Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against Belfast Health & Social Care Trust

NIPSO Reference: 201916814

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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 care and treatment the Belfast Health and Social Care Trust (the Trust) provided to the complainant at Royal Jubilee Maternity Hospital (RJMH) on 5 and 6 June 2019. The complainant said she believed the Trust failed to provide her with appropriate maternity care and that this resulted in her having to have an emergency caesarean section and, ultimately, a hysterectomy.

I obtained all relevant information, including the complainant's maternity records, and the advice of two independent professional advisers.

I considered whether the care and treatment the Trust provided to the complainant at RJMH on 5 and 6 June 2019 was appropriate and reasonable. My investigation examined the Trust's management of the induction of the complainant's labour and the first stage of her labour; the decision to deliver her baby by emergency caesarean section; the assessment of the complainant's uterine tone at the conclusion of the caesarean section; the observations performed following her return to the delivery suite for recovery after the caesarean section; the consideration of uterine atony risk factors; the management of the postpartum haemorrhage the complainant sustained; and the subsequent decision to perform a hysterectomy.

It was evident to me that the latter stage of the complainant's labour and the events that followed must have been highly distressing and traumatic, and that ultimately, in having to have a hysterectomy, the complainant experienced a completely unforeseen and devastating outcome. However, my investigation found no evidence of failing on the part of the Trust in relation to any of the concerns the complainant raised about the care and treatment she received. Rather, as highlighted by one of the independent professional advisers, it appeared that the complainant had suffered a very rare but accepted complication of caesarean section, that is, postpartum haemorrhage and hysterectomy.

I did not uphold this complaint.

THE COMPLAINT

1. I received a complaint about the actions of the Belfast Health and Social Care Trust (the Trust). The complainant raised concerns about the care and treatment she received at the Trust's Royal Jubilee Maternity Hospital (RJMH) on 5 and 6 June 2019. She said she believed the Trust *'failed to provide [her] with adequate maternity care, which resulted in an emergency caesarean section, a risk to [her] daughter's life, risk to [her] life, loss of [her] womb, a subsequent hospital admission in the following weeks and ongoing post-traumatic stress.'*

Background

2. The complainant, at 39 weeks+4 days pregnant, was admitted to RJMH at 9:00 on 5 June 2019 for induction of labour. (Her waters had broken the previous day, while she was on her way to a routine ante-natal appointment and she had been told to return to RJMH on 5 June 2019 for induction if she did not go into labour naturally.)

3. The complainant said that following her admission to the induction of labour unit at RJMH, she had a pessary inserted at around 10:00. She said she was told that due to the risk of infection, given that her waters had broken the previous day, it would not be longer than six hours before she would be taken to the delivery suite for further induction. Later that evening, however, she was told there was no room available for her in the delivery suite and that her husband should return home. The complainant said she had no recollection of having been examined since the time the pessary had been inserted that morning.

4. The complainant said she was not taken to the delivery suite until around 03:30(on 6 June 2019). She described how she was started on a drip of Syntocinon[1] and was later given an epidural. She said too that she was examined and a midwife broke a sac of water in front of her baby's head.

[1] Syntocinon is a man-made chemical that is identical to the naturally occurring hormone, oxytocin, and caused the uterus to contract.

5. The complainant said that following a drop in her baby's heart rate, she was taken to theatre for an emergency caesarean section, under general anaesthetic. She said that after the caesarean section, she was taken back to the delivery suite for recovery. The complainant described how she reported to the midwife that she felt unwell – she was having difficulty breathing, her heartbeat was raised, her skin was pale, she felt faint and felt she was bleeding heavily. The complainant said the midwife told her this was normal following a caesarean section.

6. The complainant also said that soon afterwards, the midwife became concerned about her heavy bleeding and obstetric staff were alerted. Following unsuccessful attempts to control the bleeding, a decision was taken to return her to theatre for a laparotomy. She said surgical techniques to manage the bleeding were exhausted and a decision was taken to perform a hysterectomy.

7. In bringing her complaint to my Office, the complainant said that she does not understand how going into hospital for the birth of her baby resulted in her having a hysterectomy. In particular, she is seeking an understanding of:
   - whether the management of her induced first stage of labour led to the drop in her baby's heart rate, and therefore the need for the emergency caesarean section;
   - whether the tone of her uterus was properly assessed at the end of the caesarean section, prior to her being moved out of theatre, back to the delivery suite, and why a record of this was not made at the time (she said the surgeon added a retrospective note about uterine tone to her records a number of hours later);
   - whether proper account was taken of risk factors for uterine atony (she believes atony of the uterus can be caused by prolonged labour, the use of oxytocin, induced labour and general anaesthetic);
   - whether the appropriate observations were carried out after she returned from theatre to the delivery suite, following her caesarean section; and
   - why it was necessary to perform a hysterectomy.

Issue of complaint

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

- Whether the care and treatment the Trust provided to the complainant at RJMH on 5 and 6 June 2019 was appropriate and reasonable.

9. Having considered the matters the complainant raised, I decided that in particular, my investigation would examine the following:

- the management of the induction of the complainant's labour and the first stage of her labour;
- the decision to perform an emergency caesarean section;
- the assessment of the complainant's uterine tone at the conclusion of the caesarean section;
- observations following the caesarean section;
- the consideration of uterine atony[2] risk factors; and
- the management of the complainant's postpartum haemorrhage and the decision to perform a hysterectomy.

INVESTIGATION METHODOLOGY

10. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its written comments on the issues the complainant raised. The documentation obtained included the complainant's maternity records, as well as correspondence relating to the Trust's handling of complaints the complainant made to it on 24 July 2019 and 3 July 2020 about the care and treatment she had received at RMJH.

Independent Professional Advice

11. After further consideration of the issues raised, I obtained independent professional advice from the following independent professional advisors (IPAs):

- A Registered Midwife RM RN BSc (Hons) PgCert MA, with more than 25 years' experience ('the Midwife IPA'); and
- A Consultant Obstetrician PhD MRCOG; with subspecialist accreditation in Fetal and Maternal Medicine ('the Obstetrician IPA').

[2] Uterine atony occurs when the uterus fails to contract after the delivery of the baby

12. The information and advice that informed my findings and conclusions is included within the body of this report. I should point out that the IPAs provided 'advice'; however how this advice was weighed, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

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

    The general standards are the Ombudsman's Principles:[3]

    - The Principles of Good Administration; and
    - The Principles of Good Complaints Handling.

