Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against the Western Health and Social Care Trust

NIPSO Reference: 18602

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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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SUMMARY

I received a complaint about the actions of the Western Health and Social Care Trust. The complaint concerned the record keeping of a Paediatric SHO and a staff midwife's decision not to escalate the complainant's concerns to the SHO's supervisor.

Issues of Complaint

I accepted the following issues of complaint for investigation:

(i) Was the SHO's record keeping appropriate and adequate in relation to the birth of the complainant's son on 21 April 2010?

(ii) Were the actions of the staff midwife, in speaking to the SHO and making a note in the medical record, the appropriate method of dealing with her concerns?

Findings and Conclusions

I have found maladministration in relation to the record keeping of the staff midwife. However, I have not found any failure in the record keeping of the SHO. I have also not found any failure in the staff midwife's decision not to escalate her concerns to the SHO's supervisor.

Recommendations

In relation to the maladministration and injustice that I have identified in this case, I recommend the Trust pay to the complainant by way of solatium a sum of £750 (within one month of this report) in respect of the uncertainty, distress and frustration sustained as a result of the documentation of the staff midwife's concerns.

THE COMPLAINT

1. The complainant believed that entries by the staff midwife raised serious concerns about the resuscitation of his newborn son. He also believed that the rationale provided by the paediatric SHO[1] in his written statements following the resuscitation are not consistent with his contemporaneous notes. He complained about the SHO's record keeping and the midwife's decision not to escalate any concerns she had regarding the resuscitation.

Issues of complaint

2. I accepted the following issues of complaint for investigation:

   (i) Was the SHO record keeping appropriate and adequate in relation to the birth of the complainant's son on 21 April 2010?

   (ii) Were the actions of the staff midwife, in speaking to the SHO and making a note in the medical record, the appropriate method of dealing with her concerns?

INVESTIGATION METHODOLOGY

3. In order to investigate the complaint, the Investigating Officer obtained from the Trust all relevant documentation together with the Trust's comments on the issues raised by the complainant. This documentation included medical records, statements from the SHO, the staff midwife their respective supervisors, and the Trust's complaint file.

4. After consideration of the issues, the Investigating Officer obtained independent professional advice from two independent professional advisors (IPA).

5. The information and advice which have informed my findings and conclusions are included within the body of my report. The IPAs have provided me with "advice",

[1] Junior position for a doctor who is under special training within a certain medical speciality (now replaced by ST1-ST2-ST3

however how I weigh this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards

6. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those which are specific to the circumstances of the case.

7. The general standards relevant to this complaint are the Ombudsman's Principles[2]:

    (i) The Principles of Good Administration
    (ii) The Principles for Remedy

8. The specific standards are those which applied at the time the events occurred and which governed the exercise of the administrative functions of those organisations.

9. The specific standards relevant to this complaint are:

    (i) UK Resuscitation Council guidelines;
    (ii) GMC Good Medical Practice Guidelines (2013) (the 'GMC Guidelines')
    (iii) The Newborn Resuscitation Guidelines issued by the UK Resuscitation Council; (the 'Newborn Resuscitation Guidelines') and
    (iv) Newborn Life Support Guidelines.

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

11. I have not included all of the information obtained in the course of the investigation in this draft report, but I am satisfied that everything that I consider to be relevant and important has been taken into account in reaching my findings.

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

THE INVESTIGATION

Issue 1

Was the SHO'S record keeping appropriate and adequate in relation to the birth of the complainant's son 21 April 2010?

12. The complainant has questioned the accuracy of the SHO's statements dated 30 July 2017 and 4 December 2017, which intend to clarify and explain the events surrounding the resuscitation of his baby son. In particular, the complainant has questioned the SHO's statement that there were *'copious amounts of secretions of amniotic fluid'* in his statements following the delivery. The complainant has contrasted this with the contemporaneous note in the medical records, which make no mention of amniotic fluid or copious secretions. He contended that if there were copious secretions, this ought to have been recorded in the medical chart as an indication for suctioning.

13. I have reviewed the UK Resuscitation Council Guidelines. In relation to suctioning of newborns, the guidelines state:
'Airway suction immediately following birth should be reserved for infants who have obvious airway obstruction that cannot be rectified by appropriate positioning and in whom material is seen in the airway. Rarely, material (e.g. mucus, blood, meconium, vernix) may be blocking the oropharynx or trachea. In these situations, direct visualisation and suction of the oropharynx should be performed.' 'If the lungs have not aerated, then consider an obstruction in the oropharynx or trachea which may be removable by suction under direct vision.'

