
Crown Health Enterprises / Consultant Obstetrician and Gynaecologist, Dr L / House Surgeon, Dr O / Midwife, Ms G / Midwife, Mr D / and others

Opinion - Case 97HDC6074

Complaint

The Commissioner received a complaint from the complainant's whanau about the services provided to the consumer, Ms A, on 6 March 1997 while she was an inpatient at the public hospital, trading as a Crown Health Enterprise. The complaint is that:

- *The fact that Ms A's baby was in breech position was not detected earlier. Further to this, given that there was difficulty in establishing the position of the baby, why was no ultrasound ordered?*
 - *The level of care administered by Ms G, midwife, was insufficient. Specifically, she did not perform a physical examination of Ms A and did not administer pain relief when requested.*
 - *Ms A was placed in a room with other people whilst in early labour.*
 - *The medical notes recording the events are illegible, retrospective and not time recorded. There was no examination between 8:40am and 3:30pm but the notes make it sound as if there was an examination.*
 - *In the seven hour period between 8:40am and 3:30pm Ms A received no professional nursing care.*
 - *Following the birth of her stillborn child, Ms A was returned to a ward for post-natal care. This was emotionally distressing due to the fact her child was placed beside her and there was the continual noise of newborn children.*
 - *The whanau was not asked if they would like a cultural worker involved soon after admission which occurs in some other hospitals.*
 - *The whanau were not encouraged to stay with Ms A in the delivery suite whilst she was being examined and advised of her medical plan. Ms A was too shy to ask for an explanation of the medical plan.*
 - *The whanau was not advised of the health advocate as an avenue to pursue their complaint.*
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Investigation The complaint was received on 15 May 1997. An investigation was commenced and information was obtained from the following sources:

Ms A	Complainant
Mrs B	Complainant's mother
Ms C	Whanau member
Mr D	Provider, Midwife
Ms E	Provider, Midwife
Ms F	Provider, Midwife
Ms G	Provider, Midwife
Dr H	Provider, Registrar, the public hospital
Dr I	Provider, Consultant Obstetrician and Gynaecologist, the public hospital
Dr J	Provider, Senior House Officer, the public hospital
Dr K	Provider, Registrar, the public hospital
Dr L	Provider, Consultant Obstetrician and Gynaecologist, the public hospital
Dr M	Provider, Registrar, the public hospital
Dr N	Provider, Anaesthetist, the public hospital
Dr O	Provider, House Surgeon, the public hospital
Mr P	Midwife Educator, Women's Health, the public hospital
Ms Q	Group Manager, Women's Health, the public hospital
Ms R	Group Manager, Women's Health, the public hospital
Mr S	Chief Executive Officer, Crown Health Enterprises

Ms A's relevant medical records were obtained and viewed.

The Commissioner also sought advice from an independent midwife and an independent obstetrician and gynaecologist.

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**Information
Gathered
During
Investigation**

The complainant, Ms A, was admitted to the delivery suite of the public hospital at 6:00am on 6 March 1997 following a spontaneous rupture of her membranes at 5:00am. Ms A was 19 years old, weighed approximately 125 kilograms and was approximately 38 weeks pregnant. Ms A had family support.

On 28 January 1997 Ms A booked Dr I, Consultant Obstetrician and Gynaecologist, to deliver her first baby. Dr I saw Ms A on 5 February 1997 and 12 February 1997, at 35 weeks and 36 weeks gestation respectively. During these consultations Dr I made a clinical diagnosis of breech presentation. This was confirmed by ultrasound scan on 12 February 1997.

On 26 February 1997, Dr I states that he *“had no difficulty with recognising, on clinical examination, that the baby presented by head which was unengaged, 3/5 palpable and in the left occipito lateral position”*. Dr I felt that there was no need to perform another ultrasound on this occasion as there is no guarantee that the presentation of the baby will not change by the onset of labour especially where the baby's head is unengaged and the liquor volume is high. He stated *“therefore, on admission in labour, it is the duty of the admitting staff to reconfirm the lie and presentation of the baby”*.

