Maidstone and Tunbridge Wells NHS Trust

Ref: FOI/GS/ID 6679

Please reply to:
FOI Administrator
Trust Management
Maidstone Hospital
Hermitage Lane
Maidstone, Kent
ME16 9QQ
Email: mtw-tr.foiadmin@nhs.net
www.mtw.nhs.uk

02 July 2021

Freedom of Information Act 2000

I am writing in response to your request for information made under the Freedom of Information Act 2000 in relation to Maternity service complaints.

You asked:

1. How many complaints you have received from mothers who used your maternity services between 1 January 2018 and 24 April 2021.
2. A breakdown of the allegations made in each complaint.
3. What the outcome was of each complaint.

Trust response:

Please see the following table:

Unit	Location (type)	Specialty	Incident date	Description	Outcome	Outcome code
Tunbridge Wells Hospital	Ward / Unit	Obstetrics	2019	Patient's husband upset that request for patient to be seen by a female doctor was not met, despite assurances. Unhappy with some of the comments and behaviour displayed by the male doctor who did attend.	Apology offered and explanation that a female doctor was not available and the male doctor was asked to take a history prior to a female doctor performing the examination. Apology offered for behaviour although this is not the recollection of the doctor.	Not upheld
Tunbridge Wells Hospital	Office	Obstetrics	2019	Concerns raised that when attending the recurrent miscarriage clinic, patient had to sit in waiting room with pregnant women and those with babies. When attending for the clinic the consultant was not available due to annual leave and therefore appointment had to be rebooked. Next available appointment not for 5 months. Concerns about the attitude and communication from staff member who reviewed patient. Concern that voicemail messages left advising woman to contact department for check prior to due date, when baby was miscarried over 6 months previously.	Apologies offered for poor experience. Patient should have been offered somewhere appropriate to wait - staff reminded of this. Apologies offered for poor consultation - educational supervisor informed to take forward with dr concerned. Appt brought forwards. Explanation provided around why patient was contacted for antenatal review. Work ongoing to fix the maternity system and in the meantime, staff reminded not to upload scans unless women are booked for maternity care.	Upheld
Tunbridge Wells Hospital	Ward / Unit	Midwifery	2019	Concerns raised that baby sustained damage to neck during delivery and questions around where placenta was positioned during antenatal scans.	Explanation provided as to where placenta was positioned during labour and delivery and that the condition the baby now suffers with could not have been caused during delivery as this would usually occur over a long period of time.	Not upheld
Tunbridge Wells Hospital	Ward / Unit	Midwifery	2019	Concern raised around the care provided during early labour and question asked as to why a scan was not undertaken to determine any issues. Concerns with support provided post delivery.	Explanation given as to the treatment provided, no clinical indication that a scan was required. Evidence supports that post natal care was reasonable.	Not upheld

Tunbridge Wells Hospital	Ward / Unit	Obstetrics	2020	Concerns raised with the management of bleeding during early pregnancy. Discrepancy in scanning and gestation weeks being provided. Patient suffered miscarriage and discharged, however retained products resulted in sepsis. Swabs from earlier attendances to ED not reviewed, patient diagnosed with Strep A.	Assurance offered that management of bleeding was within guidelines. Discrepancy in scanning due to position of baby and recognition that this could have been explained more clearly. No signs of any infection prior to discharge and as soon as swab results received, doctor made contact to discuss need for antibiotics.	Not upheld
Tunbridge Wells Hospital	Clinic and/or Sexual Health Clinic	Midwifery	2018	Concerns raised that adequate pain relief was not available on antenatal unit for needle phobic patient. Question asked as to why induction of labour commenced when maternity and delivery very busy.	Alternatives to injections were offered for pain relief, which were all declined. Piped entonox is not available on antenatal ward. Once patient was in active labour, staff tried to locate some portable entonox but all canisters were in use. Patient was transferred to delivery suite within 20 mins. Apology offered for short period when patient was without entonox. Assurance offered that induction was clinically necessary.	Partially upheld
Tunbridge Wells Hospital	Ward / Unit	Obstetrics	2019	Concerns raised with poor communication during induction of labour and delay in caesarean section. Observations not completed. Confusion over whether baby needed antibiotic or not.	Apologies offered that NICE guidelines for delivery within 72 hours of ruptured membranes was not met due to activity on the unit. Mother should have been given leaflet on risk of infection - discussed with Birth Centre Manager for dissemination to team. Apologies that mother did not have routine observations every 4 hours. Discussed with midwife concerned for learning. Apologies offered that mother left feeling like a nuisance and for comments made by consultant - highlighted with consultant for personal learning. No clinical indication to expedite caesarean section as all clinical indicators were stable. Apologies offered that PROM observations were not handed over to staff to complete - new system since implemented to reduce risk of this. Antibiotics were not required for baby.	Partially upheld

Tunbridge Wells Hospital	Ward / Unit	Midwifery	2018	Concerns raised with the attitude and behaviour of the midwife during this patients labour.	Conflicting accounts of events and support provided by midwife. Assurance offered that concerns have been thoroughly reviewed with the midwife.	Insufficient evidence
Tunbridge Wells Hospital	Outpatients / Day Care	Obstetrics	2020	At 12 week scan patient was advised that as she had had the Harmony test she would not be allowed to have the combined screening. Scan report states patient refused the combined screening test, this is inaccurate. Response provided through PALS is unacceptable as combined screening test measuring PAPP-A were not carried. Concerned low PAPP- A is associated with low birth weight, early birth and miscarriage. Concerned something may have been missed by sonographer that may impact on fetus growth as test not undertaken. Seeking explanation as to why combined screening test was refused.	The Harmony test is currently the most accurate first trimester screening test available and is more sensitive to picking up the risk of chromosomal abnormality than the combined screening test. This is the reason patient was not offered the combined screening test. Nonetheless, when a patient still requests the screening to be done, even after the rationale being given, then this should be done. Apology offered that we stated patient had refused the screening when this was not the case. The reviewed report documents that she declined screening, this does not reflect patients situation, as due to the drop down menu it was not possible to record rationale accurately.	Partially upheld
Tunbridge Wells Hospital	Ward / Unit	Obstetrics	2019	Concerns raised about whether there was a delay in delivery, the confusion around the category of c/section and the communication received and support from staff when baby taken to NICU. Concerns that communication between teams was poor.	Assurance offered that the category of caesarean section was appropriate given the changing picture and condition of the baby. Apology that patient found communication to be lacking, although this is not supported by staff recall. Conflicting information around the support provided for breast feeding which the maternity records indicate was extensive.	Not upheld