14. I have also considered the GMC Guidelines. I note that these guidelines state that clinical records ought to include:
'*a) relevant clinical findings; b) the decisions made and actions agreed, and who is making the decisions and agreeing the actions; c) the information given to patients; d) any drugs prescribed or other investigation or treatment; and e) who is making the record and when.'*

15. I have reviewed the baby's medical records provided by the Trust. These include the maternity notes and the baby's neonatal notes. I have considered the contemporaneous notes entered by the SHO in relation to his resuscitation. The SHO recorded his newborn examination as follows: *'Vacuum delivery for PROM[3], Increased Foetal Heart. Live born boy delivered. Poor Colour. Poor respiratory effort. Heart Rate over 100. Airway checked for secretions.'*

16. Under the section titled '*Management'*, I note that the SHO has documented as follows:
'5 inflation breaths given, still poor air entry. Airway checked again. Clear and patent[4]. 5 more inflation breaths given. Air entry improved. Neopuff given 60/min. Colour improved, tone improved, Heart Rate over 150. Activity Improved. Resp. Spontaneous at 7 min. Transferred to mother. RR[5] 60, Heart Rate 150. Pink.

17. I note that the SHO recorded the APGAR[6] scores as 5 at 1 minute, 8 at 5 minutes, and 10 at 10 minutes. The Paediatric SHO timed his note at 00:04.

18. In response to our enquiries, the Trust provided a copy of its complaints file which contained correspondence from the SHO, the Paediatric Consultant and the Acting Associate Director of Acute and Community Paediatrics. All three provided comments in relation to the contemporaneous note made by the SHO.

19. In response to the complaint, the Paediatric Consultant reviewed the SHO's entries into the chart. In an email dated 4 April 2017, she confirmed that *'There is nothing in the SHO notes that cause[d] [her] to have concerns and the fact that the baby responded rapidly confirms that the resuscitation was effective'.* She also commented that *'[a]lthough routine suctioning of the airway is no longer recommended, the airway can be suctioned to clear the airway if the healthcare*

[3] Premature Rupture of Membranes.
[4] Open and unobstructed.
[5] Respiratory Rate.
[6] A system designed to assess the condition of a newborn baby. Five features are scored 1 minute and again 5 minutes after birth. These are breathing, heart rate, colour, muscle tone and response to stimulation.

professional thinks secretions are present because they are seen on inspection of the airway or there is auditory evidence of the presence of secretions. The size of the mask chosen for initial resuscitation is a judgement call and the SHO did switch to a smaller mask when this was suggested to him. In a term infant with normal lungs it would be reasonable to reposition the airway and provide a second set of inflation breaths without jaw thrust. In general the healthcare professional at the baby's head leading the resuscitation team and would not change position, but would provide jaw thrust and the 2nd healthcare professional would provide ventilation breaths. The SHO makes no comment on assistance provided by the midwife.'

20. In an email dated 5 April 2017 the Head of Acute and Community Paediatrics also commented on the baby's resuscitation. She specifically commented on the interactions between the staff midwife and the SHO. She stated that: *'[d]uring emergencies, staff often advise colleagues to reposition the head, or offer to swap roles if an attempt fails. Professionals usually give feedback after an emergency if it is warranted rather than documenting where they could have done something differently. However, if care is compromised and apgar scores or blood gas results were not within the expected range then this would warrant explanation in the notes that there was a delay.'*
    I further note that a letter summarising both of the above views was sent to the complainant by the Trust's Medical Director, on 7 April 2017.

21. I note that in response to this letter, the complainant queried why the SHO, who had been involved in the resuscitation, was not provided with an opportunity to comment on his own records. The complainant said that no effort was made to seek the SHO's comments in relation to his entries in the baby's medical notes. As a result of the complainant's intervention, the SHO was then contacted by the Trust for comment.

22. I further note that following the complainant's second complaint, the SHO submitted two separate explanatory statements as part of the Trust's complaints process. These were dated 30 July 2017 and 4 December 2017. I note that the SHO provided a statement dated 30 July 2017 based upon a review of the case notes, a review of his entries into the notes, and his own recollection of the events surrounding his

involvement in the birth.

23. The SHO explained that after the baby was born, he was brought to him at Resuscitaire,[7] *'to be dried, stimulated, and kept warm before his initial assessment of APGAR scores.'* The SHO noted that he recalled that *'the child had a good heart rate, but had poor tone and colour, and had poor respiratory effort with copious amounts of secretions and amniotic fluid pouring from the mouth.'*

24. In relation to his interactions with the staff midwife, the SHO stated that he *'asked the attending Midwife to pass [him] the suction catheter, and [he] performed gentle oropharyngeal suction under direct vision to ensure a clear airway and ensure a good seal for the inflation breaths [he] was about to perform.' At this point the midwife insisted that [he] did not need to do any suctioning of the airway, which [he] disagreed with. [He] asked her to help with the resuscitation.*

25. The SHO *'then carried on with 5 inflation breaths to help with lung inflation as per the Neonatal Life Support (NLS) Guidelines.'* The SHO's statement described the process by which he resuscitated the baby. He explained that he disagreed with the staff midwife about the size of mask being used for the resuscitation. The SHO explained that he believed he was *'achieving a good airway seal'.* He did not document and did not recall when the second set of inflation breaths were carried out. He also did not recall whether a second mask size was used, but indicated that this was documented in the midwife's notes.

