Hospital complaints and internal investigations

This leaflet explains what happens where you have suffered traumatic treatment leading to injury and/or loss of your baby during your pregnancy, labour and birth or in the early neonatal period, and you wish to raise a complaint against the hospital for the treatment provided.

It will help you to understand the process for making a complaint, who to contact and how and what the outcome of the investigation could be. We explain the process from the viewpoint of a fictional couple, Ian and Tamsi.

fieldfisher

Why might Ian and Tamsi want to make a complaint

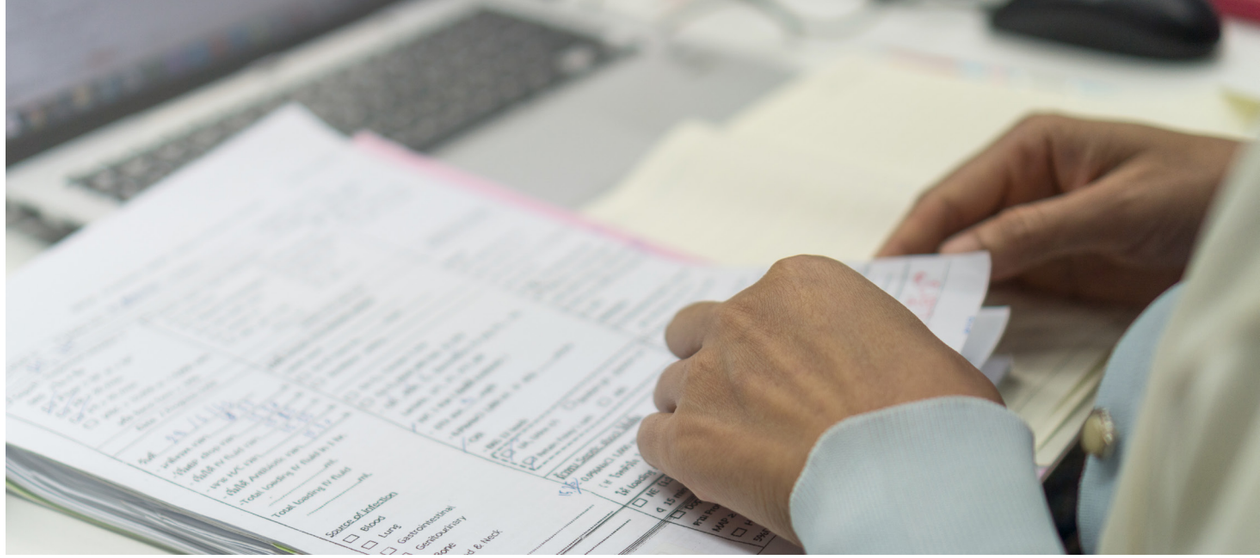
Ian and Tamsi have lost their baby son at 36 weeks due to a placental abruption. They have concerns about the treatment provided and find it hard to understand how their baby did not survive. They were not expecting a difficult birth or any problems.

PALS

A good first step for Ian and Tamsi is to make a written complaint to the PALS (Patient Advice and Liaison Service) team at the hospital where the treatment took place. Anyone affected by the actions or decisions made by the hospital can make a complaint. It is good to do this as soon as possible so that an investigation can begin.

In their written complaint, Ian and Tamsi should include a summary of the events from their perspective, accounts of what they were told by staff during the admission, and a set of questions they would like answered as part of the complaint, to include any concerns they have about the standard of care provided or any delays in the correct treatment being given. They can find information about the PALS

Other specialist organisations provide a range of support and information, including counselling services. For more detailed information, please scan the QR code.



team of the hospital online, including the address and email to write to.

We strongly recommend they request a copy of Tamsi's maternity records, which will include records relating to delivery of their baby. The baby would not have his own records because, in this case, he was stillborn. Having the records helps with the complaint questions and should clarify any explanations given to them.

They may want some help understanding the records. If Ian and Tamsi have the support of a specialist bereavement midwife or neonatal nurse, they should be able to explain the records or they can ask a specialist charity. If they have already approached a specialist law firm like Fieldfisher, we can also give an overview of the records.

Investigation by the hospital

Once Ian and Tamsi have submitted their complaint, they will receive a letter or email from the hospital confirming that an investigation will follow. Once received, they should write to the hospital asking them to confirm the scope and estimated timeframe of the investigation, that the death will be reported to the National 'Learning from Deaths in the NHS' programme, and that they will be given a copy of the report, a written response and an opportunity to meet with the investigation team if they have further questions.

Receiving and reviewing an investigation report

Once Ian and Tamsi have received the investigation report, they will be given time to review the report and consider its findings.

The report will state who has conducted the investigation and which members of staff were interviewed. It will also include a chronology of what happened and what is recorded in the medical records.
After considering the facts, the report may determine that the treatment provided was appropriate in the

circumstances. It may also determine that some or all of the treatment provided was not in line with standard practice and that different or earlier treatment should have been provided. The report may comment on whether appropriate treatment may have made a difference.

