CASE DIGEST

03/2025

WOMEN'S HEALTH

Key learning from complaints relating to Women's Health

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Foreword

from the Northern Ireland Public Services Ombudsman

There has been long standing concern across the UK (and indeed globally) about the unequal health outcomes experienced by women. Here in Northern Ireland not only do women face long waiting times for non-urgent care, they have also been disproportionately affected by the cost-of-living crisis and are more likely than men to have caring responsibilities - compounding the impact and consequences of poor health.[1]

My Office is very mindful that the healthcare service continues to operate in the face of competing demands on limited resources, with rising waiting times and challenges in recruitment and retaining skilled staff. At a time of significant pressure there are concerns about public safety and public trust, and some groups are more at risk of poor outcomes than others – an issue we explored in our Patient Safety conference [Patient Safety | NIPSO].

Public interest in, and concern about women's health issues across the UK is

1 COVID-19 will widen poverty gap between women and men, new UN Women and UNDP data shows | United Nations Development Programme

evident in several reviews of maternity services, where systemic failures led to avoidable deaths of women and their babies.[2] The recommendations of the Renfew report, commissioned by the Department of Health (DoH) in NI, highlighted the need to put women and their babies at the centre of improvements, to improve equity of access to care regionally, to improve safety within maternity care and the importance of a culture change to embed learning, accountability and improvement.[3]

The recommendations from the Renfew report are to be welcomed and implementation made a key priority. However, we also need a wider approach to improving women's health outcomes and experiences generally, not only in women-specific health care, such as maternity and gynaecology. This includes better health care data and analysis to fully understand the unequal outcomes in our system, collecting and analysing health complaint data and learning from the findings to reduce inequalities.

Through our Complaints Standards programme, NIPSO is leading a programme of work with the aim of changing the culture in public services complaints handling, a key focus of which is higher quality data, learning and improvement. We have also called for a Patient Safety Framework for NI with a focus on monitoring and reducing health inequalities.

This Case Digest focuses on some of the complaints brought to the Office in relation to women's health. We support and welcome the steps being taken by DoH to develop a Women's Health Action Plan and hope the findings shared in this Case Digest can help highlight learning to improve health outcomes and experiences of care for women in NI.

Margaret Kelly
Northern Ireland Public Services Ombudsman

2 Birth Trauma Inquiry Report 2024
3 Enabling Safe Quality Midwifery Services and Care In Northern Ireland

Role of NIPSO

The Northern Ireland Public Services Ombudsman (the Ombudsman) was established by the Public Services Ombudsman Act (NI) 2016 (the 2016 Act). The role of the Ombudsman is to independently and impartially investigate complaints brought by members of the public about public services in Northern Ireland. The Ombudsman also has the power to conduct investigations without a complaint (often referred to as 'own initiative investigation') under section 8 of the 2016 Act. The Ombudsman's investigation service is free to members

of the public and plays an important role in both providing access to justice and redress for individuals as well as supporting improvement and learning in public services.

Where maladministration is found, the Ombudsman makes recommendations to address the injustice sustained by complainants, to improve public services and to prevent future occurrence of similar failings.

The Principles of Good Administration, appropriate legislation, policy, procedures, and standards are the benchmarks against which the actions of public bodies are measured.

The Office also identifies and shares learning to help improve public service delivery. NIPSO's work is underpinned by The Principles of Good Administration and The Principles of Good Complaints Handling. The Principles of Good Administration are:

1. ***'Getting it right'*** requires public bodies to act in accordance with *'recognised quality standards, established good practice … with regard for the rights of those concerned.'*
2. ***'Being customer focused'*** requires public bodies to respond to people's needs. This means *'ensuring people can access services easily'*, being sensitive to individual needs and adhering to commitments and published service standards.
3. ***'Be open and accountable'*** providing information that is clear, accurate and complete, providing honest evidence-based explanations and giving reasons for decisions.
4. ***'Acting fairly and proportionately'*** requires public bodies to ensure complaints are investigated thoroughly and fairly to establish the facts of the case. This also means they should *'avoid being defensive when things go wrong'.*
5. ***'Putting things right'*** requires public bodies to *'acknowledge mistakes and apologise where appropriate' and* offer *'appropriate remedy when a complaint is upheld'.*
6. ***'Seeking continuous improvement'*** requires public bodies to learn *'lessons from complaints and use these to improve services and performance'.*

