communication would have supported Mrs A's recovery and understanding of the events.

The Neonatal Adviser

74. The Adviser said, on the basis of the records available that it was likely that the placental abruption, which occurred around 10.56pm, resulted in a lack of oxygen or blood flow to the brain ("acute profound hypoxia-ischemia"). It is generally considered that a foetus will tolerate ten minutes of acute profound hypoxia-ischemia before a brain injury occurs; after 25 minutes, it is unlikely the baby will survive. Unfortunately,

since Baby C was born at 11.09pm, it was likely that he had already sustained at least 13 minutes of acute profound hypoxia-ischemia, which may have caused cardiorespiratory depression (when the heart and breathing stop) at birth, requiring resuscitation and a degree of brain injury, had he survived. The Adviser said that, alternatively, the combination of acute profound hypoxia-ischemia and foetal anaemia could have resulted in severe injury developing sooner.

75. The Adviser said that the reported retroplacental clot indicated that a placental abruption had occurred which, in turn, was the likely cause of the acute profound hypoxia-ischemia.

76. The Adviser said that the RCA correctly identified that the Paediatric Team could have been called earlier resulting in earlier intubation. The Adviser said that, in the circumstances, there was an acceptable delay in the Consultant Paediatrician being called because the Paediatrician Registrar was responsible for initiating resuscitation.

77. The Adviser said it was likely that delays were caused by the Paediatric Team's unfamiliarity with the location of equipment needed to intubate (insert a tube to aid breathing) Baby C and perform an umbilical venous catheterisation. The Adviser said that the RCA failed to provide an explanation for the Paediatric Team's delay in siting the umbilical venous catheter soon after intubation. The Adviser said that whilst both the minor delay in intubation and longer delay in umbilical venous catheterisation may have contributed to the tragic outcome, it was unlikely it was the cause of Baby C's death.

78. The Adviser said that the Health Board's decision not to give Baby C a blood transfusion until his heart rate and the oxygen levels in his blood were stable was contrary to guidance (see paragraph 7) which states that it is generally accepted that, if emergency blood is available, it may be given, and if emergency blood is not available, intravenous fluid should be given.

79. It is the Adviser's view that Baby C's death should have been classified as a neonatal death not a stillbirth. The RCA referred to the WHO definition of stillbirth (see paragraph 9), adding that there needed to be no "spontaneous sign of life". The Health Board said that Baby C's heart rate was only detectable after the administration of medication, so any signs of life were not spontaneous. The Adviser noted that a heart rate was detected before drugs were given, contrary to the RCA finding, and that any heart rate detected, independent of cardiac massage, even after drugs are given, is a spontaneous heart rate and constitutes signs of life. With respect to the Health Board's comment that the heart rate recorded following the administration of medication was a spinal response caused by the drugs, the Adviser said that this explanation had no "physiological bearing". It is the Adviser's view that, although there were no signs of life in the immediate period after birth, resuscitation measures allowed sufficient circulation and oxygenation to result in transient spontaneous heart rate and gasping.

80. Finally, the Adviser said that neither the RCA nor the Health Board's complaint response fully addressed the neonatal issues that Mr and Mrs A raised.

The Health Board's comments following the draft report

81. In its response to the draft report, the Health Board has apologised for some of the failings identified and has provided details of the additional work that it has carried out in response to the lessons that have been learned.

82. I am pleased to note that the Health Board has also introduced a "Birth Choices" booklet which provides expectant mothers with information on the Health Board's facilities, so that an informed choice regarding place of birth can be made.

83. Finally, the Health Board has said that, following the draft report, it sought additional advice on the matter of whether Baby C should be registered as "stillborn" or "neonatal death". The Health Board said that, whilst there remains some difference of clinical opinion on the matter, it acknowledges the majority view that Baby C did show signs of life and

had a partial and transient response to resuscitation which, sadly, was not sustained. Therefore, it accepted that Baby C should have been registered as suffering a neonatal death. The Health Board said it wished to express its sincerest apologies to Mr and Mrs A and to reinforce that the lessons learned have been shared with the Neonatal Team to ensure that recurrence is prevented.

Analysis and conclusions

84. Mrs A complained that there had been a failure to monitor Baby C's development during her pregnancy and labour and provide her with a birth plan. Having considered the information available to me, I **uphold** this element of the complaint.

85. During her pregnancy, Mrs A was seen regularly by both the Midwifery and Obstetric Teams, however, there was no consistency as to which doctor Mrs A saw during the Consultant appointments. Contrary to the NICE guidelines and the Health Board's Guidance, fundamental matters, such as the birthing plan, were missed. The involvement of a number of different doctors appears to have resulted in a lack of ownership of Mrs A's care. Furthermore, Mrs A's choice to have her baby on the Labour Ward was disregarded.