Upon admission Ms A was examined by Ms E, midwife, who recorded a blood pressure of 120/90. Ms E advised the Commissioner that she tried to palpate the position of the baby but could not determine the presentation of the baby due to maternal size. This difficulty was recorded on Ms A's medical record. There was *“copious clear liquor, and it had an odour consistent with that of the water of pregnancy”*. Ms E attempted a cardiotocogram (CTG) but could only get a good foetal heart trace if the CTG was hand held initially. Ms A was not in labour but was experiencing backaches. Ms E documented the lie was longitudinal, probably cephalic presentation (head) and right occipito anterior (the back of baby's head lying to right and front of the mother's uterus).

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At 7:00am care for Ms A was handed over to Ms F, midwife. Dr J, senior house officer, reviewed Ms A at 7:20 am. Dr J recorded Ms A's blood pressure with a large cuff at 100/74. Dr J confirmed a pre-labour rupture of membranes at term, with no meconium liquor; cephalic presentation of the baby, although examination was difficult due to Ms A's large size. Dr J advised the Commissioner that the CTG was of a poor quality and difficult to interpret. As Dr J was a junior member of the obstetric team she raised her concerns with the night registrar, Dr H.

Dr H noted that the CTG had reduced variability and confirmed the midwife should leave it on. Dr H advised the Commissioner that she then examined Ms A's abdomen and "*thought clinically that the baby was cephalic*". At 8:00am Ms A's care was handed over to the on duty consultant and registrar.

Ms A was reviewed by Dr L, a consultant obstetrician, and Dr K, registrar at 8:30 am. Dr L was the consultant on duty between 8:00am and 1:00pm. Dr L's plan of management, after discussion with Ms A, was to wait for labour to establish on its own provided the baby's heart rate tracing (CTG) was acceptable. If labour had not established within 24 hours Ms A would be induced. Dr L stated to the Commissioner "*as she [Ms A] had just been examined, and the foetal heart rate was difficult to locate, I elected not to disturb the heart rate-tracing and did not examine her at that stage*". Dr L described the CTG as acceptable and Ms A was transferred to the antenatal ward. Dr L stated that although he did not specifically ask for a repeat CTG, he expected one to be done once Ms A went into labour. Dr L further stated "*I did not think that a scan was necessary that morning as [Ms A] was examined by a competent registrar who was in no doubt about the presentation*".

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At 8:40am Ms A was transferred to the antenatal ward. She was having occasional back pain and was subsequently reviewed by Dr O, a house surgeon, who noted that uterine contractions were coming at a rate of 1:30 minutes. Dr O advised the Commissioner that she only recollected seeing Ms A on the antenatal ward around noon and that she was in early labour contracting at a rate of 1:10 minutes, and was clinically well although in pain. In her response to the Commissioner's provisional opinion, Dr O said she cannot remember the exact number but was sure it wasn't 1:10 as the patient was not in great discomfort.

Dr O said she had been told that Ms A was being taken down to the delivery unit. Dr O did not record the time in the notes but it was recorded between an entry at 8:40am and another entry at 1:30pm.

"I met the patient after she had been fully examined and admitted by a senior registrar then seen by a consultant and a registrar who didn't question the registrar findings and set a management plan."

Dr O informed that she was not supposed to see the patient in the delivery suite and that usually the follow-up will be the responsibility of the registrar.

Ms G, a midwife, was responsible for Ms A's care between 8:40am and 3:30pm. Ms G advised the Commissioner that Ms A was placed in a four bedded room with two other antenatal patients. There are limited single rooms on the wards and these are mainly used for Caesarean Section patients.

Ms G was advised of a history of ruptured membranes, clear liquor colour, and that on palpation the lie was longitudinal and cephalic. This presentation had been confirmed by senior doctors in the delivery suite. The recent CTG was shown to Ms G. She considered it to be a satisfactory trace signed by a consultant to verify its interpretation as being that of a well, uncompromised, foetal heartbeat.

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Ms G explained the care plan to Ms A and chose not to palpate at this point as she had just been examined in the delivery suite and there was a satisfactory CTG. Ms G saw Ms A again at 9:15am to give her breakfast. At 11:00am Ms G returned to assess Ms A. Ms G advised the Commissioner that the curtains were drawn around Ms A's bed for privacy and she was sitting in a chair next to her bed with her head resting on a pillow and her eyes closed. Ms G asked a relative if Ms A was sleeping and they seemed to indicate that she was. Ms G stated that she chose to leave Ms A sleeping as she had been at the hospital since very early that morning.