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

    The specific standards and guidance relevant to this complaint are:

    - The General Medical Council (GMC) Good Medical Practice, published March 2013, updated April 2019 ('the GMC Guidance');
    - The Nursing and Midwifery Council's (NMC) The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates, published January 2015 ('the NMC Code');
    - The National Institute for Health and Care Excellence[4] (NICE) Clinical Guideline 70 - 'Inducing labour', published July 2008 ('the NICE Inducing Labour Clinical Guideline ');
    - The National Institute for Health and Care Excellence Clinical Guideline 190 – 'Intrapartum care for healthy women and babies',

[3] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.
[4] NICE guidelines are evidence-based recommendations for health and care. They set out the care and services suitable for most people with a specific condition or need, and people in particular circumstances or settings.

published December 2014 ('the NICE Intrapartum Care Clinical Guideline');

- The National Institute for Health and Care Excellence Clinical Guideline 132 – 'Caesarean section', published November 2011 ('the NICE Caesarean Section Clinical Guideline');
- The Royal College of Obstetricians and Gynaecologists (RCOG) Green-top Guideline No.52 - 'Prevention and Management of Postpartum Haemorrhage', published December 2016 ('the RCOG Postpartum Haemorrhage Guideline');
- Belfast Health and Social Care Trust Management of the Induction of Labour Guideline, published March 2018 ('the Trust's Induction of Labour Guideline')
- Belfast Health and Social Care Trust Emergency Caesarean Section Guideline, published March 2018 ('the Trust's Emergency Caesarean Section Guideline'); and
- Belfast Health and Social Care Trust Management of Major Primary Postpartum Haemorrhage Guideline, published January 2014 ('the Trust's Major Postpartum Haemorrhage Guideline').

15. I did not include in this report all of the information obtained in the course of the investigation but I am satisfied that everything that I consider to be relevant and important was taken into account in reaching my findings.

16. A draft of this report was shared with the complainant and with the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations. The complainant did not submit any comments to me on the draft report. I received comments from the Trust, which I considered before finalising this report.

THE INVESTIGATION

Detail of the complaint

Induction of labour and first stage of labour

17. The complainant said that she was unclear how going into hospital on 5 June 2019, as planned, to have her baby resulted in her needing a hysterectomy.

She raised a number of concerns about the induction of her labour and the first stage of her labour, and queried whether the care and treatment she received at those stages of her birth experience could have led the events that were to follow.

Decision to perform an emergency caesarean section

18. The complainant said she was unclear why it was necessary to delivery her baby by emergency caesarean section.

Assessment of uterine tone

19. The complainant said she considers that the tone of her uterus was not properly assessed at the conclusion of her caesarean section and that this may have led to her subsequent postpartum haemorrhage. The complainant also expressed concern that no contemporaneous record was made in her notes of her uterine tone having been assessed as good prior to her transfer out of theatre, following the caesarean section. She is concerned that the entry in her notes, which documented that there were no concerns about her uterine tone at the conclusion of the caesarean section, was not made until 17:34 which, she stated, *'was many hours after initial surgery and following a major [postpartum haemorrhage] and almost loss of life.'*

Observations following caesarean section

20. The complainant said that immediately following her return to the delivery suite for recovery, following her caesarean section, she felt unwell but that when she reported to the midwife that she felt weak and faint, had a fast heartbeat and was concerned about blood loss, she was told that '*this was normal after a caesarean section.'* The complainant believed that the appropriate observations on her were not carried out until 14:00, 26 minutes after her transfer out of theatre.

Consideration of uterine atony risk factors

21. The complainant expressed concern that risk factors for uterine atony, which she believes, include *'prolonged labour, the use of oxytocin and general anaesthetic … and labour that is induced'*, were ignored in her case.

Management of postpartum haemorrhage and the decision to perform a hysterectomy

22. The complainant said she does not understand why her bleeding could not be controlled and why she needed to have a hysterectomy.

Evidence Considered

Standards and Guidelines

23. I considered the following standards and guidelines, relevant extracts of which are included at Appendix Two to this report.
    - The NICE Inducing Labour Clinical Guideline;
    - The NICE Intrapartum Care Clinical Guideline;
    - The NICE Caesarean Section Clinical Guideline;
    - The RCOG Postpartum Haemorrhage Guideline;
    - The Trust's Induction of Labour Guideline;
    - The Trust's Emergency Caesarean Section Guideline; and
    - The Trust's Major Postpartum Haemorrhage Guideline.

The Trust's response to investigation enquiries

24. I made written enquiries to the Trust about the issues the complainant raised. The Trust's response to my enquiries is at Appendix Three to this report.

25. As part of my enquiries, I asked the Trust to provide a chronology of events relating to the care and treatment it provided to the complainant at RJMH on 5 and 6 June 2019. The chronology the Trust provided is at Appendix Four to this report.

Relevant documentation

26. I completed a review of the documentation obtained from the Trust, which included the complainant's maternity records and a copy of its file relating to the complaints the complainant made to the Trust on 24 July 2019 and 4 July 2020. Relevant extracts of the documentation examined is at Appendix Five to this report.

Independent Professional Advice

Advice obtained from the Midwife IPA

27. The Midwife IPA provided me with advice on the management of the induction of the complainant's labour and the first stage of her labour; and on the observations that were carried out following the complainant's transfer out of theatre after her caesarean section.

28. The advice the Midwife IPA provided to me is at Appendix Six to this report.

Advice obtained from the Obstetrician IPA

29. The Obstetrician IPA provided me with advice on the administration of Syntocinon while some of the complainant's membranes remained intact; the decision to perform an emergency caesarean section; the assessment of the complainant's uterine tone at the conclusion of the caesarean section; the consideration of uterine atony risk factors; the management of the complainant's postpartum haemorrhage; and the decision to perform a hysterectomy.

30. The advice the Obstetrician IPA provided to me is at Appendix Seven to this report.

Analysis and Findings

Induction of labour and first stage of labour

31. I examined several aspects of the management of the induction of the complainant's labour and the first stage of her labour.

32. Firstly, I considered whether the complainant should have been examined in the induction of labour unit during the period after she had the pessary inserted and before to her transfer to delivery suite.

33. My investigation established that following the complainant's admission to the induction of labour unit at 09:00 on 5 June 2019, she had a vaginal examination at 09:35, at which time a Propess pessary[5] was inserted. My investigation found that the complainant was transferred to the delivery suite at 04:00 on

[5] A Propess pessary contains dinoprostone, also known a prostaglandin, a naturally occurring female hormone that helps 'ripen' the cervix

6 June 2019. The maternity records I examined show that no vaginal examinations were carried out in the intervening period.