86. I am also concerned to note the Consultants' failure to document the readings from the ultrasound scans, particularly in view of Mrs A's previous history. Therefore, the growth anomalies, which were a significant concern for Mrs A, were missed. It is noted that Baby C had not grown for an approximately four-week period at the end of the pregnancy and that the size estimations Mrs A had been given had varied significantly. Furthermore, when Baby C was born, he was much smaller than the scans had predicted. It is noted that Mrs A was so anxious about the size of her baby and felt so dismissed by the Consultants, she felt that she had no choice but to pay for a private growth scan.

87. When Mrs A started her labour, it appears that she and Baby C were appropriately monitored, in accordance with the NICE guidelines, the All Wales Clinical Pathway for Normal Labour[11], and the guidance adopted by the Health Board (see paragraph 6). However, I note that, in view of the failure to explain the differences between the Labour Ward and the MLU, particularly the different approach to foetal monitoring, Mrs A did not fully understand the intermittent foetal heart rate monitoring approach (which is in accordance with the All Wales Clinical Pathway) at the MLU. As a result, Mrs A's anxiety was increased because she believed that the midwives were undertaking only ad hoc checks of the baby.

88. It is my view that the failings identified led to Mrs A experiencing an injustice. Mrs A had no consistency in care and her anxieties about her place of birth and the size of her baby were ignored. Furthermore, by failing to provide Mrs A with a birth plan, she did not understand the differences between the MLU and the Labour Ward which increased her anxiety and caused her to doubt the commitment and capabilities of the midwives caring for her.

89. Mrs A complained that there had been a failure to respond to her concerns about unusual pains during labour. Having considered the information available to me, I **uphold** this element of the complaint.

90. There were two occasions when Mrs A experienced unusual abdominal pain which she said that she reported to the examining midwives (see paragraphs 14 and 16). Mrs A said that, on both occasions, the pain was dismissed as ligament pain and no investigations of the pains were conducted. It is noted that there is no record of these pains. Neither midwife recalls Mrs A mentioning such a pain and both Mrs A and Baby C's observations had been within normal parameters. During its investigation of Mrs A's complaint, the Health Board did not dispute Mrs A's recollection. In fact, during one meeting, Mrs A was informed that the pain she experienced was

[11] www.wales.nhs.uk/sites3/page.cfm?orgid=327&pid=5786

probably the placental abruption. In view of this, it is my opinion that, on the balance of probabilities, Mrs A did inform the midwives of this unusual pain and, contrary to the NMC Code, the pain had not been documented in the records because it was thought to be ligament pain.

91. It is my view that this is service failure resulting in an injustice for Mrs A, because the time the pains occurred may have provided an accurate indication of when the placental abruption took place.

92. Mrs A complained that there had been a failure to conduct necessary tests following Baby C's birth. Having considered the information available to me, I **partly uphold** this element of the complaint.

93. When Mrs A left hospital it was believed that she had lost at least 250ml of blood. Mrs A was concerned that she had been discharged without any tests to check whether, as someone who had experienced anaemia during pregnancy, she needed further treatment. Mrs A was also concerned that the Health Board had documented her haemoglobin levels from a test undertaken over two weeks before the birth of Baby C. The Health Board said that it was its usual practice to base its clinical decisions on these earlier haemoglobin levels, particularly since, during the last test, Mrs A's levels were within normal parameters. Furthermore, since, in its view, Mrs A had not experienced a post-partum haemorrhage she did not require additional tests or treatment. It is clear that this information was not adequately communicated to Mrs A prior to discharge. Given the midwife's reaction to the amount of blood lost and the estimated levels communicated to Mrs A, it was reasonable that, without an explanation of what had happened and how that affected her, Mrs A was anxious about her own health.

94. The Health Board has accepted that there had been a failure to undertake number of tests including a TORCH test to rule out disease as the cause of Baby C's death. Whilst I understand that the midwives had been trying to facilitate Mrs A's return home as soon as possible, the tests should have been undertaken before discharge. I note that the Health Board has taken this matter on board for the future.

95. The Health Board has said that it was not possible to take samples of Baby C's umbilical cord blood to test for blood gases because there was no blood left in the cord. Whilst I note that the midwives sent a sample of the cord and the placenta for further analysis, sadly, it was the cord blood that may have provided some vital information on Baby C's condition as well as the cause of his death. I am also concerned to note that, having reviewed the records, I have seen no evidence that the Paediatric Team was informed of the absence of blood in the umbilical cord.

96. Whilst I note that the Health Board has accepted that it failed to conduct the necessary tests on Mrs A prior to discharging her from hospital, it is my view that these failings resulted in an injustice to Mrs A. Specifically, Mrs A was already distressed by the death of her son and the failure to provide her with relevant explanations increased her anxiety about her own health. Furthermore, the midwives' failure to undertake the necessary tests after the birth of Baby C put Mrs A at risk and could have affected the investigation into Baby C's death.