At 1:30pm Ms A rang her bell. Ms G advised the Commissioner that a relative stated that Ms A was having painful contractions about 10 minutes apart, and that she was having a lot of back pain. Ms A was finding it difficult to get comfortable on the bed, so she was standing at the head of the bed leaning on the bed-head. Ms G stated that she stood with Ms A for one of these contractions and palpated the strength and length. She considered the contraction to be quite short (45 seconds) and mild in strength, although it was not easy to palpate due to Ms A's overall size. The complainant's whanau stated that Ms G did not check Ms A physically or stay to monitor the pains and that when asked for pain relief Ms G advised a whanau member to wait until the pains were five minutes apart.

Crown Health Enterprises advised the Commissioner that pain relief can be administered by staff on the antenatal ward, "*However, if a women is requiring narcotic analgesia, then transfer to Delivery Suite could be an option as one would assume in most instances the women would be in established labour and requiring more intensive care*". Ms A was not in established labour at this time.

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Ms G gave Ms A a hot pack for her back pain. Ms G's assessment took 15 minutes and during that time Ms A had only one contraction. Ms G concluded that Ms A was only in very early labour. As there was an earlier satisfactory CTG Ms G chose not to monitor Ms A until she became closer to establishing in labour. She does not recall a request for medicated pain relief and stated that it is usual midwifery practice to try alternative methods of relieving pain. Ms G did not stay with Ms A from this time until the end of her shift due to other patient and ward responsibilities, but asked Ms A to keep her informed if her contractions got closer together, or stronger. At 2:45pm Ms G handed over to the afternoon shift stating that Ms A may not be far away from establishing labour and that she would need closer monitoring soon. Ms G heard Ms A's bell ring at 3:30pm but as she had handed over to the afternoon shift at this stage she left that shift to attend to Ms A.

Mr D, a midwife, attended to Ms A at 3:30pm. He encouraged Ms A with a breathing technique and listened to the foetal heart rate with a Sonicaid. This was done while Ms A was standing. Mr D states Ms A's contractions were not 1:5 at this time, however the notes record this under his signature at that time. Mr D advised the Commissioner that his intention was to make a graduated assessment of Ms A's situation. Ms A found it impossible to lie on the bed due to her discomfort. For this reason Mr D decided to defer the palpation until later, hopeful that Ms A would feel more in control during her contractions and thus more compliant to his requests. The foetal heart rate at this time was 145 beats per minute. Ms A then had a bath for about 30-40 minutes. Mr D attended to his other work and returned as Ms A was finishing her bath.

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At approximately 5:30pm Mr D attempted to locate the foetal heart rate using the Sonicaid as previously. However, this proved difficult due to the fact that Ms A's contractions were now 1:5 minutes, of moderate strength and lasting 45 seconds. Ms A was also still moving off the bed to find a more comfortable position. Mr D requested that Ms A return to the bed to ease attempts to locate the foetal heart rate. After 10 minutes of trying Mr D decided to use the CTG machine. At 5:45pm, during the time Mr D was searching for the foetal heart rate, Ms A mentioned to him seeing 'green' coloured discharge. This was unconfirmed by Mr D as he had seen no liquor since he arrived on duty.

A foetal heart rate was obtained for a few seconds on a few occasions using the CTG. The heart rates were not recorded but Mr D estimated them to be between 100-120 beats per minute. Mr D advised the Commissioner that he considered using a newer CTG or asking another midwife to search for him but decided that a vaginal examination would give more information. Mr D summarised the situation as follows: *"my suspicions were aroused and only by further investigation could I determine further management. Also the potential for an undiagnosed problem such as cord prolapse was becoming greater."*

Mr D then decided to do a vaginal examination. He said he did this because of increasing pain contraction and the need to assess if labour was established. This examination was carried out in two parts. During the first part Mr D found the cervix to be two to three centimetres dilated and felt a *"limb"* which he thought was an arm. The examination was interrupted due to Ms A getting off the bed. Mr D then completed the examination.

Mr D attempted again but could still not locate a foetal heartbeat. In view of his difficulties he called the registrar on duty, Dr M. There is some discrepancy in the evidence as to the time Dr M was called. She states that it was at 6:25pm whereas Mr D believes that it was 6:05pm. It can be stated accurately that Mr D called Dr M between 30-50 minutes after he failed to locate a foetal heart rate.