Maidstone Hospital	Clinic and/or Sexual Health Clinic	Midwifery	2018	Concerns raised that information within maternity records is incorrect, including DVT risk, BMI and father's ethnicity.	Apology offered, however midwife found it hard to records correct details as patient was not willing to discuss the pregnancy until such time as the harmony test results had been received. It was noted by the midwife the records were not complete and would require reviewing once harmony test results received. Apology offered that BMI subsequently calculated incorrectly - highlighted with doctor involved.	Partially upheld
Tunbridge Wells Hospital	Ward / Unit	Midwifery	2020	Concerns raised that investigation into issues with delivery of baby is contradictory and does not give clear picture of what happened.	Answers and clarification provided to questions about incident report.	Not upheld
Tunbridge Wells Hospital	Ward / Unit	Obstetrics	2020	Concerns raised regarding suturing of episiotomy which as left a flap of skin outside body, lack of information on common side effects with this procedure and poor experience with after care support provided after leaving delivery suite. Concerns also raised over the delay to have corrective procedure for flap of skin as it is not considered an emergency and the possible long term impact this may have on patient.	Assurance offered that repair of episiotomy was adequate and issue arose from granulation tissue which can occur in any wound healing. Documentation supports that verbal consent was obtained for procedure. Apology offered for aspects of poor care on post natal ward and this has been discussed with the team. Assurance offered that the procedure required is not urgent and that patient is a no greater risk of infection.	Not upheld
Tunbridge Wells Hospital	Ward / Unit	Midwifery	2020	Concern raised that delivery suite will not allow outside agency access to collect cord following delivery.	Explanation provided around why this is not possible at this time.	Not upheld

Tunbridge Wells Hospital	Community / GP Surgery	Midwifery	2018	Concerns that weight and height were recorded incorrectly and therefore BMI at booking was incorrectly documented.	Apology and explanation offered regarding weight being recorded incorrectly and therefore the gap and grow chart being incorrect. New chart was generated and only a slight increase in baby's growth, and able to proceed to natural delivery. Faulty scales were replaced. Midwife advised to check that scales are working before use in future. New process implemented so that both midwife and mother check and sign the gap and grow chart when it is created.	Upheld
Tunbridge Wells Hospital	Ward / Unit	Obstetrics	2020	Concerns with visiting policy on post natal and father of baby not allowed to return to post natal having left to collect item mother needed for baby. Concerns that damage was caused to baby during forceps delivery.	Apology offered and explanation that visiting restriction were in place due to COVID-19 and during the beginning of lookdown these changed a number of times and there was a lag in information sharing. Apology for damage caused to baby which is a risk of instrumental delivery which was discussed at time of taking consent.	Not upheld
Tunbridge Wells Hospital	Clinic and/or Sexual Health Clinic	Midwifery	2018	Concerns raised with attitude of midwife when attending antenatal unit. Advised to go home, however after being home for a short while returned to hospital, and delivered baby in back of the car before arriving at hospital. No midwife waiting to meet car when arrived. Feels discharged too soon following delivery.	Concerns discussed at meeting. Recollection of midwives on duty differs from that of complainant. Advice to return home was appropriate. Discharge following delivery was also appropriate.	Not upheld
Tunbridge Wells Hospital	Ward / Unit	Midwifery	2018	Concerns raised with the antenatal care in which a requested epidural was not given until she was close to delivery despite her advising she labours quickly. Felt midwives were unsympathetic and did not listen to her concerns.	Explanation provided that it was not appropriate to administer an epidural until on the delivery suite. Assurance provided that this labour was different to her previous experience in that she did not automatically require an epidural as she had not had syntocinon to induce her labour. Assurance offered that midwives were listening to her concerns and made arrangements for her to receive the epidural as soon as she was transferred to the delivery suite.	Not upheld

Maidstone Hospital	Patient or Employee's Home	Midwifery	2019	Concerns raised the jaundice was not acted upon soon enough which has resulted in long term effects for the baby.	Investigation concluded that baby should have been referred for blood testing and apology offered that this action was not taken. Discussed with staff member for learning and consideration being given to community bilirubinometers.	Upheld
Tunbridge Wells Hospital	Outpatients / Day Care	Obstetrics	2020	Concerns raised with the attitude of the sonographer during 20 week scan appointment.	Apology offered. Assurance given that this was not intentional, scan was difficult to position of baby and raised BMI of mother.	Not upheld
Tunbridge Wells Hospital	Anaesthetics / Endoscopy / Theatres / Recovery	Midwifery	2018	Concerns raised that did not pass urine for 2 days following c.section and had to be returned to theatre for complications following c.section. Feels the doctor performing the surgery made a mistake. No aftercare given for catheter. No apology offered from the obstetrician.	Apology offered that complication with surgery was not picked up sooner and that catheter was removed too soon which delayed diagnosis. A bladder management plan should have been implemented following the c-section - discussed with staff for learning. Consultant was not aware of the complication due to rotation of consultant of the day/week and hence this is why he did not apologise at the time.	Upheld
Tunbridge Wells Hospital	Ward / Unit	Midwifery	2020	Concerns raised with regards to post natal care received.	Delivery care was of a good standard but there were gaps in post natal care. Ward staff have reminded of the need to regularly check on all women and ensure that they are aware that they can summon help using the buzzer and that women are aware that they can request analgesia outside of medication round times.	Partially upheld
Maidstone Hospital	Clinic and/or Sexual Health Clinic	Midwifery	2018	Concerns raised that this was not picked up at TWH before transfer or following delivery. Baby transferred to Evelina where tests showed high blood pressure, enlarged liver and larger right kidney.	Assurance offered that all relevant screening was undertaken and that no abnormalities were identified during routine scanning.	Not upheld