Women's Health Inequalities

A key source of health inequalities data is the annual 'Health Inequalities Report' for Northern Ireland (NI). This report highlights the impact of socioeconomic inequalities. However, it focuses primarily on wealth disparity and not on gender-based health outcomes which means we lack a comprehensive overview of inequalities in women's health in NI.[4]

Women's health data from elsewhere in the UK and beyond, indicates there can be an unconscious bias against women in healthcare, specifically in the treatment of chronic pain conditions. Women are more likely to live with autoimmune conditions,[5] their pain in Accident & Emergency (A&E) is triaged as less severe than men reporting similar pain levels and they are less likely to

receive pain relief than men.[6] Despite living longer than men, women have shorter 'disability free life expectancy', indicating that women live longer, but in poorer health.[4]

DESPITE LIVING LONGER THAN MEN, WOMEN HAVE SHORTER 'DISABILITY FREE LIFE EXPECTANCY', INDICATING THAT WOMEN LIVE LONGER, BUT IN POORER HEALTH.

Health inequalities experienced by women are often referred to as the 'gender-health gap'. This health gap does not impact on all women equally, with unequal outcomes across different groups of women such as socio-economic, disability and / or ethnic background.

There are many reasons for this health gap, some of which relates to a lack of information and knowledge around women-specific health conditions. Evidence has shown that a lack of research into conditions specifically affecting women can lead to poor health advice, misdiagnosis, delayed or ineffective treatment and overall worse outcomes for women.[7] Women are also less likely to be invited to participate in medical trials and research, exacerbating the gender-gap in health data.

Research also shows that health inequalities are not limited to women-specific conditions but can be found in other areas of health such as heart disease[8], highlighting a wider concern of unequal treatment.

4 Health Inequalities Annual Report 2024
5 Why Nearly 80 Percent of Autoimmune Sufferers Are Female | Scientific American
6 Gender disparity in analgesic treatment of emergency department patients with acute abdominal pain - PubMed
7 Under-representation of women in research: a status quo that is a scandal | The BMJ
8 Bias and Biology - BHF

Women's Health in Northern Ireland

The following summary of some relevant statistics and data highlights a number of areas where women in NI are potentially at risk of poor care, treatment and/or outcomes.

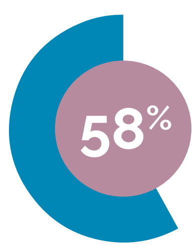
GYNAECOLOGICAL HEALTH

In 2021, the total number of women waiting for a gynaecology outpatient appointment in NI more than doubled in seven years, reaching 28,511 patients waiting as of September 2021. A 2024 review of gynaecological surgery in NI found over 37,000 women on hospital waiting lists with 5% of those waiting nearly three years for treatment.[9] The review of gynaecology services including endometriosis, incontinence, hysterectomy, prolapse and urinary tract infections revealed that these were not only among the worst waiting lists in NI but were among the worst in the UK.

A 2024 review of gynaecology surgery in NI found over 37,000 women on hospital waiting lists, with 5% of those waiting nearly three years for treatment.

MENOPAUSE

Most women will experience at least one menopausal symptom with around a third of women experiencing severe symptoms. Despite this the Royal College of Obstetricians and Gynaecologists (RCOG) found that 58% of UK women could not access local menopause services. In NI, access to care depends on what is available in local Health & Social Care Trusts with the level of service and expertise on offer varying considerably.[10]



of UK women could not access local menopause services.

INEQUALITIES WITHIN GROUPS OF WOMEN

The gender health gap in NI is not affecting all women equally, with factors such as deprivation contributing significantly to this disparity. For example, the most socio-economic deprived areas in NI have a 64% higher incidence of cervical cancer compared to the national average.[10] UK data reveals a significant health disparity between black and Asian women and white women highlighting the need for further analysis and collection of this data as the NI population becomes more diverse.

The most socioeconomic deprived areas in NI have a 64% higher incidence of cervical cancer compared to the national average.