34. I note that when one of the Trust's Consultant Obstetricians who was involved in the complainant's care at RJMH on 6 June 2019 (referred to in this report as 'Consultant Obstetrician A') wrote to the complainant on 30 July 2019, she (Consultant Obstetrician A) explained, *'… we do not perform vaginal examinations in the induction of labour unit unless it is clinically indicated to reduce the risk of infection.'*

35. I note too that when the Trust responded on 12 February 2020 to the complainant's complaint of 30 July 2019, it again explained that it was not its practice to perform *'repeat vaginal infections because of the risk of ascending infection.'*

36. The Midwife IPA advised that this aspect of the care the Trust provided to the complainant was in keeping with national and local guidelines. The Midwife IPA pointed out that the NICE Inducing Labour Clinical Guideline states that a woman should be '*reassessed 24 hours after vaginal PGE2 controlled-release pessary insertion, to monitor progress.'* The Midwife IPA advised*, 'As [the complainant] had a Propess pessary inserted at 09:[30] on 5.6.19 she would not have received a further vaginal examination until 09:30 on 6.6.[19] unless there was a clinical indication such as problems with the baby or wish for pain relief.'*

37. The Midwife IPA also highlighted the Trust's Induction of Labour Guideline provides specific direction on the performing of vaginal examinations following the prelabour rupture of membranes. I note the Trust's Guideline emphasises, *'Digital vaginal examination <u>MUST NOT</u> be performed unless the woman is in labour as it is strongly associated with increased rates of chorioamnionitis.'*

38. I accept the Midwife IPA's advice on this aspect of the care the complainant received during the induction of her labour. I consider it was appropriate, and in accordance with both the NICE Inducing Labour Clinical Guideline and the Trust's Induction of Labour Guideline that no vaginal examinations were performed during the period between the insertion of the Propess pessary at

09:35 on 5 June 2019 and the complainant's transfer to the delivery suite at 04:00 on 6 June 2019. Consequently, I do not find there was any failing in this aspect of the care provided to the complainant during the induction of her labour.

39. Secondly, my consideration of the management of the induction of labour and the first stage of labour examined whether the delay in the complainant being transferred to the delivery suite was acceptable and, if it was not, whether that delay had any impact on the standard of care she received.

40. As recorded above, my investigation established that the complainant was transferred to the delivery suite at 04:00 on 6 June 2019, some 19 hours after her admission to the induction of labour unit.

41. I note the Trust acknowledged to the complainant that there was some delay in her being transferred from the induction of labour unit to the delivery suite. When Consultant Obstetrician A wrote to the complainant on 30 July 2019, she explained, '… *there may have been some delay in your transfer to the delivery suite and that was to ensure that adequate staff were available to look after you and your partner.'* In addition, when the Trust responded on 12 February 2020 to the complainant's complaint of 24 July 2019, it acknowledged that *'there was a delay in [her] transfer [to the delivery suite], in order to ensure that adequate midwifery staff were available to care for [her].'*

42. The Midwife IPA advised that since the complainant was not due to be reassessed until 24 hours after the insertion of the Propess pessary, that is at 09:30 on 6 June 2019, the fact that she was not transferred to the delivery suite until 04:00 that day, some five hours before she was due to be reassessed, had no adverse impact on the care she received.

43. I accept the Midwife IPA's advice on this matter. While it may have been initially intended to transfer the complainant to the delivery suite sooner than proved to be the case, I do not find that the delay the complainant experienced impacted on the standard of care she received. I am satisfied that there is no evidence of failing in this aspect of the management of the induction of the complainant's labour.

44. Thirdly, I considered whether midwives ought to have realised that not all of the complainant's waters had broken before commencing the Syntocinon infusion.

45. My investigation found that, following the complainant's transfer to the delivery suite on 6 June 2019, it was decided at 04:15 to commence a Syntocinon infusion. I note the record of the vaginal examination performed at that time and the record of the previous examination at 09:35 on 5 June 2019, document that the complainant had already experienced a spontaneous rupture of membranes. My investigation established that the Syntocinon infusion was commenced at 05:00 but that it was not until the next vaginal examination was performed, at 11:40, that it was realised that some of the complainant's membranes (the forewaters) were still intact.

46. I note that when the Trust responded on 12 February 2020 to the complainant's complaint of 24 July 2019, it stated, *'The midwives … were unable to palpate the membranes during the examinations on 5 June 2019 at 09:35hrs and 04:15hrs [on 6 June 2019] and therefore they were of the belief that all of your waters had come away …on occasions, and in the absence of regular contractions, the membranes can be tightly applied to the baby's head therefore making it difficult to determine if membranes are present and intact. This would appear to have been what happened in your case.'* I note the Trust also explained,'*…with the commencement of Syntocinon drip and the onset of regular contractions, your membranes protruded through your cervical os; therefore, during the next vaginal examination at 11:40hrs … your membranes were easily palpable resulting in a successful artificial rupture of membranes.'*

47. The Midwife IPA's advice was that it was reasonable that midwives did not realise that some of the complainant's membranes were intact before the Syntocinon infusion was commenced. The Midwife IPA also said that the explanation the Trust provided of why the complainant's membranes may not have been felt before the Syntocinon infusion was started, was correct; the Midwife IPA advised, '*the membranes can be tight against the baby's head which makes it very difficult to feel them. When the woman is contracting and the membranes are intact, amniotic fluid is pushed in front of the baby's head*

(like a small balloon) and makes the membranes easier to feel in front of the baby's head.'

48. I also obtained advice from the Obstetrician IPA on this aspect of the complainant's care. The Obstetrician IPA considered that the commencement of the Syntocinon infusion while some the complainant's membranes remained intact did not have any impact on the standard of care she received.

49. I considered the explanation the Trust provided to the complainant of why it was not realised that her forewaters remained intact before starting the Syntocinon infusion, and to the related advice of the Midwife IPA and the Obstetrician IPA. It is my finding that there was no failing in this aspect of the care the Trust provided to the complainant.

50. Next, I considered whether it was appropriate to administer Syntocinon in the circumstances, and whether the Syntocinon was administered in accordance with relevant guidelines.

51. As recorded already, my investigation established that following the complainant's transfer to the delivery suite on 6 June 2019, a decision was taken at 04:15 to commence an infusion of Syntocinon.

52. The Obstetrician IPA advised me that the decision to commence the Syntocinon infusion was appropriate in the circumstances and was in accordance with the Trust's Induction of Labour Guideline. The Obstetrician IPA pointed out that the Trust's Guideline states, '*Indications for Syntocinon® infusion: For induction of labour for medical reasons or stimulation of labour in hypotonic uterine inertia by intravenous infusion …'* The Obstetrician IPA advised, '*In the complainant's case, prelabour membrane rupture would be considered the medical reason.'*

53. Having reviewed the complainant's maternity records, I note the Syntocinon infusion was commenced at 05:00 on 6 June 2019 at an initial rate of 1ml/hour and was increased incrementally during the next four and a half hours, as follows: to 2ml/hour at 05:30; to 4ml/hour at 06:00; to 8ml/hour at 06:30; to 12ml/hour at 07:00; to 16ml/hour at 08:15; and to 20ml/hour at 09:25.