Tunbridge Wells Hospital	Outpatients / Day Care	Obstetrics	2020	Concern raised that those waiting were not advised of delays in clinic. Concern that blood tests were misplaced and referral to another department not made. Concern that appointments have not been booked in line with patients request.	Apology that those waiting were not updated to delays as this should happen. Apology that blood tests misplaced, this is very unusual and cannot ascertain why this happened. On review of records no indication as to why a referral to gastroenterology is required. Apology that reception staff could not book appointments in clinic and assurance offered that we try to book scans and outpatient clinic appointments on the same day, however this is not always possible and more so now amid the COVID-19 outbreak.	Partially upheld
Community	Community / GP Surgery	Midwifery	2018	Concerns raised that pre-eclampsia was not picked up during labour, resulting in patient having to undergo emergency c.section at another hospital. HELLP syndrome also diagnosed.	Assurance offered that during antenatal period there was no clinical evidence to support pre-eclampsia.	Not upheld
Tunbridge Wells Hospital	Ward / Unit	Midwifery	2019	Concerns raised with the attitude of one midwife on the post natal unit. Concerns raised that documentation was not completed appropriately which caused a delay to discharge. Compliments also provided to the neonatal team and delivery team.	Apology offered that comments came across in a negative way. Apology offered that expectations were not set realistically and for notes being made on scraps of paper as this is not acceptable. Action that staff have been reminded of the expected documentation standards.	Partially upheld
Tunbridge Wells Hospital	Outpatients / Day Care	Obstetrics	2020	Concerns raised with handling of pregnancy in particularly to decision to have planned C section.	Investigation findings show appropriate information was provided and doctor acted in a professional manner. It is the doctor's responsibility to inform women of the potential risks, and act in their best interests. Patient was advised that a caesarean is best planned when there is a medical indication to do so. Booking a caesarean without medical indication places a woman at unnecessary risk of possible long term implications of surgery.	Not upheld

Tunbridge Wells Hospital	Ward / Unit	Midwifery	2021	Concerns raised with care provided on postnatal unit. Patient went several days without regular blood pressure medication and did not received regular pain medication following c.section. Poor communication about condition of baby and blood sugars not checked regularly. Incorrect information given regarding iron tablets.	Apology that blood pressure medication was not given for several days and this has been discussed with the postnatal team for learning. A reminder about the care plan for blood pressure medication following delivery will also be included in the weekly maternity newsletter. Apology offered that pain was not managed effectively however drug chart shows that regular pain medications being given. Apology offered that blood sugars were not recorded appropriately. Apology offered that iron tablets were offered erroneously. As learning, the concerns will be discussed anonymously, with the postnatal team and spot checks will be undertaken on documentation to ensure that diabetic charts are being completed (if required), that observations are being undertaken within guidance, and that any self-medication is documented on drug charts.	Partially upheld
Tunbridge Wells Hospital	Outpatients / Day Care	Obstetrics	2018	Concerns raised about a breach of confidentiality.	There was a breach of confidentiality. The preference for communication to mothers is now recorded on E3 and the messages left on answerphones are very generic to minimise the risk of further breaches of confidentiality.	Upheld
Tunbridge Wells Hospital	Ward / Unit	Obstetrics	2018	Concerns raised that dalteparin was not stopped sooner, which increased risk of haemorrhaging. Incorrect information provided to husband about blood loss during c.section. Concerns that babies were not feeding well following delivery, and that staff did not listen to concerns raised by parents.	Explanation provided regarding anticoagulation which was appropriately stopped at the optimum time. Apology offered that blood loss was calculated incorrectly however this was amended at the time and the correct loss advised to the patient and her husband. No evidence to support babies were not feeding well during first days, as they were behaving appropriately and producing wet and soiled nappies. Assurance offered that staff were listening and providing explanations.	Not upheld

Tunbridge Wells Hospital	Ward / Unit	Midwifery	2019	Patient wishes to raise concerns about the care and attitude of a midwife who was with her in the delivery suite. Concern raised that patient confidentiality was breached when contacting maternity triage.	Apologies offered that pain relief preferences were not met. Records suggest that patient requested epidural which was sited. Acknowledgement that records do not support patient's recollections of events. No evidence that confidentiality was breached - patient's own records were accessed on both occasions.	Not upheld
Maidstone Hospital	Clinic and/or Sexual Health Clinic	Obstetrics	2018	Concern raised with antenatal care received, and concerns about labour not being considered given previous miscarriages. Concerns with errors in letter follow debrief meeting.	Explained there was not clinical indication for induction of labour or caesarean section during pregnancy. Apology offered for error in scan letter, and assurance offer that measures have been put in place to minimise this risk in future.	Not upheld
Tunbridge Wells Hospital	Ward / Unit	Midwifery	2020	Concerns raised over breach of patient data and confidentiality.	Printed documents relating to another patient found in complainants records. Other patient advised of breach and apology provided. Response provided outlines steps taken to prevent reoccurrence. Apology provided to complainant for the distress caused.	Upheld
Tunbridge Wells Hospital	Outpatients / Day Care	Midwifery	2019	Concerns raised that gestational diabetes was not diagnosed during pregnancy results in c.section and severe pre-eclampsia. Concern that not advised of ragged membranes and went on to suffer postpartum haemorrhage.	Assurance offered that signs of gestational diabetes were not present during antenatal phase. Explanation provided that maternity records indicate that woman was advised of the ragged membranes and the risks associated with this.	Not upheld
Tunbridge Wells Hospital	Ward / Unit	Obstetrics	2019	Concerns with cleanliness of antenatal; unit, delivery suite and postnatal unit. Report of mould in bathroom on post natal ward. Report that standard of food was not acceptable and had to eat in the cafe. Concern that catering staff were rude on the ward.	Apology offered and assurance that audit scores for cleanliness are monitored. Issues have been identified with domestic staff and these are being resolved. Apology that catering staff were rude and this has been addressed and assurance that food offered is reasonable.	Partially upheld

Tunbridge Wells Hospital	Ward / Unit	Obstetrics	2020	Concern raised that following delivery, first degree tear was sutured, however secondary laceration was not, which is causing difficulties.	No evidence of tear in the maternity notes but vaginal laceration was sutured. Explanation provided that some women require further intervention following suturing once swelling has settled.	Not upheld
Tunbridge Wells Hospital	Emergency Department (ED)	Obstetrics	2019	Concerns raised with the pathway for reviewing patients with PV bleeding whilst pregnant and poor communication between teams.	Apology offered that correct pathway was not followed and this has been address with staff on EGAU.	Upheld
Tunbridge Wells Hospital	Ward / Unit	Midwifery	2019	Concern raised that sutures following delivery were done without anaesthetic. Baby did not have health check before discharge.	Assurance offered that anaesthetic was administered for stiches. Apology that baby did not have health check before discharge and explanation that these are sometime undertaken in the community.	Not upheld