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Based on advice by Mr D that he had been unable to find a foetal heartbeat and that he thought an arm was coming through the cervix, Dr M advised the Charge Midwife of Delivery Suite that it was likely that Ms A would require either an emergency caesarean delivery or may need to come to the Delivery Suite. Dr M arrived on the ward within a few minutes and repeated the vaginal examination and also performed an ultrasound scan on the ward as soon as the portable scanner could be obtained. A footling breach presentation was confirmed, at two centimetres cervical dilatation, and no evidence of cord prolapse. Foetal heart activity was seen on ultrasound but was extremely slow so an emergency Caesarean Section was ordered.

Ms A was taken to the operating theatre by Dr M and Mr D. The duty anaesthetist, theatre staff, neonatal paediatric staff and the consultant obstetrician were contacted by means of the hospital's locator system.

Dr M advised the Commissioner that she arrived in the operating theatre at 6:35pm. Ms A was asked to transfer to the operating table and then the anaesthetist, Dr N, made routine preparations for general anaesthesia while Dr M scrubbed up. Dr N advised the Commissioner that "*this was considered to be an emergency and everything that needed to be done was done as efficiently as possible to protect mother and child*". The nurses proceeded through their standard checklist and attempts were made to rapidly explain each step without compromising the need to act quickly. Obtaining intravenous access was difficult and after three attempts it was successful and was concluded just as the surgical team completed scrubbing.

Dr M stated that she did not wish to expose Ms A to the risks of surgery unnecessarily considering the likely terminal condition of the baby on leaving the antenatal ward. Dr M asked for the Sonicaid that she believed was kept in the operating theatre, only to be told there was none. It took five minutes to procure a Sonicaid. Mr D used it as Dr M was scrubbed up. Dr M was satisfied that she could hear a slow foetal heart beat and proceeded to perform the Caesarean Section. The anaesthetic start time was 6:47pm.

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A pale floppy girl weighing 3100 grams was delivered at 6:49pm with no respiratory effort or pulse. The neonatal paediatric practitioner attempted to resuscitate the baby while Dr M controlled Ms A's bleeding which is usual during a Caesarean Section. Dr M advised the Commissioner that she thinks the emergency bells were rung to obtain further assistance about eight minutes after delivery and that resuscitation was stopped at 7:09pm.

After the operation Ms A was transferred to another theatre so as to have some privacy when she awoke. Ms A's whanau were contacted to come and see her there, and Dr M and Mr D stayed with her until she was awake enough to talk.

Ms A was then transferred to the postnatal ward. The Bereavement Team saw her postnatally as prescribed in the public hospital's protocols. Ms A and the whanau were happy with the postnatal cultural support but were very unhappy at the additional stress placed on Ms A in the postnatal ward. Ms A and her baby shared a room with other mothers and their babies. This caused her overwhelming emotional stress as she heard the sounds and cries of other babies.

Crown Health Enterprises undertook three reviews of this incident. Two written reports were completed by Mr P and Dr I which were reviewed by Dr T who reported verbally to management.

An autopsy was carried out which concluded the baby died as a result of hypoxia. The reasons for the hypoxia are unknown.

Ms A recovered well physically and was discharged three days after the operation. Crown Health Enterprises advised the Commissioner that traditionally mothers with stillborn infants have been cared for on a postnatal ward. However, Crown Health Enterprises have since made it a policy that women with stillborn infants are given the choice of staying in a postnatal ward or the gynaecology ward.

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Opinion – Case 97HDC6074, continued

**Code of
Health and
Disability
Services
Consumers'
Rights**

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 1

Right to be Treated with Respect

- 2) *Every consumer has the right to have his or her privacy respected.*
- 3) *Every consumer has the right to be provided with services that take into account the needs, values, and beliefs of different cultural, religious, social, and ethnic groups, including the needs, values, and beliefs of Maori.*

RIGHT 4

Right to Services of an Appropriate Standard

- 2) *Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.*
- 3) *Every consumer has the right to have services provided in a manner consistent with his or her needs.*
- 4) *Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.*
- 5) *Every consumer has the right to co-operation among providers to ensure quality and continuity of services.*

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**Code of Health
and Disability
Services
Consumers’
Rights
*continued***

*RIGHT 10
Right to Complain*

6) *Every provider, unless an employee of a provider, must have a complaints procedure that ensures that –*

...