26. The SHO's statement also documents his discussion with the staff midwife. *'After leaving the infant with the parents [the SHO] had a discussion with the midwife who expressed her concerns that [he] did not do as she had suggested during the resuscitation, with regards airway clearance and [his] reluctance to change the mask. [The SHO] explained that as leader of the resuscitation [he] had disagreed with her assessment and that the air entry into the infant's lungs had improved with changing the airway positioning using jaw thrust. [The SHO] said that there had not been a problem with mask size as she had suggested because a good airway seal was achieved throughout the resuscitation.* The SHO then suggested that if the

[7] A warming therapy platform which includes the components needed for resuscitation.

midwife still had concerns about his proficiency, *'then [he] would encourage her to bring it to the attention of [his] supervising paediatric consultant.'*

27. I note that the SHO provided further clarification in a subsequent statement dated 4 December 2017. He clarified that he recalled '*from memory that there was copious amounts of fluid in the mouth of the infant which I suctioned to clear his airway and help with making a good mask seal. It is not unusual for amniotic fluid and secretions to be present in the airway of a newborn'.* The SHO believed that this *'might be the reason why [he] did not specifically document the presence of same in this instance'.*

28. I note that the SHO also clarified that the jaw thrust technique is a two person technique that was performed by him and the midwife. The SHO also recalled that *'a good airway seal was achieved throughout the resuscitation efforts by [the SHO] and the Midwife.'*

29. The SHO also noted that this resuscitation was not subsequently raised with his supervising consultant.

30. In response to investigation enquiries, the Paediatric SHO provided further clarification of the content of his note during the resuscitation and his statements during the Trust's complaints process. He explained that he *'used the term "copious" in [his] statement of 4 December 2017 (and also in the context of his statement dated 30 July 2017) to indicate an amount of amniotic fluid present that [he] felt suctioning would aid in terms of the delivery of mask ventilation.'* The SHO also confirmed that *'[t]he complainant is correct to state that [the SHO] did not specifically document the presence of same in this instance'.* His statement also stressed that he '*would not have employed the use of oro-pharyngeal suctioning unless significant secretions were present in the airway of a newborn baby'.*

31. I note that when asked why he was able to recall this specific occasion, the SHO explained that he was able to recall his involvement in this resuscitation *'more readily than might otherwise have been the case because of the discussion that [he] had with [the staff midwife] afterwards.'*

32. The SHO again emphasised that the infant responded well to the resuscitation provided and that the resuscitation was effective.

Independent Professional Advice

33. The Investigating Officer obtained independent professional advice from a Paediatric Consultant for the purposes of this investigation. This Paediatric IPA was asked to comment on the SHO' contemporaneous notes and whether his record keeping was appropriate. The Paediatric IPA advised that *'there was appropriate documentation of the steps taken by the SHO during the resuscitation of [the baby]. It is not normally necessary to document in full detail every indication for each action taken'.*

34. Specifically in relation to the indications for suctioning and the presence or absence of amniotic fluid, the Paediatric IPA advised that *'[t]he paediatrician present at the delivery would not normally be the one documenting the presence and amount of amniotic fluid, unless he was informed by the midwife and there were concerns regarding this (e.g. if amniotic fluid was excessive or minimal, or if it was meconium or blood-stained, or smelly).'*

35. The Paediatric IPA advised that although the SHO *'did not document what his findings were when the airway was checked…[i]t is appropriate to not have a documentation of every indication for every action taken'.* The Paediatric IPA further advised that *'[a]lthough the indications for performing suction were not documented, one would assume that the SHO had noted secretions for him to perform oropharyngeal suction on the baby.'* In relation to the totality of the records made by the SHO, the Paediatric IPA advised that *'the SHO documented his actions and decision making in the management of the resuscitation. As there was still poor air entry with the recommended 5 inflation breaths, the airway was checked again to ensure this was patent, and 5 more inflation breaths were given before the air entry improved.*

36. The IPA also commented generally on the SHO's contemporaneous notes in relation to the resuscitation. The IPA advised that although the SHO *'did not document the airway manoeuvres used (jaw thrust), the size of the mask used or whether and*

when the mask was changed for a different size, but it is not normally necessary to document in such detail.' He documented that the colour, tone, heart rate, and activity then improved after he provided further inflation breaths. Neopuff breaths were then given at 60 per minute, breathing was established by seven minutes and the baby was transferred to mother'.