Maidstone Hospital	Ward / Unit	Midwifery	2020	Concerns raised in respect of being eligible to give birth at the birthing centre. Patient has been waiting for confirmation of this and despite chasing repeatedly the service was advised there was no consultation booked and no record of assessment. Patient feels the birthing centre is disorganised and not friendly or good at communicating.	Patient received poor standard of communication, as a result patient's suitability to use the birth centre was not assessed and she missed out on the opportunity to use this facility. Following learning has been introduced: - A system to ensure that referrals are checked by the team daily and followed up to ensure they have been completed. - The need to ensure that more junior staff who are less familiar with working at the birth centre are fully supported. - All birth centre staff have been made aware of the centre email address. An aide memoire to has been added the office telephone with the email address clearly identified. -The team has been reminded of their professional responsibility to ensure that all messages and calls from women are documented on their electronic healthcare records. -All team members will use the generic email for referrals and the senior midwife on duty each shift will be responsible for checking the inbox and electronic calendar to ensure that referrals are followed up. Additionally, all referrals regarding women's suitability must now be copied to the ward manager, to facilitate timely discussion with consultant as part of the multi-disciplinary team.	Upheld
Tunbridge Wells Hospital	Anaesthetics / Endoscopy / Theatres / Recovery	Midwifery	2018	Patient would like to know why dissolvable stitches were used to close her c-section wound when she had previously expressed a preference for them not to be used.	Apology offered, despite this being discussed it was missed and incorrect sutures used. Discussions have taken place to ensure that any changes to normal practice are documented on the theatre board.	Upheld

Tunbridge Wells Hospital	Ward / Unit	Midwifery	2020	Pt had an awful experience, following attendance, initially for bleeding, but then delivery of her baby. She suffered a lot of pain and lack of understanding that she was further along in her labour than staff expected. Pt had wanted an epidural, due to the level of pain she was encountering, but when she was finally examined, she was fully dilated and could not have any further pain relief, other than gas and air.		Still under investigation
Tunbridge Wells Hospital	Ward / Unit	Midwifery	2019	Concerns raised that incorrect advice was given by midwifes by phone which resulted in the patient delivered her baby on the pavement outside her house. Lack of information regarding circumstance of birth in maternity notes.	Explanation that patient experienced a precipitous labour which would have been frightening, but was unpredictable. Advice given on first call to stay at home was clinically correct. Apologies that on second call, midwife left couple with the impression it was their choice whether to come in or not - discussed with team for learning. Information provided during call did not indicate that woman was about to deliver baby. Assurance offered that location of birth is documented in records.	Not upheld
Tunbridge Wells Hospital	Ward / Unit	Obstetrics	2019	Concerns raised with after care received following birth of twins. No assistance, advice or support provided, delays with pain relief and no treatment despite being advised iron levels were low. Discharged despite one twin losing weight.	Assurances provided that aftercare received was appropriate, however apology offered. Assistance was provided and there is no evidence to support that pain medications were not administered. Treatment for low iron levels was administered. Assurance offered that babies lost weight initially following birth and the discharge was reasonable.	Not upheld
Tunbridge Wells Hospital	Ward / Unit	Midwifery	2019	Concerns raised that not listened to during labour and pain relief ineffective. Did not feel listened too when requesting caesarean section. Poor communication.	Apology offered however healthcare records indicate discussion with mother regarding care. No evidence to support c.section requested.	Not upheld

Tunbridge Wells Hospital	Clinic and/or Sexual Health Clinic	Midwifery	2018	Numerous concerns raised about treatment for PE's during pregnancy, lack of communication and understanding, Poor standard of care post-natally, attitude and manner of paediatric doctor and poor clinical advice with regards to the baby.	Apology and assurance offered that treatment for PE's was appropriate, with treatment plan being communicated. Assurance offered that correct clinical advise was provided and apology for way doctors manner perceived.	Not upheld
Maidstone Hospital	Outpatients / Day Care	Obstetrics	2020	Concerns about your antenatal consultation and about the contents recorded in health care records.	Apology given for the inaccurate record keeping and assurance that this will be amended once maternity notes are available.	Upheld
Tunbridge Wells Hospital	Outpatients / Day Care	Obstetrics	2019	Concerns raised about the manner of the doctor who reviewed this patient in antenatal clinic and the advice provided during the appointment.	Apology offered, doctor has now left the Trust so unable to address concerns directly.	Not upheld
Tunbridge Wells Hospital	Ward / Unit	Midwifery	2018	Concerns raised that baby born in a poor condition and that investigation into events has not accounted for the reason why. Parents would like to know why the baby was born in a poor condition.	Explanation provided that there is no evidence to support that alternative action would have resulted in a different outcome for the baby. Sadly, there is no explanation as to why the baby was born in poor condition.	Not upheld
Tunbridge Wells Hospital	Ward / Unit	Midwifery	2018	Concerns raised that requests for pain relief during labour were not met and that staff were unfriendly and rude.	Explanation provided that pain management during labour was sufficient, however labour progressed extremely quickly and therefore epidural was not appropriate. Apology for behaviour of staff.,	Not upheld
Tunbridge Wells Hospital	Ward / Unit	Midwifery	2018	Concerns raised about the lack of care provided by the midwife on the delivery suite, poor communication and lack of aftercare following delivery.	Explanation provided that care during labour was appropriate and in line with guidelines. No evidence to support that there was a lack of aftercare following delivery.	Not upheld
Tunbridge Wells Hospital	Ward / Unit	Obstetrics	2019	Concerns raised that mother was sent home from maternity triage, despite being 3 cms dilated and contracting. Baby born in the car on way back to hospital. Mother asked to spend the night on the post-natal unit, but was refused.	Explanation provided that when attended maternity triage, woman was not experiencing contractions and was not in labour and therefore decision to not admit was reasonable. No clinical reason for mother to remain on the post natal unit.	Not upheld