54. The Midwife IPA advised that the administration of the Syntocinon infusion was *'in accordance with both the Trust Guidelines and the British National Formulary.* I note the Trust's regime for the administration of Syntocinon is set out in Appendix 2 to the Trust's Induction of Labour Guideline. This states that Syntocinon is to be administered at an initial rate of 1ml per hour, and increased incrementally at 30 minute intervals up to the maximum licensed dose, 20mls per hour. (Higher doses, up to 32mls per hour, can be administered, following review by an obstetrician.)

55. I accept the advice I received from both the Obstetrician IPA and the Midwife IPA. I am satisfied that it was appropriate to commence a Syntocinon infusion after the complainant's transfer to the delivery suite, and that the Syntocinon infusion was administered in accordance with relevant guidelines. Consequently, I do not find any failing in this aspect of the care the complainant received.

56. I then considered whether the complainant ought to have been examined more frequently while the Syntocinon infusion was being administered.

57. As recorded already, my investigation found that the complainant had a vaginal examination at 04:15 on 6 June 2019, prior to the Syntocinon infusion being started. The next vaginal examination was not carried out until 11:40.

58. I note that when the Trust responded to the complainant's complaint on 12 February 2020, it advised that its *'normal practice would be to perform a vaginal examination following 4 hours of the onset of regular contractions'*.

59. I note too that the Trust's stated practice is in keeping with the NICE Intrapartum Care Clinical Guideline. This recommends a vaginal examination every four hours once a woman is in established first stage of labour, which the Guideline defines as when *'there are regular painful contractions and there is progressive cervical dilation from 4cm.'*

60. In advising on this aspect of the complainant's care, the Midwife IPA pointed out that when the Syntocinon infusion was commenced at 5:00 on 6 June 2019, the complainant was not contracting but that when she was reviewed by a

doctor (referred to in this report as 'the ST3') at 08:30, she was having three (irregular) contractions every 10 minutes. The Midwife IPA also highlighted that the complainant's notes document that it was planned at that time to reassess her four hours after the onset of regular contractions. The Midwife IPA further advised that there *'was no indication to undertake a vaginal examination prior to 11:40hrs given that [the complainant] was not having regular contractions.'*

61. I accept the advice the Midwife IPA provided to me, and having considered all the relevant evidence, I am satisfied that there was no failing on the part of the Trust in relation to this element of the care it provided to the complainant.

62. Finally, with regard to the management of the first stage of the complainant's labour, I considered whether the action taken to manage the frequency and intensity of her contractions, after the Syntocinon infusion had been increased to a rate of 20ml per hour, was appropriate and in accordance with relevant standards and guidelines.

63. My investigation established that when it was realised, as a result of the vaginal examination carried out at 11:40 on 6 June 2019, that the complainant's forewaters were still intact, an artificial rupture of membranes (ARM) was performed. Subsequently, at 12:25, the midwife noted there was *'little resting tone'* between the complainant's contractions. The complainant's maternity notes document that the midwife then reduced the Syntocinon infusion to 12mls per hour and repositioned the complainant on to her left side. The notes also document that the complainant's baby's heart rate at this time was 110 beats per minute (bpm) but by 12:27, this had dropped to 100bpm. The notes document that the midwife then stopped the Syntocinon infusion completely and repositioned the complainant on to her right side but that when this action had no effect, she (the midwife) called for assistance.

64. I note that in responding on 12 February 2020 to the complainant's complaint of 24 July 2019, the Trust explained, *… when an internal examination and when an ARM is performed, there is a release of the oxytocin hormone that can lead to a strengthening of your contractions, which appeared to happen in your case*

… should the contractions become too intense or frequent, the Syntocinon infusion will be reduced or stopped …'

65. In advising on this matter, the Midwife IPA highlighted that the NICE Intrapartum Care Clinical Guideline makes recommendations on the action to be taken if there are any concerns about the baby's wellbeing. I note the NICE Guideline states, '*… be aware of the possible underlying causes and start one or more of the following conservative measures based on an assessment of the most likely cause(s): encourage the woman to mobilise or adopt an alternative position (to avoid being supine) …. reduce contraction frequency by reducing or stopping oxytocin if it is being used …'*

66. The Midwife IPA advised that the action the midwife took in the complainant's case was in line with this recommendation in the NICE Guideline. It was also the Midwife IPA's view that there was no indication in the complainant's notes that action to manage the frequency and intensity of the complainant's contractions ought to have been taken sooner than was the case.

67. Again, I accept the Midwife IPA's advice, being satisfied that the complainant's maternity notes and the NICE Intrapartum Care Clinical Guideline support the view that the midwife's actions, on noting the frequency and intensity of the complainant's contractions and the drop in her baby's heart rate, were appropriate. I am satisfied therefore that my investigation found no evidence of failing in this aspect of the care the Trust provided to the complainant.

68. In summary, having examined the concerns the complainant raised about the Trust's management of the induction of her labour and the first stage of her labour, I find no evidence of failing on the part of the Trust. I do not therefore uphold this element of the complaint.

69. However, I must record my concern that, as highlighted by the Midwife IPA, the complainant's maternity notes do not evidence that she was informed of possible side effects of the Propess that was administered in the induction of labour unit on 5 June 2019 or that she provided her informed consent for its use. Although this is not a matter the complainant raised in bringing her complaint to me, it is important that I highlight it in this report, particularly given

that the NICE Inducing Labour Clinical Guideline and the Trust's Induction of Labour Guideline both make it clear that informed consent for the use of Propess in women with ruptured membranes should be obtained and documented. Furthermore, the NMC Code requires that midwives *'make sure that [they] get properly informed consent and document it before carrying out any action'* while the GMC Guidance requires doctors to be *'satisfied that [they] have consent or other valid authority before [they] … provide treatment …'.*

70. I note the Midwife IPA did not raise any concern in her advice to me that the lack of documentation of the complainant having given her informed consent regarding the Propess had an impact on the standard of care she received. Nonetheless, it is my expectation that the Trust will give careful consideration to this matter and to the need to remind relevant staff of the specific requirement to seek informed consent for the use of Propess for a woman with ruptured membranes, and that the giving of this consent is documented in the woman's records

Decision to perform an emergency caesarean section

71. I considered whether the decision to deliver the complainant's baby by emergency caesarean section was appropriate in the circumstances, and taken in accordance with relevant guidelines.

72. My review of the complainant's maternity notes established that when the stopping of the Syntocinon infusion at 12:27 on 6 June 2019 had no effect on the complainant's baby's heart rate, which by then had fallen to 100bpm, the midwife called for assistance. The notes document that by 12:29, when a more senior midwife arrived in the delivery room, the baby's heart rate had dropped to 70-80bpm. The notes also record that the ST3, who had reviewed the complainant earlier that morning, arrived in the delivery room at 12:33 and administered Terbutaline[6] but that this had no effect. It is documented in the notes that at 12:36 the decision was taken to transfer the complainant to theatre because by then her baby's heart rate had been low for seven minutes and there were no signs of recovery. It is also documented that the

[6] A drug that helps to prevent and slow contractions

complainant arrived in theatre at 12:42, a decision was taken that an emergency caesarean section should be carried out. I note the complainant's baby was delivered at 12:49.