37. The IPA further advised that the steps taken by the SHO were consistent with the Newborn Resuscitation Guidelines. In particular, the IPA noted that it was *'entirely appropriate for the SHO to visualise the airway and perform suction when the baby had a poor response to the initial 5 inflation breaths.'*

38. In relation to his conversation with the midwife, the Paediatric IPA stated that there was no obligation for the SHO to document his conversation with the midwife about the management of the resuscitation because *'his management was not wrong, nor against guidelines, and had not led to any consequences for the baby.'*

39. In conclusion, the Paediatric IPA noted that *'[f]rom the documented maternal and baby records provided, [The Paediatric IPA found] that there was appropriate documentation of the steps taken by the SHO during the resuscitation of [the baby]. It is not normally necessary to document in full detail every indication for each action taken.'*

40. The Paediatric IPA also stated that *'despite the difference in opinion between him and the midwife, the steps taken by the SHO did not go against Newborn Resuscitation Guidelines… More importantly, [the baby] was adequately resuscitated and did not come to any harm from having had oropharyngeal suction.*

Analysis and Finding

41. I have carefully considered the complaint made by the complainant, the responses provided by the Trust, the responses provided by the SHO, the relevant guidelines, and the advice provided by the Paediatric IPA. I have considered the notes made by the SHO in the medical chart and his subsequent statements in relation to the resuscitation and his conversation with the staff midwife thereafter. I have also considered the comments of the Paediatric Consultant who was the SHO's

supervisor.

42. I note that the SHO's contemporaneous record documents that he *'checked for secretions'*. I also note that the SHO's record then states that he checked the airway again, after attempting 5 inflation breaths. I have also considered the SHO's subsequent written statements, which note that he recalled *'copious amounts of secretions and amniotic fluid in the mouth of the infant*'.

43. I note that the SHO explained that the presence of secretions would not be an unusual finding and surmised that because this would not be unusual, this might be the reason why he *'did not specifically document*' the presence of secretions and amniotic fluid in this instance.

44. In his third statement, I note that the SHO elaborated on his use of the term copious. I have considered the SHO's explanation that he used the term copious *to 'indicate an amount of amniotic fluid present that [he] felt suctioning would aid in terms of the delivery of mask ventilation'.* I also note the SHO explanation that he would not have used oropharyngeal suctioning unless significant secretions were present. I note the advice of the Paediatric IPA, who agreed that *'although the indications for performing suction were not documented, one would assume that the SHO had noted secretions for him to perform oropharyngeal suction on the baby.'*

45. In relation to the presence and amount of amniotic fluid, the Paediatric IPA advised that *'[t]he paediatrician present at delivery would not normally be the one documenting the presence and amount of amniotic fluid, unless he was informed by the midwife and there were concerns regarding this (.e.g. if this was excessive or minimal, or if it was meconium or blood-stained, or smelly)'.*

46. I accept the Paediatric IPA's advice that the presence of amount of amniotic fluid is not typically documented by the Paediatrician, unless this issue is raised by the midwife. In this instance, the staff midwife did not note any concerns regarding the amniotic fluid and there is no evidence to suggest she expressed any concerns regarding the amniotic fluid to the SHO.

47. I have considered the advice provided by the Paediatric IPA. I note that the Paediatric IPA advised that, *'it is appropriate to not have a documentation of every indication for every action taken during the resuscitation.'* The Paediatric IPA also noted that *'the SHO documented his actions and decision making in the management of the resuscitation.'* I have considered the Paediatric IPA's analysis of the SHO' contemporaneous record. Although the Paediatric IPA has indicated the SHO did not record certain events, the IPA has concluded that *'it is not normally necessary to document in such detail.'*

48. It is not disputed that the SHO failed to contemporaneously document the presence of secretions. This is an important aspect of the baby's presentation at birth and it is of concern that this was not recorded at the time as it could, in another case, have implications subsequently for a newborn's care.

49. The SHO documented that the *'airway [was] checked for secretions'.* After he administered 5 inflation breaths, he noted that there was '*still poor air entry.'* It was documented that the baby was suctioned. The SHO then documented that the *'[a]irway [was] checked again.'* And this this time the airway was *'[c]lear and patent.'* From this entry, it is clear that the SHO was concerned about a blockage of the baby's airway. As the SHO also documented that he *'checked for secretions',* it is also clear from his note that he was concerned that secretions might be blocking the airway. The SHO then documented the steps taken to resuscitate. He also documented the clinical progress, noting the apgar scores and the baby's improved heartrate, colour, and respiratory rate.

50. I have considered the Paediatric IPA's advice that *'there was appropriate documentation of the steps taken by the SHO during the resuscitation.'* However, I am concerned that the SHO did not note the presence of secretions which he later recalled. I accept that the SHO's documentation adequately conveyed the steps taken during the resuscitation. Based on the IPA advice, overall the SHO record keeping, with the exception of the failure to record the presence of secretions, was adequate and I find his care and treatment in this respect was reasonable.

Issue 2: Were the actions of the staff midwife, in speaking to the SHO and making a note in the medical record, the appropriate method of dealing with her concerns?