Tunbridge Wells Hospital	Ward / Unit	Obstetrics	2020	Concerns raised that c.section commenced despite patient being able to feel pressure and cold spray on right hand side. Question asked as to why baby was born desaturated.	Expatiation provided as to how numbness was monitored. Several delays to commencement of procedure as patient advised that she could still feel the spray. Procedure only commenced when no cold sensation reported. Assurance offered that it is widely documented that a general anesthetic can depress the respiratory efforts in newborn babies and that this is short-lived.	Not upheld
Tunbridge Wells Hospital	Ward / Unit	Midwifery	2018	Concerns raised with the advice provided in EGAU with regards to anti-D injections, which was subsequently contradicted, causing distress and confusion to the patient.	Apology offered that advice provided was not to the required standard and this has been discussed with the team.	Upheld
Tunbridge Wells Hospital	Ward / Unit	Midwifery	2018	Concerns raised that mother and baby discharged too soon as concerns had been raised that baby not feeding well. Concerned that baby only feeding every 6 hours, which staff advised was all right. Quality of food and why number of calories is not included for patient and visitor information.	Assurance offered that baby was being monitored and feeding adequately before discharge. Explanation provide around food and explained that calorific value currently under consideration within the directorate.	Not upheld
Tunbridge Wells Hospital	Ward / Unit	Midwifery	2018	Concerns raised that delivery method caused damage to baby. Mother not aware of instrumental delivery and was due for planned c-section. Mother was not adequately monitored during labour resulting in instrumental delivery as fully dilated when taken to theatre.	Apology offered that delivery method caused damage to baby with is a rare but recognised complication of instrumental delivery. Mother was counselled on instrumental delivery. Mother was adequately monitored during labour.	Not upheld
Tunbridge Wells Hospital	Ward / Unit	Midwifery	2019	Concerns raised that emergency buzzer was not activated in a timely way and communication poor. Concern that patient has been left with a catheter following a forceps delivery.	Assurance offered the timeframe for emergency buzzer and treatment was appropriate. Apology that communication could have been better and it is recognised that communication can slip when an emergency situation arises. Long term catheterisation following a forceps delivery is rare.	Not upheld

Tunbridge Wells Hospital	Ward / Unit	Obstetrics	2020	Concern that delay in baby being born following waters breaking caused baby to be born with pneumonia. Concern that baby sustained damage to nerves in arm/shoulder when on SCBU when gaining cannula access.		Still under investigation
Tunbridge Wells Hospital	Outpatients / Day Care	Obstetrics	2019	Complaint regarding the standard of care received during antenatal period	Assurance offered that no reason to suspect any anomalies from scan or nuchal measurement. Raised maternal BMI made imaging difficult. When recognised that baby was small for gestation, appropriate measure taken.	Not upheld
Tunbridge Wells Hospital	Ward / Unit	Midwifery	2020	Concerns raised that there was a delay in maternity triage in reviewing this patient. Pain relief was not adequate. Delivery felt rushed and patient felt unsupported.	Assurance offered that our records indicate that there was not a long delay when attending maternity triage, however, department was busy and women prioritised due to clinical need. No evidence to support that additional pain relief was requested. Apology for feeling rushed and unsupported as records indicate one to one support provided.	Not upheld
Tunbridge Wells Hospital	Outpatients / Day Care	Obstetrics	2020	Concern raised that despite being advised consideration would be given to caesarean section due to large size of baby, this was delayed. Concerns that investigations not undertaken into significant weight gain during labour and discharged with swollen legs.		Still under investigation
Tunbridge Wells Hospital	Ward / Unit	Midwifery	2019	Concerns raised that scan findings were not shared with patient, namely that no fetal heartbeat was found. No follow up scan was arranged and despite numerous attempts to be reviewed on EGAU kept being advised to wait for 12 week scan. Attitude of doctor who reviewed patient who disputed the dates provided and changed these on the scan report. Patient not provided with blood clotting injection despite requesting these.		Still under investigation

Tunbridge Wells Hospital	Anaesthetics / Endoscopy / Theatres / Recovery	Midwifery	2020	Concerns that baby sustained laceration to head and cephalhematoma during delivery. Concerns with comment made by surgeon.	Apology offered that baby suffered cephalhematoma during delivery. Investigation advises that it is not possible to advise whether this was caused by forceps used during delivery as very little traction was used. Apology that we cannot clarify this point. Investigation advises that surgeon does not recall making the comment mentioned and that this would not be something they would say.	Not upheld
Tunbridge Wells Hospital	Ward / Unit	Obstetrics	2019	Concern raised that several comments in maternity notes are incorrect and skin to skin was not achieved as gown was placed over kangaroo wrap.	Apology offered that information was not correctly entered into maternity notes and that skin to skin contact was not achieved. This has been raised with the midwife involved for her learning.	Upheld
Tunbridge Wells Hospital	Outpatients / Day Care	Obstetrics	2020	Concerns raised with regards to breach of patient confidentiality, difficulties in taking blood, attitude of staff and images identifying gender of baby recorded on mobile phone when this was not wanted.	Investigation confirms information governance breach. The other patient involved has been contacted and informed of the information governance breach, full disclosure of the nature of the information that had been shared in error has been provided and an apology has been offered. Apology offered for poor communication experienced.	Partially upheld
Tunbridge Wells Hospital	Ward / Unit	Obstetrics	2018	When attending maternity triage, sweep undertaken without consent being obtained and was not required as patient was not overdue. Patient suffered a largish bleed as a result and patient was sent home.	No evidence to support that sweep was undertaken during internal examination.	Not upheld
Crowborough Birth Centre	Ward / Unit	Midwifery	2020	Internal investigation and HSIB investigation already undertaken. Concerns raised that, despite assurance given that patient would be transferred to TWH if there were any signs of difficulties during labour, the transfer did not occur soon enough. Patient says she was displaying signs of there being a problem (cold and shivering) but little action was taken.	Explanation provided that there was no evidence to support patient was cold and shivering, all observations were within normal limits, although paracetamol given which may have masked signs of a temperature. The correct procedure has been reiterated to staff. Emergency drills taking place to ensure all staff are aware of correct procedures.	Not upheld