9 Tens of thousands of women are on gynae waiting lists in NI | BBC News

10 Women's gynaecological health in Northern Ireland - Research Matters

MATERNITY SERVICES

Northern Ireland has been without a Maternity Strategy since 2018. The Renfrew Report, commissioned by the DoH, looked at the safety of maternity and newborn services (Oct 2024) and highlighted a number of concerning findings, concluding that women in NI *"were not consistently receiving the quality of care they need and expect in pregnancy, labour and birth, and postpartum".* The report highlighted the need for a coordinated approach, the development of better interdisciplinary structures and processes, a significant change in culture, and a radical shift in the relationship with women to bring about the changes needed to improve services.[3]

Rates for stillbirths, perinatal and neonatal deaths exceed the UK average and have poorer outcomes than the rest of the UK. Rates in all Trusts in NI are slightly higher than UK average, but one Trust is currently red-flagged, meaning rates of perinatal mortality are over 5% greater than the UK average. In the past five years of reporting, every Trust in NI has been red-flagged at least once.[11]

11 Perinatal mortality data viewer MBRRACE-UK

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Women's Health Action Plan for Northern Ireland

In 2024 The Community Foundation for Northern Ireland and their *'Nothing About Us Without Us'* (NAUWU) group launched the results of a survey into women's health and the need for a Women's Health Strategy for Northern Ireland.

The key findings from the survey highlighted the high proportion of respondents (over 79%) who on occasions, felt they were not listened to by health professionals and more than 50% found that the services they needed were not accessible.[12]

Action has begun on some of these issues, with the DoH announcement of the development of a Women's Health Action Plan[13] in February 2024.

The Action Plan will focus on addressing women's health throughout their life, including fertility and pregnancy, post-natal healthcare, baby loss, menopause, and gynaecological services. Also announced at the time was the intention to facilitate a wider public conversation about women's health, with women's voices at the centre of the discussions. This is currently underway and in November 2024, Health Minister Mr Mike Nesbitt launched an online survey to hear directly from women about their specific health needs and experiences.[14]

12 Nothing About Us Without Us - Women's Health Strategy Survey
13 Minister Swann outlines Women's Health Action Plan | Department of Health
14 Women encouraged to take part in NI-wide health survey | Department of Health

About this Case Digest

The purpose of this case digest is to highlight some of the investigations made into complaints about women's health. The cases were selected to illustrate some of the key areas of concern and to highlight learning to improve public services.

Whilst some of the findings and areas for improvement are unique to women's health, many of the failings are reflective of concerns found in many of our health investigations. However, the significant impact experienced by women as a result of these failings, coupled with well documented concerns regarding the gender-health gap and the need for improved maternity provision, make these issues worth highlighting.

The key failings and recommendations are detailed below, and summaries of the cases can be found in the Appendix.

Key Themes of Failings and Areas for Improvement

Informed Choices and Consent for Women

It is essential that health care providers empower patients to be partners in their own healthcare. Informed consent means providing patients with choice in their own care, explaining the potential advantages and disadvantages, and what could happen if they chose no action. This can lead to greater patient satisfaction and empowerment.

In one case, our investigation found that the rationale for decision making should have been better explained to a patient and her family to alleviate their concerns and reassure them that the correct investigations were taking place. In another case, we found that the Trust had not provided appropriate information on Induction of Labour (IOL) at the complainant's antenatal clinics. Our investigation raised concerns about the quality of documented information regarding the benefits, risks and alternatives to IOL. Had the complainant received this information prior to childbirth, it may have reduced her distress during the birth of her child.

Listing to women's concerns

It is a fundamental tenant of good medical care to listen to patients. When the National Institute of Clinical Excellence (NICE) issued guidance on diagnosis and treatment for endometriosis, the key message was 'listen to women' and believe women when they describe their pain. The themes of national reviews on pregnancy and childbirth have also highlighted the need to listen to the concerns of women before and during childbirth.

An example from our investigations found that the Trust failed to provide appropriate care and treatment by not escalating a woman's concerns about increasing pain for senior medical review, which may have avoided the tragic loss of her baby.

Documentation and record keeping

Effective documentation of patient interactions is crucial for patient safety and is key for quality assurance. Good record keeping facilitates safe handovers of patients between healthcare professionals, identifies where escalation is required or patterns emerge, allowing for earlier diagnosis and intervention. Poor and inadequate documentation also limits learning from negative outcomes and hinders the identification of areas for improvement.

Our investigations found poor documentation in several cases, including failures to appropriately record phone conversations and to assess a patient's condition over the phone. This resulted in a lost opportunity to encourage the complainant to attend hospital sooner and hindered safe handover of care between staff.