97. Mrs A complained that there was a failure to conduct a full investigation into the cause of Baby C's death, and that the Health Board failed to adequately respond to her complaint. Having considered the information available to me, I **uphold** this element of the complaint.

98. When Baby C was born, there had been a failure to document significant information about the placenta and umbilical cord and Baby C's blood gases. These failings impeded the clinicians' investigation into Baby C's death and resulted in Mr and Mrs A being given several different explanations before it was concluded that Baby C had died because of a placental abruption.

99. It is my view that, whilst the clinicians had wanted to help Mrs A understand what happened to her son, sharing different theories about the cause of his death did nothing but add to Mr and Mrs A's distress

and ultimately, caused confusion and distrust of the clinicians as their theories changed. I note that the Health Board has apologised for this point and has said that, in future, it will ensure that all investigations are complete before sharing any explanations with family members in these situations.

100. With respect to the Health Board's complaint handling, Mrs A's complaints have been numerous and complex and it was reasonable that, in the circumstances, the Health Board took its time to ensure that an appropriate and sensitive response had been provided. However, it is noted that, whilst the Health Board undertook an investigation and an RCA into the matter (which identified a number of lessons to be learned), the responses shared with Mrs A were inaccurate and failed to fully address the issues that had been raised.

101. As a result of these failings, Mrs A has experienced unnecessary anxiety and the relationship of trust between her and the Health Board has broken down, as she feels that she has to check every point made.

102. Mrs A complained that there had been a delay in Baby C seeing a paediatrician and receiving treatment. Having considered the information available to me, I **uphold** this element of the complaint.

103. It is my view that, given the circumstances, the Paediatric Team should have been fast bleeped as soon as Mrs A experienced a bleed, so they could be in attendance when Baby C was born; this would have resulted in earlier intubation. I am concerned to note, however, that the Paediatric Team delayed inserting the umbilical venous catheter until after the First Consultant arrived. This was unreasonable and caused delays in blood samples being taken and in the administration of important treatment.

104. With respect to the attendance of the First Consultant, I note that the delay was caused by incorrect location information being provided during the fast bleep process, which was avoidable.

105. The Health Board has stated that it chose not to give Baby C a blood transfusion until his heart and oxygen levels were stable. However, this action was contrary to advice provided by the Resuscitation Council UK.

106. Despite the above, it is impossible to say, with any certainty, that the delays to treatment and the decision not to administer a blood transfusion affected Baby C's chance of survival. That said, the service failure that I have identified has resulted in an injustice for Mr and Mrs A, who have been left questioning the quality and timeliness of the care that Baby C was given and wondering whether, if there had been no delays in attendance and treatment, their son would have survived.

107. Mrs A complained that the Health Board incorrectly registered Baby C's death as "stillborn". Having considered the information available to me I **uphold** this element of the complaint.

108. The Health Board said that it classified Baby C's death as a stillbirth rather than a neonatal death because there had been no spontaneous signs of life; the documented heart rate and gasping breaths were not taken into account because they occurred as a result of the intubation and medication given to Baby C.

109. It is noted that the definitions of a stillbirth as described by UK legislation and the WHO do not require a **spontaneous** sign of life to be necessary to record a "neonatal death". Both documents state that there must be **no** sign of life. Furthermore, the Health Board's own policy does not require a spontaneous sign of life. In the case of Baby C, there was some sign of life and Baby C's death should have been recorded, as the Third Consultant indicated (see paragraph 79), as a neonatal death, not a stillbirth.

110. The injustice arising from the decision to record a stillbirth has been significant for Mr and Mrs A. In particular, they believed that when Baby C had been passed to them he had been alive and had died in their arms. Additionally, Mr and Mrs A would have received birth and death certificates for their son, rather than a stillbirth certificate.

Recommendations

111. I **recommend** that, within one month of the final report, the Health Board:

(a) Provides Mr and Mrs A with a meaningful apology for the failings identified in this report

(b) Pays Mrs A the sum of £4500 in recognition of the distress, delay and uncertainty she experienced in this matter, the cost incurred for the private scan and the time and trouble in bringing her complaint to this office.

112. I **recommend** that, within three months of the final report, that:

(a) The Health Board identifies the clinicians and midwives responsible for the care of Mrs A and Baby C and discusses the content of this report in their supervision sessions, sharing any lessons learned with colleagues within the department

(b) The Health Board ensures compliance with the process for providing information to parents of babies that have been stillborn or neonatal death

(c) In light of the Health Board's comments (see paragraph 83) it changes Baby C's status from "stillborn" to "neonatal death"

113. I would also **suggest** that the Health Board shares the action plans created as a result of the RCA and the investigation by the SoM with Mr and Mrs A, and arranges a meeting to discuss the improvements that have been made, within the Health Board, to ensure that the failings identified are not repeated.

114. I am pleased to note that in commenting on the draft of this report **the Health Board** has agreed to implement these recommendations.

Nick Bennett 5 June 2018
Ombudsman

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