73. I note that in responding to my investigation enquiries, the Trust stated *'Due to concerns about [the complainant's] daughter's wellbeing during labour, delivery via caesarean section was recommended and consent to proceed with this procedure was obtained from [the complainant].'*

74. I note too that when Consultant Obstetrician A wrote to the complainant on 30 July 2019, she explained that *'the most likely cause for why [the complainant's] baby's heart rate dropped and why [the complainant] required an emergency caesarean section'* was that she was '*contracting too quickly'.* Consultant Obstetrician A also informed the complainant, *'… when we took a sample of blood from your baby's cord, the acid levels suggested that this baby did need to be delivered when it was.'*

75. In addition, I note that the Trust's Emergency Caesarean Section Guideline lists a number of circumstances in which an emergency caesarean section is appropriate. These include, *'Persistent fetal bradycardia[7] on CTG[8] (decision to move to theatre must be made at 6 minutes from the start of the bradycardia with the aim of delivering the baby by 12 minutes).'* The Obstetrician IPA's advice to me was that the decision to perform an emergency caesarean section and the timings related to that were in keeping with this aspect of the Trust's Emergency Caesarean Section Guideline.

76. I also note that the NICE Intrapartum Care Clinical Guideline makes recommendations regarding the management of acute bradycardia. The final recommended step, when other action such as correcting any underlying causes and taking 'conservative measures' (such as encouraging the woman to adopt a different position or reducing Syntocinon) have been ineffective, is *'Expedite the birth if acute bradycardia persists for 9 minutes.'* The Obstetrician IPA advised that the decision to perform the caesarean section was in line with

[7] Slowing of the fetal heart rate
[8] Cardiotocography (CTG) monitors the baby's heart rate and contractions of the uterus

this recommendation, as the complainant's notes record that *'on auscultation in theatre [fetal heart rate] was 78bpm',* which was more than 9 minutes from the onset of the bradycardia.

77. The Obstetrician IPA further advised that on the basis of his review of the cardiotocograph, and the complainant's medial and midwifery notes, he considered the decision to deliver the complainant's baby by emergency caesarean section was appropriate and reasonable in the circumstances.

78. Having considered all the available evidence relating to this element of the complaint, including the complainant's maternity notes and the Obstetrician IPA's advice, which I accept, I am satisfied that in the circumstances, the decision to deliver the complainant's baby by emergency caesarean section was appropriate. I am satisfied too that that decision was taken in accordance with relevant Trust and NICE guidelines. Consequently, having found no evidence of failing in this aspect of the care the Trust provided to the complainant received, I do not uphold this element of her complaint.

Assessment of uterine tone

79. I considered whether the complainant's uterine tone was appropriately assessed at the conclusion of her caesarean section, and whether appropriate action was taken to manager her uterine atony prior to her transfer out of theatre. I also considered whether the retrospective documenting of the assessment of the complainant's uterine tone was appropriate in the circumstances.

80. The complainant's notes (her Intranatal Record of Management/Care) document that her baby was delivered by caesarean section at 12:49 on 6 June 2019. They also document that at 12:49, *'IV medications as per Anaesthetic Kardex'* were administered; that at 13:05, *'Egrometrine IV'* was administered by the Anaesthetist *'on request"* and that at 13:34, the complainant was extubated and transferred back to the delivery suite.

81. A retrospective entry was made in the notes at 13:20 by the ST3 who performed the caesarean section. This documents that Syntocinon and

Ergometrine were administered after the delivery of the complainant's baby and that the plan was to *'observe [blood] loss'.*

82. A further retrospective entry was made in the notes at 17:34 by the obstetrician who assisted with the caesarean section (referred to in this report as 'the ST6'). This documents that following the delivery of her baby, the complainant's uterus was '*atonic';* that an injection and an infusion of Syntocinon were administered as well as an injection of Ergometrine; and that *'Tone [was] good at end of procedure. No concerns'.* (I will return to the making of this retrospective entry in the notes later in this section of my report.)

83. In responding to my investigation enquiries, the Trust said that the complainant's uterine tone '*was documented as poor'* immediately after the birth of her baby but that this had improved by the end of the surgery '*following the administration of a dose of Syntocinon, a further infusion of Syntocinon and a dose of Ergometrine.'*

84. I note that when the Trust responded on 31 July 2020 to the complainant's complaint of 3 July 2021, it provided details of the action that was taken to manage her uterine tone following the delivery of her baby. The Trust informed the complainant that, in line with the Trust's standard practice, anaesthetic staff *'administered a dose of Syntocinon, a drug used to stimulate the muscles of the uterus to cause contractions, to make the uterus contract …'*; that *'at the request of surgeons, given their clinical findings and their assessment of [her] potential risk of bleeding due to the poor tone of [her] uterus at this time, surgeons requested that a further infusion of Syntocinon was commenced'*; and that '*an injection of Ergometrine, medication used to cause contraction of the uterus, was also administered…'.*

85. I note the Obstetrician IPA advised that the NICE Caesarean Section Clinical Guideline does not make specific recommendations on the assessment of uterine tone at the conclusion of a caesarean section. The Obstetrician IPA's advice, nevertheless, was that *'It would be usual, and established good practice, to assess the uterine tone at the conclusion of Caesarean Section.'*

86. The Obstetrician IPA commented that there was no specific documentation regarding this in the caesarean section operative note the ST3 completed but that there was *'clear documentation made at 17:34 by the ST6 covering the Caesarean section which states "uterus atonic, Syntocinon stat, Syntocinon infusion, Ergometrine given. Tone good at end of procedure. No concerns."'*

87. The Obstetrician IPA also highlighted that the complainant's estimated blood loss was documented as 800ml, which, he advised, was *'not excessive, and supports … that there was not uterine atony at the conclusion of the Caesarean Section*. I note he referred too to the entry the midwife made in the complainant's notes at 14:00 – '*Pads and bedsheet changes, lochia moderate'* - which, he said, *'also supports that there was not uterine atony at the conclusion of the Caesarean Section.'* The Obstetrician IPA advised that from the information available, the complainant's uterine tone and level of blood loss were acceptable at the time of her transfer out of theatre.