Development of a learning culture within women's healthcare specialties

This was a key recommendation from the Renfew Report and aligns with recommendations made in our individual investigations. Our recommendations include the importance of good documentation to facilitate future learning, reflective practice from staff and debriefing when there are negative outcomes or patient complaints. Audits for quality control and quality improvement, sharing recommendations with staff and staff training were also recommendations from the cases, which aim to create a culture of learning and improvement.

Openness and transparency with patients

An apology was recommended in all of the cases included in this digest. There will always be some degree of power imbalance between patients and clinicians, and patients may feel particularly vulnerable in hospital settings. Along with informed consent and information sharing it is crucial to involve patients in their own care. To be effective this includes empowering women to raise concerns or ask questions and answering these fully and truthfully. Openness also builds trust and provides reassurance for patients.

Equality of access to regional services

Whilst not every Trust is expected to provide the full range of specialist care patients may need, it is reasonable to expect equal access to regional services. One case highlighted the inequity of access to the only pre-term birth clinic in NI (in Belfast Trust). Our recommendation, which was shared with the Department of Health (DoH), highlighted the need to develop region-wide referral pathways to allow access for all women regardless of the Trust area in which they live.

Recommendations and Conclusion

Where an investigation finds failings, the Ombudsman makes recommendations to provide redress for the individual complainant and also for wider service improvement. Typical recommendations in health complaints are outlined below.

APOLOGY

An apology as an acknowledgement of error can provide emotional relief for those who are aggrieved from failings in care and treatment. NIPSO has published Guidance on Issuing an Apology to public bodies.

Guidance on Issuing an Apology

AUDIT

In cases where we suspect that failings may be widespread, we recommend an audit of records to identify whether similar failings have occurred without a complaint being made, and therefore have not been addressed. This allows any patterns or trends to be recognised and broader improvements put in place.

STAFF TRAINING AND REFLECTION

We recommend staff training and reflection to encourage learning and development, to foster a supportive environment for staff to improve their own practice and learn from complaints.

We then follow-up and request evidence to ensure that any recommendations made are being implemented.

For example, following a NIPSO investigation the Belfast Health and Social Care Trust sent a survey to expectant mothers, regarding

the prenatal midwife-led Induction of Labour service for inpatients and outpatients. The survey revealed both positive feedback and shortcomings of the service, which led to the Trust revising their Induction of Labour (IOL) information booklet and developing a video for women considering the procedure. The information produced now helps ensure expectant mothers have up-to-date information on the procedure.

An investigation into the South Eastern Health and Social Care Trust asked for audit research on the medical management of endometriosis, which involved reviewing retrospective patient records for those on the waiting list for surgery for endometriosis. The findings of this were shared with staff and included recommendations on how discussions on medical management are documented and information sharing with patients. We also recommended that patients receive information from the Royal College of Obstetrics and Gynaecology and patient support groups.

Case Summaries

CASE 1: TRUST FAILED TO PROVIDE CONSULTATION TO WOMAN ON AMNIOCENTESIS (SEHSCT)

A woman whose baby was diagnosed with cleft lip through an ultrasound at prenatal clinic, complained about not receiving amniocentesis[15] consultations.

Despite requesting amniocentesis consultations, these were not provided, and she did not receive any further consultation on the risks and benefits of amniocentesis during her pregnancy. Her baby was born with a syndrome caused by a chromosomal abnormality called Patau Syndrome (Trisomy 13)[16] and she questioned why this had not been diagnosed during her pregnancy ultrasounds.

Our investigation found that the Trust had failed to provide clear and accurate information on amniocentesis, including the risks, despite the fact the patient had requested it twice. We recommended an apology, along with a review of the information and procedures about amniocentesis offered to patients, and a review of the accessibility of the ultrasound image archive within the Trust.

15 Amniocentesis is a prenatal test for chromosomal abnormalities and genetic disorders.
16 Patau syndrome is a serious, rare genetic disorder caused by having an additional copy of chromosome 13 in some or all of the body's cells.

CASE 2:
APPROPRIATE RISK-SCORING WAS NOT DONE BY TRUST FOR WOMAN WITH OVARIAN MALIGNANCY (WHSCT)

This complaint was brought by the family of a woman who sadly passed away from a respiratory tract infection following a suspected ovarian cancer diagnosis. The investigation concluded there was no failing in the decision to cancel an MRI scan, but the rationale should have been better explained to the patient and family to alleviate their concerns and provide reassurance that the correct investigations were taking place. We found that although most patients would be referred to a tertiary cancer centre, this would have delayed her original treatment and would not have altered the illness's progression. Our investigation found a failure to record the risk of malignancy index (RMI)[17] score for the ovarian mass and clarifying the scoring protocol used to assess malignancy risk.