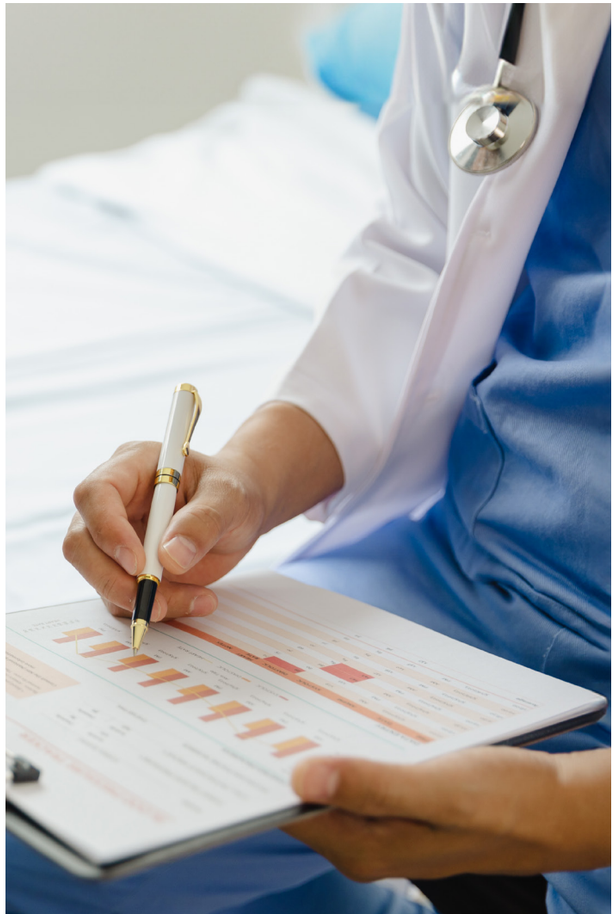
Ian and Tamsi should have the opportunity to review the report and to inform the hospital of any factual discrepancies or issues they have with the report. They can also ask further questions that have arisen. The investigation team should then respond to these additional concerns. Ian and Tamsi may also be offered the option to meet the investigation team to discuss the findings, and whether there will be changes to hospital practices to help improve treatment provided and prevent further deaths.

If Ian and Tamsi are unhappy with the report or consider it found failings in their treatment, they can speak to a solicitor to review the report and any other documentation to decide whether there is the possibility of bringing a legal claim.

The Perinatal Mortality Review (PMRT)

When a baby dies before, during or after birth the hospital(s) where mother and baby were looked after should review the care as part of a perinatal or neonatal review and is when a clinical team looks through the hospital notes to understand the events that led up to the death of the baby. This is separate to the complaint process and/or internal investigation process explained earlier in this guide. This PMR would form part of standard care for Ian and Tamsi, and should be provided for them so they have as much information as possible about why their baby died. It also means hospitals can learn from what happened so as to improve care and prevent, if possible, future deaths.

Tamsi and Ian should be told a review is going to take place and be offered an opportunity to ask questions and provide information about their care for the review panel. They do not attend the review panel meeting. After the review they will then be invited to an appointment with their consultant to discuss the findings. This might be wrapped up in a debrief meeting if it happens after the review meeting and Ian and Tamsi should ask if the PMR has taken place and the outcome. If there is an MNSI investigation the PMR will be postponed to after the MNSI is complete. More information about this process is found on our website by using our QR code.



Maternity and Newborn Safety Investigations Programme

This is a national programme that investigates certain cases of early neonatal deaths, intrapartum stillbirths and severe brain injury in babies born at term following labour. It also investigates maternal deaths. Hospitals are required to report all baby cases where events go unexpectedly on a portal and indicate if the case fits the MNSI criteria for investigation by the MNSI.

If the MNSI investigates the circumstances of your baby's birth, the hospital will stop its internal investigation and instead you will be invited to meet a lead midwife investigator from the MNSI who will conduct an investigation independently of the hospital. The hospital must provide all the records to the MNSI investigator who will interview the clinical staff involved in your care. At the end of their investigation, they will produce a report detailing their findings which they will share with you.

The MNSI does not investigate cases where health issues present before the birth led to the poor outcome for your baby. They do not investigate cases where a baby is born before 37 weeks gestation.

More information

Knowing what to say when framing your complaint and how to respond to an investigation report can be difficult, particularly when you are trying to cope with a traumatic birth and baby loss.

If you need advice about preparing a complaint and how to interpret an investigation report, you can contact us on our **free helpline number 0800 047 2791**, or email us on **maternitylaw@fieldfisher.com.**

How can I get further information and advice?

Fieldfisher is an award winning, leading firm of medical negligence specialists, recognised for going the extra mile for our clients. To get more advice about your own circumstances, or to assist you in supporting a family you are caring for, please contact one of key contacts Caron Heyes or Christina Gardiner, or contact us on our **free helpline 0800 047 2791** or email us on **maternitylaw@fieldfisher.com.**

Simply fantastic in dealing with my medical negligence claim, listened to my thoughts about the situation. Legal knowledge and instinct are amazing, always professional, positive and unbelievably supportive during sad and challenging times.

Caron Heyes
caron.heyes@fieldfisher.com

Caron Heyes is a Director in the medical negligence team and has worked in the medical negligence sector for many years specialising in bringing claims for adults and children injured during the antenatal, birth and neonatal period.

Christina Gardiner
christina.gardiner@fieldfisher.com

Christina Gardiner is a Senior Associate Solicitor and runs a varied caseload, including complex, high value cases involving birth injury. She works with medical related charitable organisations AvMa and sits on the board of trustees for the Open Hands charity.