Tunbridge Wells Hospital	Ward / Unit	Midwifery	2021	Concerns raised that during an internal examination a sweep was undertaken without patient consent. Concern raised that woman felt pressurized into agreeing to internal examination.Compliments to both delivery suite and postnatal unit staff.		Still under investigation
Maidstone Hospital	Ward / Unit	Midwifery	2020	Concerns raised with standard of care received from Maidstone Birth Centre, including incorrect advice, informed consent not given for episiotomy, lack of support with breastfeeding.	Assurance offered that correct advice was provided when contacting the Maidstone Birth Centre. Evidence supports that consent was provided for episiotomy. Apology for lack of support for breastfeeding, notes confirm support provided when requested. Areas of learning have been identified and the midwife has undertaken a reflective exercise. Appropriate feedback to staff has been taken forward.	Not upheld
Tunbridge Wells Hospital	Ward / Unit	Obstetrics	2019	Concerns raised the doctor did not wear gloves during internal examination, poor communication between teams and with patient, who then got an infection which she believes was poorly managed and was as a result of doctor not wearing gloves.	Assurance offered that investigation and statements support that doctor was wearing gloves during examination. Statements support that mother and partner were kept updated during labour and delivery. Explanation provided that infection was discussed as part of consenting process and that it is quite common, and not as a result of the doctor not wearing gloves.	Not upheld
Tunbridge Wells Hospital	Ward / Unit	Midwifery	2018	Concerns raised that left for long period without pain relief or review and then had to have an assisted delivery as too tired to delivery baby.	Apology offered as the unit was exceptionally busy that day, however timeframe indicated was not unreasonable.	Not upheld
Tunbridge Wells Hospital	Ward / Unit	Midwifery	2021	Concerns raised with postnatal care received including long waits for medications, blood pressure monitoring not taking place as indicated and having to chase anticoagulation treatment and rationale for iron tablets. On return for blood pressure monitoring, patient had to transfer to TWH and was separated from their newborn baby for a period of time which she advises has caused her psychological damage.		Still under investigation

Tunbridge Wells Hospital	Outpatients / Day Care	Obstetrics	2019	Concerns raised with the information provided on an ultrasound report which contained the incorrect date of birth and address. When the patient contacted the department to advise of the errors the report was changed to reflect the correct name, however other information had changed.	Apology offered for errors on report. Operator searched for patient using name only and selected the wrong person. Reminder issued to staff around use of unique identifiers. In reissuing report, the operator mistakenly clicked on a drop down box and made an incorrect selection. Report since reissued.	Upheld
Tunbridge Wells Hospital	Ward / Unit	Midwifery	2019	Concern that coccyx was fractured during delivery of baby. Concern that repair after ventouse delivery caused some tightness which required surgical repair.	Apology for damage to coccyx which is a rare complication of vaginal delivery. Assurance offered the suturing was appropriate and tightness was caused by scar tissue, which did require surgical intervention.	Not upheld
Tunbridge Wells Hospital	Ward / Unit	Obstetrics	2020	Concerns raised regarding maternity care. Patient seeking compensation.	Assurance offered that maternity care was appropriate and within Trust and NICE guidelines.	Not upheld
Tunbridge Wells Hospital	Outpatients / Day Care	Obstetrics	2021	Concern raised that partner will not be permitted to attend 12 week antenatal scan.	Apology offered that partner cannot attend due to risk assessment, need for social distancing and in order to keep our staff safe. Actions in place to begin to allow partners to attend antenatal appts and 20 week scanning by way of home covid testing.	Not upheld
Tunbridge Wells Hospital	Ward / Unit	Midwifery	2020	Anticoagulants were not prescribed following a caesarean section which has resulted in the woman developing large blood clots in her left leg.	Assurance offered the correct risk assessment was undertaken and that anticoagulants were not required.	Not upheld
Tunbridge Wells Hospital	Ward / Unit	Midwifery	2019	Concerns raised with the manner of the consultant who reviewed this woman when she was admitted for elective c.section. Concerns with care provided on post natal ward and that discharge was too soon following delivery. Concerns with advice given regarding feeding.	Apology for manner of doctor, who was a locum, and no longer works for the Trust. Evidence supports that care provided on post natal unit was reasonable and discharge was appropriate. Assurance offered that all midwives follow the same guidelines since May 2019 on introduction of Unicef baby friendly guidelines.	Partially upheld

Tunbridge Wells Hospital	Ward / Unit	Midwifery	2018	Concerns raised that only consent was given for epidural and not for forceps or ventouse delivery method, or episiotomy. Episiotomy wound became infected and long delay with being reviewed by doctor. Caesarean section required to delivery the baby.	Investigation and evidence suggests that consent was obtained for assisted delivery and episiotomy. Apologies that wound became infected - this is risk despite appropriate sterile techniques being used. Caesarean section was required when assisted delivery was unsuccessful.	Not upheld
Tunbridge Wells Hospital	Ward / Unit	Midwifery	2021	Concerns raised with attitude of staff during delivery, lack of equipment on post natal. Delay in being seen in maternity triage when passing blood clots which resulted in retained placenta which required surgery. Concern with perineal wound not healing.		Still under investigation
Maidstone Hospital	Outpatients / Day Care	Midwifery	2019	Concern raised that blood results were not acted upon therefore incorrect advice was given to patient. Concern that advice given when contacting maternity triage was not appropriate given the circumstances.	Apologies offered that PAPP A test result not shared until 20 weeks scan - however, this was because no action was needed until that point. Acknowledgement of how difficult it was to retain lots of information. Apologies for lack of care shown when patient called triage in labour. Patient was misinformed by staff member. Unfortunately, due to absence of record keeping, it's not clear who this was.	Upheld
Tunbridge Wells Hospital	Ward / Unit	Obstetrics	2019	Concerns raised that delays during labour caused baby to be born in a poor condition, requiring cooling, which mother feels was not commenced in a timely way.	Assurance offered that there were no delays during labour and that there was no clinical indication to undertake and earlier caesarean section. Assurance offered that baby received cooling within guidelines.	Not upheld
Tunbridge Wells Hospital	Ward / Unit	Midwifery	2020	Concerns raised that tongue tie was not identified and when it was, the appropriate referral was not made.	Apology that computer error occurred during referral process resulting in tongue tie team not receiving the referral. As soon as this was identified, further referral made, however this coincided with COVID-19 lockdown and therefore procedure could not be booked. The computer error is resolved.	Upheld