We could not determine if the family was informed about a diagnosis of pulmonary sepsis until they viewed the medical certification and cause of death (MCCD). The IPA considered hospital acquired pneumonia as a more appropriate cause of death but could not determine the patient's condition or communication to the family due to missing medical documentation. However, the IPA suggested that on balance from other records that the family was likely informed, and pain relief was adequate.

We found maladministration in the Trust's loss of the patient's medical records for periods of her admission to Altnagelvin Hospital. The Trust failed to follow its own procedures to locate misplaced documents, causing injustice to the complainant by not fully addressing her complaint and diminishing trust in how complaints are handled.

We recommended an apology, service improvements for complaint handling and record keeping, and a random audit of ovarian cancer patients' RMI scores and their calculations. We also recommended a region-wide protocol for RMI scoring and risk assessment due to discrepancies between NICE and RCOG systems and shared this report with the Chief Medical Officer.

17 Risk of malignancy index is a scoring system to determine how likely an ovarian mass is malignant/cancerous

CASE 3:
TRUST FAILED TO LISTEN TO WOMAN'S CONCERNS AND ESCALATE THESE CONCERNS, RESULTING IN THE LOSS OF HER BABY (SHSCT)

A woman with a history of caesarean births experienced severe abdominal pain during the later stages of her pregnancy and attended hospital. Despite receiving pain relief and being scheduled for another caesarean delivery, her pain worsened, and she expressed her concerns to the staff. However this was not escalated appropriately to senior doctors for review. On the second day of her admission she was reviewed and scans showed that tragically, her baby had passed away.

Our investigation established serious failings in this case; her pain had not been appropriately documented on Obstetric Early Warning Score (OEWS)[18] charts, which may have prompted an earlier senior review. The pregnancy was considered high risk given the woman's previous history. The increased pain and OEWS were indications of potential uterine dehiscence and the need for an emergency caesarean. A timely emergency caesarean would most likely have resulted in the baby being born alive. The investigation also found falsification of midwifery records, which constitutes a serious breach of the NMC Code of Practice. The Serious Adverse Incident investigation conducted by the Trust made recommendations for individual care plans for all antenatal inpatients and OEWS training for midwives. The NIPSO investigation further recommended an apology to the patient, full audits to review staffing levels and obstetric and midwifery records, and staff training on escalating concerns about high-risk patients.

18 OEWS refers to an "Obstetric Early Warning Score" a system used to monitor and assess a pregnant woman's vital signs and other physiological parameters to identify early signs of potential complications or clinical deterioration, allowing for timely intervention and escalation of care.

CASE 4: TRUST FAILED TO GAIN INFORMED CONSENT FOR TREATMENT OF AN ABSCESS (WHSCT)

A woman was hospitalised due to a Bartholin's abscess[19], after she continued to feel unwell despite receiving antibiotic treatment from her GP. Specialist gynaecology doctors performed an incision and drainage but could not insert a catheter for further drainage of the abscess. They advised her to continue with the antibiotic course prescribed by her GP. Despite the initial procedure, the woman continued to feel unwell and returned to hospital a few weeks later. A second procedure was performed but she developed sepsis as a serious but rare complication.

Our investigation found that although the continued antibiotic treatment was appropriate, hospital staff failed to obtain informed consent for both procedures, including informing the patient of the risks and complications. They also failed to offer appropriate second-line treatments after the first incision failed. Our investigation also found maladministration in how the Trust determined whether there should be a Serious Adverse Incident (SAI) investigation into this case.

Recommendations asked the Trust to apologise, review the case again under the SAI criteria and document how this was applied and reasoning for the decision made. We also recommended staff training on informed consent and informing patients of alternative treatments and risks for Bartholin's abscess.

19 A Bartholin's cyst, also called a Bartholin's duct cyst, is a small fluid-filled sac just inside the opening of the vagina.