88. I note it was also the Obstetrician IPA's advice that the action the Trust took to manage the complainant's uterine tone at the conclusion of the caesarean section was appropriate and in accordance with established good practice. The Obstetrician IPA advised that this action was also in keeping with the Trust's Emergency Caesarean Section Guideline. I note that this states, *'Oxytocin 5 international units by slow intravenous injection should be administered at CS to encourage contraction of the uterus and to decrease blood loss. As emergency CS is associated with a higher risk of PPH, Oxytocin IV Infusion 20 units/hour or 40 units/hour can be considered prophylactically but its use is at the discretion of the obstetrician carrying out the caesarean section.'*

89. I accept the Obstetrician IPA's advice. I am satisfied that the evidence supports that the complainant's uterine tone was assessed at the conclusion of her caesarean section and that appropriate action was taken to manage her uterine atony. I am satisfied too that the evidence indicates that the complainant's uterine tone was acceptable at the time she was transferred out of theatre. That said, I would urge the Trust to give careful consideration to the recommendation the Obstetrician IPA made in identifying any learning or service improvements that were highlighted by this case. His recommendation

was that the Trust *'consider adding an item on the Caesarean Section [operative] proforma regarding uterine tone at the end of the procedure.'*

90. Turning then to the complainant's concern about the lack of contemporaneous documentation in her notes of the assessment of her uterine tone at the conclusion of her caesarean section, I note that in response to my investigation enquiries, the Trust commented that the ST6, who assisted with the caesarean section, *'recorded a summary of [the complainant's management at 17:34 hrs*.' The Trust said, *'This is a retrospective entry as [the ST6] was assisting at [the complainant's] caesarean section and her subsequent surgery and this would have been the earliest opportunity to record her findings and subsequent management.'*

91. The Obstetrician IPA's advice on this matter was that it was reasonable in the circumstances that the ST6 did not make an entry in the complainant's notes until 17:34. The Obstetrician IPA also commented, *'If there had been no subsequent complications, then [the ST6] would not necessarily have needed to make any additional documentation.'*

92. In addition, the Obstetrician IPA advised that the retrospective documenting of the complainant's care and treatment, in the circumstances seen in this case, is in keeping with the GMC Guidance. I note that in this respect, the GMC Guidance states, *'Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.'*

93. I note that the Obstetrician IPA did not consider that the retrospective entry the ST6 made in the complainant's notes at 17:34 had any impact on the standard of care the complainant received.

94. Again, I accept the Obstetrician IPA's advice. I am satisfied that on the basis of that advice, and the other evidence I considered, that it was reasonable in the circumstances (assisting at the subsequent management of the complainant's postpartum haemorrhage and at her hysterectomy) that the ST6 did not make the relevant entry in the complainant's notes until several hours after the

caesarean section. I am satisfied too that this action had no adverse impact on the standard of care the complainant received.

95. In summary, having found that the complainant's uterine tone was assessed at the conclusion of her caesarean section; that appropriate action was taken to manage her uterine atony; that her uterine tone was acceptable at the time she was transferred out of theatre; and that it was reasonable in the circumstances, that the ST6 retrospectively documented the complainant's uterine tone at the conclusion of the caesarean section, I do not uphold this element of the complaint.

Observations following caesarean section

96. My investigation considered whether observations, following the complainant return to the delivery suite from theatre after her caesarean section, were carried out in accordance with relevant guidelines. I also considered whether appropriate and timely action was taken when the complainant's condition was noted to have deteriorated.

97. My investigation established that following the caesarean section procedure, the complainant was extubated at 13:34 and transferred to Room 5 in the delivery suite for recovery.

98. I note that in response to my investigation enquiries about this element of the complaint, the Trust said a review of the complainant's Obstetric Early Warning Score (OEWS)[9] chart had been completed. It said the OEWS chart *'confirms that maternal observations began at 13:39hrs and then every 5 minutes thereafter until 14:20hrs.'* The Trust said too that the OEWS chart indicated that *'While [the complainant's] heart rate was slightly elevated, this was somewhat lower than that which was recorded while in theatre.'* The Trust continued, *'As other observations were within normal limits at this time, the plan was to continue to observe.'* In addition, the Trust stated that the midwife who carried out the observations on the complainant while she was in recovery *'documented that [the complainant] was not fully alert following her general*

[9] The OEWS system and action protocol are designed to help identify deterioration in the woman and ensure appropriate early intervention.

anaesthetic but that her respiratory rate and oxygen saturation levels were within normal limits.' It said too that this midwife *'noted a heavy loss per vagina at 14:10hrs and informed the sister in charge who attended at this time.'*

99. I note the Trust's Emergency Caesarean Section Guideline states, *'Following … general anaesthesia observations (heart rate, blood pressure, respiratory rate, oxygen saturations, sedation score, temperature, nausea and pain score) should be continued every 5 minutes for 15 minutes, every 15 minutes for the remaining hour, every 30 minutes for the next hour, and 4 hourly thereafter until observations are stable.'*

100. I note too that the Trust's Guideline for Observations after Obstetric Theatre (which is at Appendix 2 to the Trust's Emergency Caesarean Section Guideline) sets out the same regime for post-obstetric surgery observations.

101. My review of the complainant's OEWS chart found that it documented that observations, which included the complainant's respiratory rate, oxygen saturation level; temperature; heart rate; blood pressure; lochia[10]; uterine tone, neuro response and pain score, were performed every five minutes from 13:39 to 14:09 (at 13:39; 13:44; 13:49; 13:54; 13:59;14:04 and 14:09) and at 14:15; 14:20; 14:30 and 14:35.

102. The Midwife IPA's advice on this matter was that the OEWS chart documented that observations *'were carried out 11 times between 13:34 and 14:35 before [the complainant] was returned to theatre at 14:39'*. (I should highlight that the Midwife IPA expressed some uncertainty about the time she believed observations commenced, due to the quality of scanned record provided to her. My review of the OEWS chart confirmed that, as the Trust stated in its response to my enquiries, the first observations recorded on the OEWS chart were performed at 13:39, rather than 13:34, as suggested by the IPA.) The Midwife IPA also advised that documenting of the observations on the [OEWS] chart was appropriate and in keeping with relevant guidelines.

[10] Vaginal blood loss

103. In relation specifically to the monitoring of the complainant's uterine tone and her blood loss, while she was in recovery, I note the Midwife IPA advised that *'between 13:[39] and 14:09 the midwife had documented that the uterus is well contracted and that the lochia … is normal. At 14:15 the midwife has documented that the uterus is relaxed and atonic (not contracted) and the lochia is documented as trickling. This coincides with when the midwife called for help and complies with both national and local guidelines.'*

104. I am satisfied that the evidence relevant to this element of the complaint demonstrates that the appropriate observations were carried out, at the appropriate times, following the complainant's return from theatre. I am satisfied too that these observations were appropriately documented on the OEWS chart, in line with relevant guidelines.

105. I am mindful that the complainant maintains that her post-surgery observations did not start until 14:00. In this regard, and as the Midwife IPA highlighted in her advice to me, I consider it possible, given the entry made at 13:50 in the complainant's notes (her Intranatal Record of Management/Care) which documents she was *'not fully alert yet',* that the complainant does not recall the observations that were performed at 13:39, 13:44, 13:49 and 13:55.