51. The complainant said that because the staff midwife's note indicates that she believed there had been "poor resuscitation" and "poor airway management", she ought to have escalated these concerns to the SHO's supervisor. He believed that the reason given by the staff midwife for not escalating her concerns in her subsequent statement is at odds with her contemporaneous notes.

52. I have considered the NMC Code: Standards of conduct, performance and ethics for nurses and midwives 2008. Part 32 states that a midwife *'must act without delay if [they] believe that… a colleague or anyone else may be putting someone at risk.'*

53. I have reviewed the medical records provided by the Trust. This includes the maternity notes and the baby's neonatal notes. I have considered the contemporaneous notes entered by the staff midwife in relation to the resuscitation. The staff midwife recorded her evaluation as follows *'Live baby boy born. Baby to Resuscitaire. Dried, stimulated, damp towel removed. Paed. The SHO present. Suction performed, advised against, no need. Face mask applied, too big. 5 inflation breaths given, no air entry. Repositioned head further 5 inflation breaths given. Heart rate checked, >100bpm. Advised to use small appropriate mask to fit body: same given and used. [The SHO] advised to use my assistance: advised to swap: airway central and the SHO observation of HR[8], apgar score. Jaw thrust used, and inflation breaths given. Chest wall movement, and ventilation breaths given. Baby colour improved, HR >100; breathing spontaneously.'*

54. The staff midwife went on to note her conversation with the SHO after the resuscitation was completed. She noted: *'the SHO did not use my skills effectively and very reluctant to take my advice: spoken to by myself __[9]resuscitation; poor*

[8] Heart Rate.
[9] The complainant has read this word as being 'poor', whereas Staff Midwife states the note refers to 'post'.

airway management. Not happy.'

55. In response to investigation enquiries, the Trust provided a copy of its complaints file which contained a statement from the staff midwife, dated 5 January 2017. The statement was prepared at the request of the Interim Head of Midwifery. The staff midwife's statement was based on her recollection of the events and on her review of the records.

56. She explained in her statement that she advised against the SHO using oropharyngeal suction *'as this practice was no longer required unless there was meconium present.'* She also stated that she '*spoke with the SHO post resuscitation of the baby and advised him of the importance of good communication and team work.'* She recalled that he was unhappy with this conversation.

57. In his 30 July 2017 statement (seven years after the baby's birth), the SHO detailed his recollection of his conversation with the staff midwife after the resuscitation. He recalled that the staff midwife '*expressed her concerns that [he] did not do as she suggested during the resuscitation, with regards airway clearance and [his] reluctance to change the mask. [He] explained that as the leader of the resuscitation [he] had disagreed with her assessment and that the air entry into the infant's lungs had improved with changing the airway positioning using jaw thrust. He said that there had not been a problem with mask size as she had suggested because good airway seal was achieved throughout the resuscitation. Following a further exchange of views, [he] suggested that if [the staff midwife] had concerns about [his] proficiency then [he] would encourage her to bring it to the attention of [his] supervising paediatric consultant'.*

58. In a subsequent statement dated 8 February 2018 (almost eight years after the birth), the staff midwife also clarified that she *'did not escalate any concerns at the time to [the SHO'] Senior Consultant, as [she] did not have any concerns about the SHO/ resuscitation technique or proficiency. [Her] discussion with the SHO was in regards to utilising Midwifery skills in resuscitation*'.

59. In response to investigation enquiries, the Trust reiterated that the staff midwife's

note stated ‘post resuscitation’ not ‘poor’ resuscitation. The Trust also indicated that ‘*the staff midwife has reviewed her statement and the infant’s notes. She disagrees that her statement is at odds with her notes. After discussion with the Head of Midwifery, she has reflected on her documentation as to how this has caused any confusion.’* The Trust also stated that she *‘discussed with the SHO after the resuscitation and this would be good practice’.*

Independent Professional Advice

60. The Investigating Officer obtained independent professional advice from a Midwife for the purposes of this investigation. This IPA was asked to comment on whether the actions of the staff midwife, in speaking with the SHO and making a note in the chart, was the appropriate method of dealing with her concerns.

61. The Midwifery IPA advised that, based upon her review of the records and statements, *‘[t]his would have been both appropriate and professional on behalf of both parties to raise concerns at the time, out of the labour room and away from the parents and other professionals who were on duty at the time.’*

62. The Midwifery IPA advised that if a midwife wishes to raise concerns about the actions of a Paediatric SHO, the Midwife can *‘challenge another clinician at the time if they feel that clinical tasks or procedures are being performed incorrectly or unsafely.’* The Midwifery IPA also referenced the NMC Code, Standards of conduct, performance and ethics for nurses and midwives 2008 which state ‘*You must act without delay if you believe that you, a colleague, or anyone else may be putting someone at risk.’*

63. The Midwifery IPA advised that *‘It was right for the Midwife to raise her concerns with him directly, as she correctly did, rather than not say anything at the time but instead just report the incident of concern to his supervisor.’* The Midwifery IPA also commented that the staff midwife, as with any midwife, could *‘escalate her concerns, in this case, to [the SHOs] supervisor who would be his Registrar or his Consultant if she felt his practice was either unsafe or not within national or local guidance. This was not the case in this instance.’*