- b) *The consumer is informed of any relevant internal and external complaints procedures, including the availability of–*
- i. *Independent advocates provided under the Health and Disability Commissioner Act 1994; and*
 - ii. *The Health and Disability Commissioner.*
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Crown Health Enterprises / Consultant Obstetrician and Gynaecologist, Dr L / House Surgeon, Dr O / Midwife, Ms G / Midwife, Mr D / and others

Opinion – Case 97HDC6074, continued

Other Relevant Standards and Protocols	<p>Standards in Place at Time of the Complaint</p> <p><i>Guidelines for Management of Premature Rupture of Membranes – (PROM)</i></p> <p><i>Premature rupture of the membranes is spontaneous loss of liquor prior to the onset of labour. If liquor is not definitely seen on admission then confirm the diagnosis by speculum examination and take cervical swabs if immediate induction of labour is not planned.</i></p> <p><i>Digital examination should not be performed unless for assessment of the cervix immediately prior to insertion of vaginal prostaglandin E2. Cord compression is excluded by a normal foetal heart tracing.</i></p> <p><i>Discuss the benefits (mainly spontaneous labour), and risks, (mainly infection) of waiting for the onset of spontaneous labour. In general, it should be recommended that labour be induced somewhere between 12 & 24 hours after ROM, unless there is concern of foetal or maternal condition indicating more immediate delivery. The exact timing of induction will depend on the patient's wishes, as well as the work load on Delivery Suite and the time of day.</i></p> <p><i>If Gestation greater to or equal to 37 weeks.</i></p> <p><i>Transfer to 'A' Floor or Postnatal Ward to which the woman will later go with her baby or if social circumstances appropriate, send home. Temperature should be checked 4 hourly either in the hospital or at home and the patient reassessed if the temperature is over 37degrees C. Those women going home should be advised against sexual intercourse.</i></p> <p><i>Method of Induction</i></p> <p><i>If primigravida and the cervix was not effaced at the initial speculum examination, then give prostaglandin E2, 3mgms, inserted into the posterior fornix.</i></p>
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Other Relevant Standards and Protocols continued *If after 4 hours the Bishop's score is less than or equal to 6, then give 1.5mgms PG.E2.
If the Bishop's score is greater than 6 or not in labour after a further 4 hours, then commence a Syntocinon infusion.*

If parous then commence the Syntocinon infusion after 12-24 hours without a further vaginal examination.

Further digital vaginal examination should not be carried out until there is a need to assess progress in labour.

The Protocol (Currently in Place)

Antenatal Management of Patients with Spontaneous Rupture of Membranes (SRM) at 37+ weeks and not in established labour who have been admitted to the Antenatal Ward.

Outcome Standards:

Accurate documentation maintained including:

Foetal heart rate –4 hourly

Temperature and pulse (Blood pressure when necessary) –4 hourly.

CTG is recorded (as per standard) daily or repeat with the onset of painful, regular uterine contractions 1:10.

Process Standards:

On admission:

Complete abdominal palpation and auscultation of FH and record.

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Other Relevant Standards and Protocols *Spontaneous Rupture of Membranes (SRM) Not in Labour – Cephalic Presentation – Term – Delivery Suite*

continued

Process Standards:

Document in the obstetrical notes a verbal history from the woman which includes:

A brief antenatal history, including anything of particular significance which may impact on ongoing care.

Record a 20 minute baseline CTG tracing, the foetal heart should be reactive with no decelerations.

With confirmation of SRM, clear liquor, cephalic presentation, not in labour a febrile, term pregnancy, healthy foetus.

Initiate the following procedure: admit woman to antenatal ward to await spontaneous labour.

NZ College of Midwives Handbook for Practice

Scope of Practice:

“This care includes preventative measures, detecting complications in mother and child, accessing medical assistance when necessary and carrying out emergency measures.”

Code of Ethics:

“Midwives have a responsibility to ensure no action or omission on their part places the woman at risk”.

Standard Six:

“Midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk”. Three of the criteria are:

- 1. ensure potentially life threatening situations take priority;*
- 2. demonstrates competency to act effectively in any emergency situation;*
- 3. identifies deviations from the normal, and after consultation with the woman, consults and refers appropriately.*

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Opinion – Case 97HDC6074, continued

Opinion: Right 4(2) and Right 4(3)

Breach

Midwife, Mr D In my opinion midwife, Mr D, breached Rights 4(2) and 4(3) of the Code.