Tunbridge Wells Hospital	Ward / Unit	Midwifery	2020	Concerns raised with the care provided from one midwife, the manner of the anaesthetist in theatre, and that mother's wishes were not respected in terms of cutting cord and breastfeeding. Conflicting information provided on postnatal unit and visit times on neonatal not adhered to.	Apology for care provided, however investigation supports that care was adequate. Apology that wishes were not adhered to, and explanation this was due to an emergency situation and therefore communication lacking. Assurance that this has been discussed with the midwifery team. Assurance offered that information provided was adequate and apology that this was found to be conflicting. Visiting times on neonatal were adhered to.	Not upheld
Tunbridge Wells Hospital	Ward / Unit	Midwifery	2018	Concerns raised that delay between waters breaking to delivery of the baby caused an infection in both mother and baby. Concerns with the way in which consent/agreement to legal waiver was obtained whilst mother was in pain and distress.	Explanation of management of labour provided. Time between rupture of membranes and delivery did not exceed guidelines. Explanation around requirement to take informed consent from patient prior to intervention.	Not upheld
Tunbridge Wells Hospital	Ward / Unit	Midwifery	2018	Concerns raised following SI investigation with content of report. Feels that had a caesarean section been performed sooner, baby would have survived.	Recognition provided that an earlier appointment could have resulted in a different outcome, although we cannot know with certainty. Apology offered. Patient was offered next available date for caesarean, but there was a delay in booking the consultant appointment.	Partially upheld
Tunbridge Wells Hospital	Ward / Unit	Midwifery	2020	Numerous concerns raised with birth experience, including being transferred to hospital prematurely, suffering nerve damage to foot following intervention, and baby requiring resus. Several suggestions made as to how the experience could have been better.		Still under investigation

Tunbridge Wells Hospital	Ward / Unit	Midwifery	2021	Concerns raised with care post delivery. Lack of attention following birth including not changing pad, being left for long period, cot not available until some time later, baby checks not done and told to go to Maidstone Birth Centre for tests, however, when arrived, nobody was expecting them. Another patients notes found in this patients notes.	Apology offered for the care provided postnatally. Team have been reminded to ensure new parents are clear on the support provided post delivery on the delivery suite,that any soiled sheets and pads should be checked and changed and that cots are replaced if removed from the delivery room. Assurance that begin asked to attend Maidstone Birth Centre for new born check is reasonable given the specialist nature of this check and apology that nobody was expecting them however it is recorded that the midwife did call and advise of their attendance. Apology that another patients notes were misfiled. This is under investigation and patient will be contacted with the outcome.	Partially upheld
Community	Community / GP Surgery	Midwifery	2019	Concerns that growth chart was incorrectly completed, had this been plotted correctly this may have indicated problem sooner. No heartbeat identified on scan at 35 weeks and baby stillborn.	Apology provided that on one occasion the growth chart was not completed. As the baby was not below the 10th centile at birth, it is extremely unlikely that there would have been any interventions to deliver the baby early, preventing a stillbirth. Actions identified new training for Gap and Grow is being rolled out. Fetal Wellbeing midwife is due to start in April. Community Team Leads to be trained and be Champions for Gap and Grow. Each community midwife has been issued with a set square to aid accurate plotting.	Not upheld
Tunbridge Wells Hospital	Ward / Unit	Midwifery	2019	Multiple concerns raised of the management of this woman when she attended for induction and caesarean section, including poor communication, continuity of care, manner of doctor and some midwives.	Assurance offered that induction was conducted at the appropriate stage and caesarean section was as a result of lack of progress in labour. Investigation supports that communication was appropriate. The concerns raised about the manner of the doctor and some midwives has not been supported by the investigation.	Not upheld

Tunbridge Wells Hospital	Ward / Unit	Midwifery	2020	Concerns raised with decisions made during labour, staff not listening, and lack of checks to see if waters broken and dilatation.		Still under investigation
Tunbridge Wells Hospital	Outpatients / Day Care	Midwifery	2019	Concerns raised about upsetting comments made during the 20 week scan.	Apology offered for upsetting comments and explanation provided that sonographer would need to advise patients if there were any issues with obtaining scan imaging such as raised BMI, as in this case. Concerns have been discussed with sonographer for learning.	Partially upheld
Tunbridge Wells Hospital	Ward / Unit	Obstetrics	2020	Concerns raised that care during labour was not adequate. Concern that patient reacted to epidural and spinal block resulting in CPR. Concern that post natal care was below expectations. Clarity sought around diagnosis of baby.		Still under investigation
Tunbridge Wells Hospital	Ward / Unit	Obstetrics	2020	Concerns raised in respect of postnatal care received resulting in poor patient experience. Complainant advises that patient did not receive timely pain relief, patient was left isolated in side room, not checked upon and needs were not considered by staff. Complainant alleges staff had poor attitude and were insensitive in their interaction with patient.	Apology offered that pain relief was, on occasion, late as patient was not on the ward at the time. Explanation provided that patient administered pain relief is being implemented to help new parents administer their own pain medications when visiting baby's on the neonatal unit. Investigation supports that patient was checked frequently, however, apology offered that new parents did not feel supported.	Partially upheld
Tunbridge Wells Hospital	Ward / Unit	Obstetrics	2019	Concerns about a delay in prescribing antibiotics. Patient found staff to be rude and dismissive. When patient was referred to EGAU by GP, EGAU refused to see her and patient had to go to ED. Gynaecologist on that occasion was very rude. Patient discharged with antibiotics at the wrong dose and only 2 days supply. When patient attended to get further supplies, none were available.	Assurance offered that antibiotics were prescribed when there was a clinical need to do so. Apology for being sent to ED as this is no the correct pathway and this has been discussed with the staff member. Apology for manner of gynae doctor. Explanation that antibiotics prescribed are controlled antibiotics and therefore only small amount available out of pharmacy hours.	Not upheld

Tunbridge Wells Hospital	Ward / Unit	Midwifery	2020	Concerns raised that management of urinary retention was not appropriate.	Investigation findings show that the guidelines for MTW and Kings for urinary retention management differ explaining the different approaches taken by the two Trusts. Management of trial without catheter and care provided was appropriate. Apology provided if patient has not been informed that she could bring her baby with her for breastfeeding.	Not upheld
Tunbridge Wells Hospital	Ward / Unit	Midwifery	2020	Concerns raised with management of pregnancy and labour, that labour was not diagnosed soon enough despite calls to the birth centre, that midwife washed hands with gloves on between tasks, the mother not fully informed of events during c.section and that polymorphic eruption of pregnancy was not diagnosed soon enough.	Assurance offered that information provided by maternity triage and Maidstone Birth Centre was appropriate given presenting symptoms. Assurance that monitoring took pace at the correct time. Assurance that midwives would and do not wash gloves between use. Review of notes reveals no mention of a rash in antenatal period, but mentioned during postnatal and advice provided.	Not upheld
Tunbridge Wells Hospital	Ward / Unit	Obstetrics	2020	Concerns raised that father of baby was not permitted to leave the post natal ward and return. He says this is in contradiction to the signage on the ward and that on the Internet site.	Apology offered and explanation that this was a difficult time with changes being made frequently prior to hospital lockdown.	Upheld
Community	Community / GP Surgery	Midwifery	2021	Concern raised with care being provided by community midwife. scan not being booked, appointments not as scheduled, information not recorded accurately, lack of extra growth scans as recommended with IVF.	Our investigation has shown that the scan was actually booked and the letter auto generated and sent to the mother. Growth scans were in line with guidance. There was an inaccuracy recorded in the mother's records due to human error and has been corrected. The midwife who made this clerical error is aware of her mistake and will ensure she takes care in future.	Partially upheld