64. The Midwifery IPA commented that the staff midwife *'acted appropriately'* and was not required to take any additional action in relation to her concerns. This IPA also advised that *'It is important to understand that there may often be a difference of opinion between staff…However, if concerns are dealt with professionally and correctly and at the time, then this is appropriate management.'*

65. The Midwifery IPA also commented that if the clinician leading the resuscitation considered that suctioning was appropriate, *'then that was at their discretion'.*

66. I have also obtained Independent Professional Advice form a Paediatric IPA for the purposes of this investigation. This IPA was asked to comment on whether the SHO's resuscitation was in accordance with the applicable guidelines. The Paediatric IPA commented that *'[a]lthough there had been a disagreement between the SHO and the midwife about how [the baby] was resuscitated, he did not come to any harm as seen by his apgar scores'.*

67. The Paediatric IPA concluded that the SHO's management was *'not wrong, nor against guidelines, and had not lead to any consequences for the baby'.* This IPA also found that *'it [was] entirely appropriate for the SHO to visualise the airway and perform suction when the baby had a poor response to the initial 5 inflation breaths.'*

The complainant's Response to the Draft Report

68. The complainant believed that the SHO must have felt that the staff midwife was questioning his proficiency because he *'suggested that if [the staff midwife] had concerns about [his] proficiency, then [he] would encourage her to bring it to the attention of [his] supervising consultant'.* The complainant has also highlighted the SHO's statement that his *'involvement in the resuscitation of [the baby] was not subsequently raised by [his] supervising consultant. Hence, [he] presumed that SM had reflected on matters following our discussion, post-resuscitation, and had decided that no further action was required…'* The complainant believes that these statements demonstrate a *'recurring theme of concern that surely touches more upon the proficiency element'.*

69. The complainant does not accept the staff midwife's contention that her concerns related only to the SHO 'not using midwifery skills effectively'. However, the complainant also acknowledges that '*the reason or reasons for not escalating her concerns is known only to [her]'.* The complainant believes that her request to swap positions with the SHO, along with her prompt to the SHO to change the size of mask and noted issues regarding formation of a seal, demonstrate that she must have had concerns about the SHO's proficiency. The complainant also believes the adjective 'poor' suggests a low or inferior standard and 'airway management' relates to a set of manoeuvers and medical procedures to prevent or relieve airway obstructions. The complainant believes that the logical conclusion to is that there was a question in the staff midwife's mind at the relevant time regarding the proficiency of the SHO's skills and believes it is '*incredible and unsustainable to draw the interpretation that contemporaneous notes'*. The complainant also believes that the situation must have been sufficiently concerning to the midwife that it was noted in the maternity notes. Finally, the complainant notes that this entry '*has been a source of great distress to both him and his wife.'*

Analysis and Finding

70. I have carefully considered the complaint. It raises serious concerns and is appropriate and proportionate in the circumstances, given the implications for patient safety. I have reviewed the responses by the staff midwife, the Trust's responses, the entries in the medical records and the IPA's advice. In particular, I have given due weight to the subsequent statements provided by the staff midwife, who provided her rationale for not escalating her concerns to the senior consultant.

71. I have considered the Midwifery IPA's advice in relation to the circumstances under which a Midwife ought to escalate concerns to a supervising Paediatrician. In particular, I accept the Midwifery IPA's standard that *'any midwife can escalate her concerns, [to a] senior who would be his Registrar or Consultant if she felt his practice was either unsafe or not within the national or local guidance.'*

72. I have also considered the Midwifery IPA's advice that *'there may often be a difference of opinion between staff… [h]owever, if concerns are dealt with*

professionally and correctly and at the time, this is appropriate management'.

73. I accept the Midwifery IPA's advice that differences of opinion between professionals are to be expected, and that such disagreements ought to be discussed professionally and contemporaneously, although not every disagreement requires escalation to a supervisor. Whether the staff midwife ought to have escalated her concerns depends on if, in her discretion, she believed that the SHO's practice was either unsafe, or not within the national or local guidance.

74. In assessing whether the staff midwife ought to have escalated her concerns, I have given consideration to the wording of her contemporaneous records within the patient chart. I note that there is a dispute over this wording. The complainant believes that the staff midwife noted that there had been '*poor resuscitation'.* He believes that such an entry indicates that the staff midwife had expressed concerns about patient safety and has queried why these concerns were not escalated to the SHO's supervisor.