CASE 5: TRUST FAILED TO PROVIDE OPTION OF CERVICAL STITCH FOR PATIENT WHO HAD EXPERIENCED PREVIOUS MISCARRIAGES (WHSCT)

A woman complained to our office that she had not been offered appropriate maternity care following two miscarriages in 2018 and 2020, which may have been preventable. Following the loss of her first baby, the complainant raised with her consultant obstetrician the possibility that she may have cervical incompetence[20], given that she had experienced similar symptoms to those described in literature on miscarriage. During her subsequent pregnancy, the complainant reiterated these concerns to a new consultant obstetrician, who agreed to monitor the length of her cervix fortnightly and that a cervical stitch would be considered should the cervix shorten under 25mm. When her cervix measured 25mm, her consultant decided not to insert a cervical stitch and chose to continue monitoring the length instead of inserting a stitch. However, her cervix shortened further a short time later and a stitch was eventually inserted. Despite this, the complainant's membranes ruptured, and tragically, her baby was stillborn.

Our investigation established failings regarding the lack of a choice given to the complainant about insertion of a cervical stitch when her cervix measured 25mm.

Additionally there were record keeping inaccuracies, in the complainant's discharge letter and issues relating to the post-mortem of her baby.

In response, the consultant obstetrician had reflected on their practice and accepted that at the time they may have been experiencing cognitive bias regarding their practice and accepted the failings found in this case. While this does not change the negative experience of the complainant, it is hopefully reassuring in respect to improving future practice.

This complaint also raised the disparity in access to pre-term birth clinics based on geographical location in Northern Ireland. At the time of this complaint, the only pre-term birth surveillance clinic

20 Cervical incompetence is when the cervix shortens during pregnancy, putting the woman at risk of miscarriage or premature birth.

was located within the Belfast Health and Social Care Trust (BHSCT). However, this is not a regional clinic and has no clear referral pathway or guidance for women at risk of pre-term birth and miscarriage. At the time of writing this case digest, the only surveillance clinic remains at BHSCT, representing ongoing inequality in access to preventative care for women.

We made several recommendations, including providing an apology, conducting a random sample audit of patients who have experienced miscarriages to ensure recommended blood tests are being performed, and training and reminders for staff to adhere to National Institute for Clinical Excellence (NICE) and ensuring accurate documentation.

CASE 6:
TRUST FAILED TO GIVE INFORMATION ABOUT INDUCTION OF LABOUR TO PATIENT (BHSCT)

A woman complained about her painful experience during labour and shared her concerns that she and her baby were put at risk. Our investigation found that whilst her clinical care was of an appropriate standard and that the Trust anaesthetist had obtained informed consent for an epidural, the Trust did not however provide appropriate information on Induction of Labour (IOL)[21] at the complainant's antenatal clinics. The Independent Professional Advice sought on this case, raised concerns about the quality of documented information regarding the benefits, risks and alternatives to IOL. Had the complainant received this information prior to childbirth, her expectations could have been better set and potentially reduced her distress during childbirth.

We recommended an apology, and for staff to be reminded of Trust and National guidance on intrapartum care and Induction of Labour. We also recommended a sample audit to assess communication of IOL with other women, the updating of Trust policy on IOL in line with NICE Guidance, as well as a review of other Trust policies.

21 Induction of labour is when childbirth is started artificially by healthcare professionals. This can be done with medication or by inserting sterile instruments into the cervix.

CASE 7:
TRUST DID NOT PROVIDE ADEQUATE PAIN RELIEF TO COMPLAINANT, LEADING TO TRAUMA FOLLOWING BIRTH OF HER CHILD (SEHSCT)

A woman with a history of mental ill health had concerns and anxiety around giving birth and proactively discussed these with her consultant obstetrician. As a result, it was agreed she would be induced before her due date and an epidural was planned. Despite this she did not receive an epidural[22] during labour and experienced significant pain and distress, due to a delay with the taking and reporting of blood samples from the laboratory, as well as a lack of clear communication on what blood tests were required, if any. There were also delays in transferring the complainant to the labour ward during active labour, depriving her of the opportunity to have her partner there for support and comfort.

We found the Trust failed to provide appropriate care and treatment by not following the plan for an epidural and that the staff's actions were not person-centred regarding her mental well-being during her childbirth. An apology was recommended and a review of local guidelines on epidural analgesia and whether blood samples are required for all patients. It was also recommended that Trust staff reflect on the report's findings and conduct a random sampling audit of patients who requested an epidural and assess whether these were successfully implemented.

22 An epidural is a type of pain relief that involves injecting medication into the epidural space of the spine. This can also be used as an anaesthetic during surgery or caesarean births.