Tunbridge Wells Hospital	Ward / Unit	Midwifery	2018	Concerns raised about treatment during labour and delivery and attitude and manner of a couple of midwives. Feels c.section should have been performed sooner and unclear whether there was an infection present.	Explanation provided that c.section was not indicated any sooner due to the fetal weight of the baby. Assurance offered the monitoring was adequate during labour and within recommended guidelines. No evidence can be found to support that the placenta had an infection following delivery, however intravenous fluids and antibiotics were given as temperature rose. Apology offered for manner of midwives.	Not upheld
Tunbridge Wells Hospital	Ward / Unit	Midwifery	2018	Concerns raised with the level of maternity care received following delivery and also in the community. No arrival times provided by community midwives.	Investigation concludes that level of care received on post-natal unit was reasonable. Explanation provided that arrival times are not given in community due to workloads and commitments. Apology offered for the distress this caused.	Not upheld
Tunbridge Wells Hospital	Ward / Unit	Midwifery	2018	Concerns that due to multiple attempts for instrumental delivery, patient sustained damage to vaginal wall. She has been advised that she was stitched incorrectly following the procedure and that she sustained a 4th degree tear.	Apology offered for damage caused during delivery however this is a recognised risk. Explanation provided that she sustained a 2nd degree tear.	Not upheld
Tunbridge Wells Hospital	Anaesthetics / Endoscopy / Theatres / Recovery	Obstetrics	2020	Concern raised with emergency c.section resulting in in situ catheter. TWOC unsuccessful and now under urology team. Concerns raised with process of TWOC which caused significant pain, that prescription for antibiotics was delayed, manner of staff members of maternity triage.		Still under investigation

Tunbridge Wells Hospital	Ward / Unit	Obstetrics	2019	Concerns raised the MTW website contains incorrect information. When patient phoned EGAU to attend due to bleeding in early pregnancy she was advised that she would need GP referral when website informs that in cases with recurrent miscarriage, patient can attend directly. Also website indicates this early pregnancy service at both hospital sites, when only available at TWH.	Apology offered that NHS website contained incorrect information and this has been addressed.	Upheld
Tunbridge Wells Hospital	Ward / Unit	Midwifery	2019	Concerns raised with treatment received on postnatal ward, delays in receiving medications and attitude of some staff members.	Apology offered for poor experience. Assurance offered that antenatal room was appropriate, cleaned in between each use and for sole patient use.Apology that there were occasions when medications not given due to patient being away from the ward. Assurance offered that directorate are working on patient administered pain medications for when women leave the ward to visit their baby on neonatal. Apology that it was not clear that parents complete red child healthcare record and this will be discussed with new parents at the point of issuing the book.	Partially upheld
Tunbridge Wells Hospital	Ward / Unit	Obstetrics	2021	Concerns raised that despite women asking not to be cut again, doctor continued with episiotomy. Concerns about behaviour of doctor and management of swabs during haemorrhage.		Still under investigation
Tunbridge Wells Hospital	Emergency Department (ED)	Midwifery	2018	Concerns raised that emergency scan was not available for patient who attended the ED with bleeding in early pregnancy. Advised to contact the emergency gynae unit the following day to arrange a scan, however gynae unit were unaware that the patient would call and no scan was available. Nobody contact the patient following the medical management despite advising that a phone call would be made.	Scan was booked for 5 days following ED attendance. Dr attempted to scan whilst in the ED, but images were unclear. Apology offered that patient was advised somebody would contact her as this is not correct and EGAU staff have been reminded of the need for accurate communication.	Partially upheld

Maidstone Hospital	Outpatients / Day Care	Midwifery	2020	Concerns raised with communication during antenatal appointment was inappropriate, that opinions were not considered or listened to by the doctor and that self discharge form was signed under duress.	Assurance offered that advice provided was appropriate and essential in drawing attention tot he risk of continuing with pregnancy over 42 weeks' gestation. Evidence does not support that self discharge was signed under duress.	Not upheld
Tunbridge Wells Hospital	Clinic and/or Sexual Health Clinic	Midwifery	2018	Concerns raised that conflicting information given regarding timing of induction. Advised would not go over 41 weeks , however then advised would only look to induce at 41+6 weeks.	Incorrect information provided that would not go over 41 weeks gestation and apology offered for the confusion caused.	Upheld
Tunbridge Wells Hospital	Ward / Unit	Obstetrics	2021	Concern raised that patient discharged without anticoagulants following c.section. Patient suffered a clot.	Assurance offered that risk assessment was undertaken and low risk determined. Discharge without anticoagulants was appropriate.	Not upheld
Tunbridge Wells Hospital	Clinic and/or Sexual Health Clinic	Midwifery	2019	Patient not advised prior to attending an apppointment that injection would not be available. When patient attended for appointment a week later, concerns raised about that advice provided by the receptionist to 'go and find a midwife'.	Apology for manner of receptionist when attending for appointment, this has been discussed with the member of staff involved. Apology that injection was not available, however this could have been sough from pharmacy and this has been addressed with the staff on duty. Assurance offered that timeframe for injection was appropriate.	Partially upheld
Tunbridge Wells Hospital	Ward / Unit	Midwifery	2020	Concerns raised that pain management during labour and delivery was not adequate. Concern raised with standard of support and care on post natal ward.	On review of maternity records. there is no evidence to support that additional pain relief was requested. Assurance offered that staff attempt to ensure all new mother's individual needs are met, and this has been discussed with the wider team as a point of learning.	Not upheld