75. However, the Trust and the staff midwife state that this entry reads '*post resuscitation'.* When read in full, the Trust's position is that the staff midwife's note reads: '*the SHO did not use my skills effectively and very reluctant to take my advice: spoken to by myself* ***post*** *resuscitation; poor airway management. Not happy.'*

76. I have also considered the subsequent statements of the staff midwife and the SHO describing their recollection of the conversation. I particular, I note that the staff midwife stated that she recalled that she *'spoke with the SHO post resuscitation of the baby and advised him of the importance of good communication and team work'.*

77. I also note the SHO's recollection that the staff midwife '*expressed her concerns that [he] did not do as she suggested during the resuscitation, with regards airway clearance and [his] reluctance to change the mask'.* The SHO recalled that he explained his reasons for disagreeing with her assessment and *'suggested that if [the staff midwife] had concerns about [his] proficiency then [he] would encourage her to bring it to the attention of [his] supervising paediatric consultant'.*

78. I have considered the staff midwife's explanation as to why she did not escalate her concerns. In her statement, the staff midwife clarified that she *'did not have any concerns about [the SHO'] resuscitation technique or proficiency'*, but that she did have concerns about the SHO *'in regards to utilising Midwifery Skills in resuscitation'.* I find this explanation to be consistent with her contemporaneous note, where she stated that she believed *'the SHO did not use [her] skills effectively'* and that he was *'very reluctant to take [her] advice*'.

79. In relation to the dispute over whether the staff midwife's note reads as *'poor resuscitation'* or *'post* resuscitation', I consider the staff midwife to be best placed to interpret her own handwritten contemporaneous record. I also find that the recollections of the SHO and the staff midwife are consistent with a conversation that happened *'post resuscitation'.*

80. I also consider the statements provided by the SHO and the staff midwife to be supportive of a finding that the staff midwife did not raise any concerns about patient safety. Having reviewed these statements, I find that there is no evidence in the contemporaneous notes nor in the subsequent statements, that anyone raised a concern about any potential impact to the baby. The concerns raised by the staff midwife pertained to the SHO's management and communication during the resuscitation. This is consistent with the staff midwife's contemporaneous note that, in her opinion, there had been *poor airway management'.*

81. I note that the IPA advice and the statements by the staff midwife, the SHO, and the SHO's supervisor all agree that the resuscitation was carried out appropriately and that the baby responded well to the resuscitation. The Paediatric IPA advised that *'[a]lthough there had been a disagreement between the SHO and the midwife about how [the baby] was resuscitated, he did not come to any harm as seen by his apgar scores'.* I have not found any evidence to support an opinion that there had been a *'poor resuscitation'* of the baby.

82. Therefore, I accept the Trust's position that the staff midwife's contemporaneous record reads '*the SHO did not use my skills effectively and very reluctant to take my advice: spoken to by myself* ***post*** *resuscitation; poor airway management. Not*

happy.'

83. I have considered whether the SHO' resuscitation was in accordance with the applicable guidelines. On this point, I accept the Midwifery IPA's advice that *'if there were copious secretions and the clinician leading the resuscitation felt [suctioning] was appropriate then that was at their discretion'.* I accept the Paediatric IPA's conclusion that the SHO' management was *'not wrong, nor against guidelines, and had not lead to any consequences for the baby'.*

84. I also accept the Midwifery IPA's advice that *'the resuscitation was undertaken correctly in accordance with The Resuscitation Council (UK) guidelines in place at the time, tailored specifically to clinical practice in the New-born Life Support resuscitation.'* Having reviewed the contemporaneous notes, the statements provided, and the IPA advice, I also accept the Midwifery IPA's conclusion that it *'was not the case in this instance'* that the staff midwife '*felt [the SHO'] practice was either unsafe or not within national or local guidance.'*

85. As the staff midwife's concerns did not relate to patient safety and because the baby was appropriately resuscitated by the SHO in accordance with The Resuscitation Guidelines (UK), I accept the Midwifery IPA's conclusion that the staff midwife '*acted appropriately'* in discussing her concerns with the SHO in person without escalating to his supervisor.

86. I also accept the Midwifery IPA's conclusion that it was *'both appropriate and professional on behalf of both parties to raise concerns at the time, out of the labour room and away from parents and other professionals who were on duty at the time.'* Based on the evidence considered and the IPA advice, I have not upheld this element of the complaint.

87. I have considered the learning point raised by the Midwifery IPA. In particular, I have considered the Midwifery IPA's advice that '[a] more thorough documentation of the conversation written by the midwife between herself and the neonatal SHO would have been helpful.' The Midwifery IPA advised that a more thorough documentation of the conversation *'would have been useful in understanding the situation from the*

point of view of both clinicians at the time.' Alternatively, the Midwifery IPA advised that *'[i]f documentation is not written within the patient notes then a separate written account could have been written by the midwife and given and discussed with her midwifery manager.'*

88. I have reflected upon the recommendations outlined by the Hyponatremia Inquiry. In particular, I note the Inquiry's recommendation that *'[r]egistered clinicians and other registered healthcare professionals, who believe or suspect that treatment or care provided to a patient by or on behalf of any healthcare organisation by which they are employed has caused death or serious injury to the patient, must report their belief or suspicion to their employer as soon as is reasonably practicable.'* In the context of this recommendation, I consider it to be essential for healthcare practitioners to document clearly whether they are concerned about care that that may have *'caused death or serious injury to [a] patient.'* Based on the evidence in this case, there was no such risk. However, in my view, the staff midwife having raised and recorded her concerns, ought as a matter of good practice, to have recorded why she did not escalate her concerns to a more senior level. This would have provided more openness around her decision in this regard.