CASE 8:
TRUST STAFF DID NOT TAKE OPPORTUNITIES TO REASSESS PATIENT WHEN SHE WAS IN PRE-TERM LABOUR (SEHSCT/BHSCT)

A woman in preterm labour presented to the Emergency Obstetric Unit at the Ulster Hospital and was initially assessed and referred for medical review. She was later transferred to the Royal Jubilee Maternity Hospital (RJMH) due to the lack of neonatal cot availability in the Ulster Hospital.

Once the complainant was transferred to the RJMH, she progressed through labour but had to undergo a caesarean birth due to the baby not presenting headfirst (malpresentation). The patient also experienced placental abruption[23] and the investigation found that this was correctly managed. However, during examination to ensure full dilation, an assessment of the baby's presentation was not performed, and neither was this recorded. We also found that an episiotomy[24] was performed inappropriately, causing unnecessary pain and an invasive procedure for the complainant.

We recommended that the SEHSCT apologise to the complainant. We also recommended a change to the Triage Unit procedures where midwives are trained to reassess women in suspected pre-term labour at least hourly, and to review if they require escalation to medical staff. We recommended that the BHSCT apologise to the complainant and provide staff training on the importance of abdominal palpation or ultrasound scanning to confirm the baby's presentation. We recommended that both Trusts discuss the investigation findings with the staff involved in the complainant's care.

23 A serious complication of childbirth when the placenta detaches from the wall of the womb before birth. This can cause bleeding in the vagina and uterus.

24 An episiotomy is a surgical incision made between the vagina and anus to widen the opening for childbirth. This is done to help the baby pass through the birth canal and prevent severe tears, which are more difficult to repair.

CASE 9: COMPLAINANT WAS NOT WARNED ABOUT RISK OF INFECTION AND HAD CONCERNS DISMISSED BY TRUST STAFF (BHSCT)

A pregnant woman experiencing spontaneous rupture of membranes[25] (SROM), attended the Royal Jubilee Maternity Hospital and was discharged home with temperature sticks. However, she was not provided with an explanation of how or why to use these. When she later called the hospital about feeling unwell, she was dismissed and told to attend later that day for her scheduled induction of labour appointment.

The investigation found failings in the information provided to the complainant following SROM, including the lack of literature on infection risk following SROM, the impacts on labour and how to use the temperature sticks. In addition, the complainant's phone conversations were not recorded accurately, and her condition was not fully assessed, including questions about her health and foetal movements. This resulted in missed opportunities to encourage the complainant to attend hospital sooner and the lack of accurate documentation hindered safe handover of care between staff. For example, the patients timely transfer to the labour ward could not be determined due to insufficient records. After labour and treatment for sepsis the patient was discharged, however the records surrounding the decision to discharge were inadequately completed and there was no evidence of a medical review and care plan post-discharge. We recommended an apology for the complainant, staff training on record keeping and the importance of information provided to and the assessment of women experiencing SROM.

25 Spontaneous rupture of membranes is when the amniotic sac breaks during pregnancy, also known as "waters breaking". When this happens before labour it can cause an increased risk of infection to the pregnant woman, and delivery should be induced within 24 hours. This can happen on its own, but if it does not, it must be induced medically.

CASE 10:
COMPLAINANT EXPERIENCED UNACCEPTABLE DELAYS FOR SURGICAL TREATMENT FOR ENDOMETRIOSIS (SEHSCT)

We received a complaint from a woman who had been diagnosed with severe Stage IV endometriosis[26] and whilst having been placed on the urgent list to undergo surgical excision[27] in September 2016, due to waiting list delays her surgery did not take place until September 2020.

Our investigation found that the delay for surgery was unacceptably long and that ongoing review and scans to assess disease progression were reactive to the patient's requests, and not proactive to minimise the impact on this woman's life.

We also found that there was a failure to offer the patient hormonal treatment for disease progression. We recommended an apology, a random sample audit of records to review patients being offered hormonal therapies for endometriosis, and a review of policies by the Trust for patients with Stage III and IV endometriosis being referred to other Health and Social Care Trusts for surgery.

26 Endometriosis is a chronic health condition where tissue from the lining of the womb (or endometrium) is found elsewhere in the pelvis. The most severe form is Stage IV, where this tissue is found deeper in the abdomen, including on the bladder, nerves and bowel.
27 Surgical excision is a surgical procedure to remove tissue.

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