106. Turning to whether appropriate and timely action was taken by the midwife when she observed the complainant's condition was deteriorating, I note that the complainant's OWES chart documents that at 13:39, 13:44 and 13:49, 13:54 and 13:59, the complainant's blood loss was '*normal'* and her uterine tone was *'contracted'*. The complainant's Intranatal Record of Management/Care documents that at 14:00, the complainant's lochia was *'moderate'* and that medical staff were *'aware'*.

107. I note that when the Trust responded on 31 July 2020 to the complainant's complaint of 3 July 2020, it informed her, *'…at 14:00hrs the midwife noted that your vaginal blood loss was moderate and immediately informed the obstetric staff … at 14:10 hrs the midwife observed that your vaginal blood loss was becoming heavier and she promptly informed the sister in charge who subsequently notified the obstetric consultant … at 14:18hrs the consultant had*

arrive to perform an assessment and by 14:31hrs a further three doctors were present to assist … as there were concerns regarding your ongoing blood loss, the timely decision was made to return you to theatre at 14:37hrs for examination under general anaesthetic.'

108. My review of the complainant's OEWS chart and her Intranatal Record of Management/Care confirmed the timings and events the Trust referred to in its complaint response: I found that the Intranatal Record of Management/ Care documents that by 14:10, *'heavy [per vagina] trickle'* was observed, and that a more senior midwife was informed and came into Room 5. It also records that at 14:12, other midwifery staff and medical staff were informed and they also attended the complainant. The OEWS chart documents that at 14:15, the complainant's blood loss was a *'trickle';* that her uterus had become '*relaxed/atonic*; and that she looked unwell. The Intranatal Record of Management/Care then documents that a consultant obstetrician (referred to in this report as 'Consultant Obstetrician B') attended the complainant at 14:18; that at 14:31, three other obstetric staff, including the ST3 and the ST6, were in the room; and that at 14:37, the decision was made to return the complainant to theatre.

109. In advising on this element of the complaint. the Midwife IPA referred me to the NMC Code, which requires that midwives recognise and work within the limits of their competence, and that they '*accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care [and] make a timely referral to another practitioner when any action, care or treatment is required.'* The Midwife IPA advised that she considered that the care provided when it was realised the complainant's blood loss was becoming heavier, was appropriate.

110. I accept the Midwife IPA's advice on this matter. I am satisfied that the complainants' records demonstrate that appropriate and timely action (the alerting of the senior midwife and obstetric staff) was taken when the midwife realised the complainant's condition was deteriorating.

111. In summary, being satisfied that, following the complainant's transfer from theatre, the appropriate observations were performed in the delivery suite, in accordance with relevant guidelines, and that appropriate and timely action was taken when the complainant's condition subsequently worsened, I do not uphold this element of the complaint.

Consideration of uterine atony risk factors

112. My investigation considered whether uterine atony risk factors were present in the complainant's case, and if they were, whether appropriate consideration given to them.

113. When the Trust responded to my investigation enquiries about this matter, it said, *'All relevant risk factors were taken into account in the care of [the complainant]. Treatment for atony of the uterus had been administered … After surgery, OEWS were commenced at 13:39hrs, and the scores included one yellow and one red, the observations continued at 5min intervals as per the action protocol, medical staff were made aware of this at 14:00hrs (i.e. within the required 30 mins). At 14:12hrs medical staff attended.'*

114. In providing advice on this element of the complaint, the Obstetrician IPA explained that uterine atony risk factors can be 'pre-existing' or' evolving'

115. The Obstetrician IPA advised that in the complainant's case, the Trust's consideration of pre-existing risk factors appeared to have been addressed in the Trust's response of 12 February 2020 to the complainant's complaint of 24 July 2019. He referred to the Trust having informed the complainant, '*[the Childbirth and Loss Midwife] reassured you that the average blood loss following vaginal birth would be approximately 500mls, and whilst your loss was slightly more than average, she explained that this was possible due to your episiotomy … following repair of your episiotomy at your previous delivery, there were no further concerns regarding your blood loss.'* The Obstetrician IPA said he therefore considered that *'there do not appear to have been any pre-existing risk factors for uterine atony.'*

116. The Obstetrician IPA further advised that he considered evolving risk factors - caesarean section and general anaesthesia - were taken into account. He

advised that the complainant *'was adequately monitored following her caesarean section, which led to prompt recognition of the postpartum haemorrhage.'*

117. It is evident that evolving risk factors for uterine atony and postpartum haemorrhage, that is, caesarean section and general anaesthesia, were present in the complainant's case. As already recorded in this report, it is my finding that the observations carried out on the complainant following her caesarean section, performed under general anaesthetic, were appropriate and in keeping with relevant guidelines. I therefore accept the Obstetrician IPA's advice that the Trust did give consideration to those risk factors. I am satisfied that this advice, and the other evidence I considered does not support the complainant's view that uterine atony risk factors were ignored. Consequently, I do not uphold this element of the complaint.

Management of postpartum haemorrhage and decision to perform hysterectomy

118. I considered whether the complainant's postpartum haemorrhage was managed appropriately, in accordance with relevant guidelines, and whether the decision to perform a hysterectomy was appropriate and reasonable in the circumstances, and taken in accordance with relevant guidelines.

119. My investigation established that when the complainant's blood loss was noted at 14:10 to have become heavier, senior midwifery staff and obstetric staff were alerted. I also established that at 14:18, Consultant Obstetrician B arrived in Room 5 and commenced an assessment of the complainant's condition. Consultant Obstetrician B then implemented a number of measures to attempt the stop the bleeding but when these measures were ineffective, a decision was made to transfer the complainant back to theatre. My investigation also established that following a number of further interventions by obstetric staff, a decision was taken to perform a hysterectomy.

120. I note that when Consultant Obstetrician A wrote to the complainant on 30 July 2019, she stated that after the complainant was returned to theatre, at 14:39 on 6 June 2019, she (Consultant Obstetrician A) and Consultant Obstetrician B,

'exhausted all of the routine surgical techniques to manage heavy bleeding and so we made the decision to move for hysterectomy as a life saving measure for you. As routine for our unit we called [Gynaecology Oncologist] … to come to assist with this procedure as he performs this surgery on a more regular basis that what we do.'

121. I note too that in its response of 12 February 2020 to the complainant's complaint of 24 July 2019, the Trust stated *'…the operating surgeons attempted all the standard measures to control your bleeding and unfortunately, these were not successful and in order to manage and control your blood loss, the difficult decision was taken to perform a hysterectomy.'*

122. The Obstetrician IPA's advice, on the basis of his review of the complainant's maternity and medical notes, was that her postpartum haemorrhage was managed in accordance with relevant guidelines, including the Trust's Major Postpartum Haemorrhage Guideline.