89. I note that the current complaint arose because the complainant reviewed the staff midwife's comment in the medical records that she was *'not happy'* and that, in her opinion, there had been *'poor airway management.'* In the broader context of the recommendations of the Hyponatremia Inquiry, I consider that it is good practice for such concerns to be fully recorded. I consider that this should include documentation of how the concerns were dealt with and any decisions taken about whether to escalate concerns. Without more context to the staff midwife's note that she was *'not happy'*, the complainant had no way of knowing whether her concerns were addressed. More importantly, the complainant could not have known that these concerns were not related to any potential impact to the health of his new born son. The complainant has appropriately questioned these issues.

90. I accept that, in this instance, it was not necessary to escalate concerns to the Paediatric Consultant and therefore there was no failure in the care and treatment provided to the baby. However, I have also given consideration to the Midwifery IPA's advice that it would have been good practice for the staff midwife's concerns to

be fully documented, including her reasons for not escalating her concerns. In considering this issue I have had regard to the Principles of Good Administration.

91. The Third Principle requires public servants, to be 'Open and Accountable' by stating the criteria for decision making and giving full reasons for their decisions. I consider that the staff midwife's failure to document her reasons for not escalating her concerns fails to meet this principle. This failing constitutes maladministration. As a consequence of this maladministration, the complainant experienced the injustice of uncertainty and frustration as to the nature of the staff midwife's concerns, whether the concerns should have been escalated and whether these concerns had any adverse impact on his child's health.

92. I have considered the complainant's response to my draft report, specifically his analysis of the SHO's statements. While I agree with the complainant's opinion that the SHO may have believed that '*he stood a chance of being spoken to by his supervisor'*, I do not concur with the complainant's analysis that the SHO '*must have felt that the staff midwife was questioning his proficiency.*' I find that the statements by the SHO indicate that he was unsure whether the staff midwife had concerns about his proficiency, as indicated by the phrase *'if [the staff midwife] had concerns...*'. I note that, whether the staff midwife believed her concerns related to patient safety was a matter for her to reflect upon and decide. The staff midwife's subsequent statements and actions establish that her concerns were not related to patient safety and this determination is supported by both IPAs.

93. I have also considered the complainant's concerns about the staff midwife's entries in the record. Although the complainant believes these entries indicate that the staff midwife must have had concerns about the SHO' proficiency, I note that the complainant accepts that 'the reason or reasons for not escalating her concerns is known only to [her]'. The staff midwife has reflected upon her interaction with the SHO in her subsequent statements. Although I agree with the complainant that the staff midwife's entries in the medical record could be read to convey a concern about patient safety, I am persuaded by the staff midwife's subsequent explanatory statements that she did not have any such concerns and therefore, did not escalate her concerns to the SHO's supervisor. These statements have informed my conclusion that she did not have concerns about patient safety. As noted by the

midwifery IPA; *'[i]t is important to understand that there may be a difference of opinion between staff'*. Two qualified medical professionals can have a difference of opinion about treatment options without one provider believing the other is administering unsafe treatment. However, I understand that the staff midwife's entries in the record have caused confusion over what her concerns actually were. I also accept that this confusion has been a '*source of great distress'* for the complainant and his wife and this has informed my findings at paragraphs 90 and 91 above. This is absolutely understandable.

94. I have considered the concerns raised by the complainant and I note that both the Paediatric IPA and Midwifery IPA have advised that no harm came to the baby during the resuscitation. I hope that the complainant is reassured by this advice.

CONCLUSION

The complainant submitted a complaint to me about the Western Health and Social Care Trust (the Trust). I have investigated the complaint and have found the SHO's record keeping was adequate. I have also found that the staff midwife appropriately raised her concerns with the SHO directly.

I have also found that as the baby did not sustain any harm and the SHO's resuscitation was consistent with the applicable guidelines, there was no indication for the staff midwife to escalate her concerns to the SHO's supervising consultant.

In relation to the maladministration and injustice that I have identified in this case, I recommend the Trust pay to the complainant by way of solatium a sum of £750 (within one month of this report) in respect of the uncertainty, distress and frustration sustained as a result of the documentation of the staff midwife's concerns.

I have observed the issue regarding the Trust's complaints handling process which will be picked up separately in further correspondence with the Chief Executive. This issue is not commented upon within this report

MARIE ANDERSON
Ombudsman **June 2019**

APPENDIX ONE

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.