Mr D first assessed the complainant, Ms A, at 3:30pm and recorded the contractions were 1:5 minutes. Although he assessed foetal heart rate at this stage, using a Sonicaid, he did not initiate a CTG. At 5:30pm the foetal heart rate was recorded as 145 beats per minute and reactive. A CTG was not used for this measurement and there is no evidence as to how reactivity was determined. I note this was the first recording of foetal heart rate since Ms A was admitted to the ward. While Mr D advised that he was required to attend to other patients and that he considered the CTG machine to be unreliable, Ms A was now contracting 1:5 minutes and a CTG should have been arranged.

Mr D advised the Commissioner that he carried out an assessment at 4:30pm. He thought that the presentation was cephalic and the foetal heart rate was 140 after the palpation. This is not recorded in the notes. Record keeping is an important part of the midwives' role. In my opinion this assessment should have been included in Ms A's medical record. Some time between 5:20pm and 5:45pm Mr D found Ms A contracting 1:5 lasting 45 seconds which felt 'soft' on palpation. Ms A could not keep still and the foetal heart rate was found to be between 100-120 beats per minute. The possibility that this was a maternal pulse was eliminated.

In my opinion, it was not reasonable for Mr D to delay in arranging this CTG. In response to my opinion Mr D stated "*CTG difficulty earlier with [midwife, Ms E] Therefore there was little to gain in attempting a difficult CTG when mobility and FHHR [Foetal Heart Rate] with a Sonicaid was favoured.*" The fact that Ms A kept moving off the bed did not eliminate Mr D's obligation to advise Ms A of the need to effectively trace the foetal heartbeat. By undertaking a vaginal examination further delays occurred and after the first part of the examination when Mr D found a "limb" he should have called assistance without delay. He also should have advised Ms A not to get off the bed.

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**Opinion:
Breach
Midwife, Mr D
*continued***

Finally, while there is much dispute around the timings, in my opinion, there was an inappropriate delay between the diagnosis of a problem and the call for senior assistance.

In summary in my opinion Mr D's actions did not comply with standards and did not minimise potential harm to Ms A and her baby.

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Midwife, Ms G / Midwife, Mr D / and others**

Opinion – Case 97HDC6074, continued

Opinion: Right 4(2)

No Breach

Midwife, Ms G In my opinion midwife, Ms G, did not breach Right 4(2) of the Code.

My midwifery advisor considered that although neither the consultant obstetrician and gynaecologist, Dr L, nor registrar, Dr K, had actually palpated the complainant, Ms A's, abdomen to determine the presentation, it was reasonable for Ms G not to do a palpation or CTG at 8:40am. I was also advised that it is accepted practice to expect the support people to time contractions. At the 1:30pm examination Ms G felt a contraction that lasted for 45 seconds which did not meet the definition of established labour which is contraction 2-3 in 10 minutes lasting at least 45 seconds with discomfort / pain and dilatation of the cervix.

Opinion: Right 4(2)

No Breach

Midwife, Ms E In my opinion midwife, Ms E, carried out an appropriate examination of the complainant, Ms A, on admission.

While Ms E did not raise her concerns about the presentation of the baby verbally with the doctors present, she documented her concerns about the presentation of the baby and the difficulty getting a CTG recording of the foetal heart rate. Ms E also noted a raised blood pressure of 120/90 and heavy proteinuria.

Opinion: Right 4(2)

No Breach

Midwife, Ms F In my opinion midwife, Ms F, carried out her duties in accordance with professional standards.

Ms F recorded assessments about contractions, liquor, and foetal movements. She noted the lack of variability on the CTG tracing. This trace was subsequently approved by the consultant, Dr L, who had the ultimate responsibility.

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Opinion – Case 97HDC6074, continued

Opinion: Rights 4(2) and 4(4)

Breach

**Consultant
Obstetrician
and**

**Gynaecologist,
Dr L**

In my opinion the consultant obstetrician and gynaecologist, Dr L, breached Rights 4(2) and 4(4) of the Code.

Dr L was the senior consultant on duty. He was the most senior person to examine the complainant, Ms A, and made the decision to transfer her to the ward. In my opinion he bore the major responsibility for the events that followed.