123. I note the Obstetrician IPA highlighted that the Trust's Guideline recommends that when a postpartum haemorrhage has been identified, *'…, management involves four components, all of which must be undertaken SIMULTANEOUSLY: 1. Communication. 2. Resuscitation. 3. Monitoring and investigation. 4. Arresting the bleeding.'*

124. In this regard, the Obstetrician IPA advised, '*There appears to have been clear communication … and appropriate escalation including activation of the Major Obstetric Haemorrhage Protocol … There is clear documentation of prompt resuscitation with fluid, blood, platelets, fresh frozen plasma, and cryoprecipitate … There is clear documentation of ongoing monitoring of vital signs, ongoing estimated blood loss, and point of care/laboratory investigations … There is clear documentation of a stepwise approach to arresting the bleeding, including appropriate use of medical agents (e.g. haemobate, tranexamic acid), and conservative surgical measure, including a Bakri balloon (intrauterine compression device) and B-Lynch suture (extrauterine compressions suture), and Bakri/B-Lynch in combination.'*

125. I note that the *'stepwise approach to arresting the bleeding'* the Obstetrician IPA highlighted, is in keeping with the RCOG Postpartum Haemorrhage Guideline. This states, '*Clinicians should be prepared to use a combination of pharmacological, mechanical and surgical methods to arrest [postpartum haemorrhage]. When uterine atony is perceived to be the cause of the bleeding, then a sequence of mechanical and pharmacological measures should be instituted in turn until the bleeding stops …, 'If pharmacological measures fail to control the haemorrhage, surgical interventions should be initiated sooner rather than later.*

126. It was also the Obstetrician IPA's advice that the decision to proceed to hysterectomy was appropriate and reasonable in the circumstances, and that it was taken in accordance with relevant guidelines. The Obstetrician IPA advised, *'In particular, [the decision] is in accordance with [the Trust's Major Postpartum Haemorrhage Guideline] which states, "Resort to hysterectomy should be considered earlier rather than later. A second obstetrician should be involved in the decision for hysterectomy or consultant gynaecologist if in attendance".'* The Obstetrician IPA advised too that the decision was in keeping with the RCOG Postpartum Haemorrhage Guideline, which, I note, states, *'Early recourse to hysterectomy is recommended … Hysterectomy should not be delayed until the woman is in extremis or while less definitive procedures with which the surgeon has little experience are attempted.'*

127. There is no doubt that the decision to perform a hysterectomy to control the complainant's postpartum haemorrhage must have had life-changing consequences for her, and her family. I am satisfied, however, that the evidence available to me supports that before that decision was made, all appropriate alternative measures to arrest the complainant's bleeding were attempted, and were ineffective. I am satisfied too that, in the circumstances, it was appropriate to proceed to hysterectomy, as a life-saving measure, and that the decision to do so was made in accordance with relevant guidelines. Consequently, I do not uphold this element of the complaint.

CONCLUSION

128. I received a complaint about the care and treatment the complainant received at the Trust's RJMH on 5 and 6 June 2019. The complainant said she believed the Trust failed to provide her with appropriate maternity care and that this resulted in her having to have an emergency caesarean section and, ultimately, a hysterectomy. She raised concerns about a number of different aspects of the care and treatment she received and stated that she was seeking an understanding of how going into hospital to have her baby resulted in such an outcome.

129. I investigated whether the care and treatment the Trust provided to the complainant at RJMH on 5 and 6 June 2019 was appropriate and reasonable. My investigation examined the Trust's management of the induction of the complainant's labour and the first stage of her labour; the decision to deliver her baby by caesarean section; the assessment of the complainant's uterine tone at the conclusion of the caesarean section; the observations performed following her return to the delivery suite for recovery after the caesarean section; the management of the postpartum haemorrhage she sustained; and the subsequent decision to perform a hysterectomy.

130. I gave careful consideration to all the available evidence available to me, which included the complainant's medical and maternity notes; the Trust's response to my enquiries; its response to the complaints the complainant submitted to it about the care and treatment she received at RJMH on 5 and 6 June 2019; and the independent clinical advice I obtained from a Midwife IPA and an Obstetrician IPA.

131. I am in no doubt that events during and following the complainant's labour and the birth of her daughter at RJMH on 6 June 2019 must have been highly distressing and traumatic for her and her husband, particularly given that those events had a completely unforeseen and devastating outcome. However, my investigation found no evidence of failing on the part of the Trust in relation to any of the concerns the complainant raised about the care and treatment she

received. In this regard, I am mindful of the Obstetrician IPA's comment in concluding his advice to me – that the complainant's postpartum haemorrhage and the resulting necessary hysterectomy were a very rare but accepted complication of caesarean section. Given the findings of my investigation, I do not uphold the complainant's complaint about the care and treatment she received at RMJH on 5 and 6 June 2019. I hope, however, that this report addresses the complainant's concerns and goes some way towards reassuring her that the care and treatment she received was appropriate.

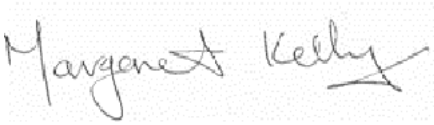
133. I should also highlight that as I recorded earlier in this report, it is my expectation that the Trust takes note of the lack of documented informed consent in relation to the Propess that was administered during the induction of the complainant's labour, and that it considers the need to remind relevant staff that informed consent for the use of Propess for women with ruptured membranes must be obtained and documented.

134. When it commented on the draft of this report, the Trust said that it gave all women undergoing induction of labour information specific to their clinical condition. The Trust nevertheless recognised the lack of documentation regarding informed consent in relation to the administration of Propess in the complainant's case. It said that this matter had been brought to the attention of relevant staff and that it would continue to highlight the importance of well-documented consent, in relation to the risks and benefits of the administration of Propess in the presence of ruptured membranes.

135. In addition, I also urge to the Trust to give careful consideration to the Obstetrician IPA's recommendation that it amend the caesarean section operative note to allow for the assessment of uterine tone at the end of the procedure to be clearly documented.

136. In commenting on the draft of this report, the Trust said that while the complainant's uterine tone was not documented on her caesarean section operative note, *'women are not transferred from an obstetric theatre setting until this is established and on-going uterine atony, or associated post-partum haemorrhage, have been excluded as clinical concerns.'* The Trust informed

me that its caesarean section operative note was being updated to specifically include information about uterine tone.



MARGARET KELLY
Ombudsman **17 January 2022**

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

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

2. Being customer focused

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

3. Being open and accountable

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

4. Acting fairly and proportionately

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

5. Putting things right

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

6. Seeking continuous improvement

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

Appendix Two

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

Getting it right

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

Being customer focused

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

Being open and accountable

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

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

Acting fairly and proportionately

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

Putting things right

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

Seeking continuous improvement

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