During Ms A's admission it was recorded that a breech presentation had been identified three to four weeks previously. Both midwife, Ms E, and senior house officer, Dr J, had concerns about the presentation and these were recorded and raised with Dr H, the night registrar. In particular Dr H was concerned about the CTG variability and requested continued monitoring. On admission the midwife recorded a blood pressure of 120/90 and "heavy" proteinuria. Both should have been followed up. In particular blood tests should have been ordered.

The only CTG carried out was the trace that began at 6:30am and ultimately finished at 8:00am. The only portion of the trace which was interpretable was that between 7:30am and 8:00am and this trace showed reduced variability although there were no decelerations or episodes of tachycardia or bradycardia. The advisor considered that the trace "*could not have been described as indicating satisfactory foetal wellbeing and certainly warranted further monitoring within a short period of time*".

In my opinion Dr L did not meet the standard required. He did not appropriately consider the recorded medical history thoroughly. He should have examined Ms A, reviewed blood pressure, ordered blood tests, insisted on further CTG monitoring and considered an ultrasound scan in these circumstances. Ms A should not have been transferred to the antenatal ward without these examinations occurring.

Dr L was unable to rely on previous assessments as the history as recorded and assessed by himself and by his team from the time of Ms A's admission made it clear that there was much uncertainty.

Continued on next page

Crown Health Enterprises / Consultant Obstetrician and Gynaecologist, Dr L / House Surgeon, Dr O / Midwife, Ms G / Midwife, Mr D / and others

Opinion – Case 97HDC6074, continued

**Opinion:
Breach
Consultant
Obstetrician
and
Gynaecologist,
Dr L *continued***

Even if Dr L considered it appropriate to transfer Ms A to the antenatal ward (which I do not accept), in the circumstances Dr L should have noted that the CTG was in question and recorded the need for an assessment of foetal heart rate by the antenatal ward staff upon arrival to the ward and four hourly thereafter.

In my opinion, this lack of detailed examination, diagnosis and record keeping was not only a breach of professional standards but did not minimise potential harm to Ms A or her baby.

**Response by
Consultant
Obstetrician
and
Gynaecologist,
Dr L**

Response by Dr L

In response to my opinion Dr L provided advice from his own expert supporting his actions in terms of the CTG and his ability to rely on his staff. This response to my other issues is as follows:

“i) ***He did not review the recorded medical history thoroughly***
I definitely did review [Ms A's] Antenatal record and her admission notes prior to seeing her I did note from the admitting midwife's notes that she was unsure of the presentation, but felt it was cephalic.

The midwife also had recorded a blood pressure of 120/90 and cuff size was not specified. Blood pressure taken by [Dr J] with a large cuff was recorded as 100/74. A lady of [Ms A's] size needs a large cuff to get correct blood pressure readings.

Continued on next page

**Crown Health Enterprises / Consultant Obstetrician and
Gynaecologist, Dr L / House Surgeon, Dr O /
Midwife, Ms G / Midwife, Mr D / and others**

Opinion – Case 97HDC6074, continued

**Response by
Consultant
Obstetrician
and
Gynaecologist,
Dr L continued**

Heavy proteinuria was also noted by the midwife who also wrote that she had ruptured membranes and draining copious clear liquor. Liquor, as you know, has a high protein content. [Dr J] examined [Ms A] and felt the presentation to be cephalic and got it checked by [Dr H] the Registrar on duty. I also noted that a satisfactory recording of the foetal heart rate could not be made because of technical reasons (obesity), but this was being done during my rounds.

I do not think that I missed any significant recorded medical history.

- ii) He should have examined [Ms A]**
[Ms A] was examined by [Dr H], the Registrar on duty who, on handing over to me, did not express any doubts as to the presentation. Registrars are part of our team and we do not routinely counter check all their clinical findings. If they are unsure, then we definitely check their findings. I reiterate that [Dr H] did not express any uncertainty to me.

With [Ms A] being already examined by three different individuals within a short period since her admission, I feel that there has to be a very good reason for another person to examine her again.

- iii) He should have reviewed blood pressure – ordered blood tests**
As mentioned earlier, blood pressure taken with a large cuff, which is the correct procedure in her case, was normal at 100/74. In a woman with ruptured membranes, the urine will always be mixed with liquor which is rich in protein. Blood tests and special investigations are done to confirm/refute clinical suspicions and in this clinical context, blood tests would be an unnecessary investigation.

Continued on next page

**Crown Health Enterprises / Consultant Obstetrician and
Gynaecologist, Dr L / House Surgeon, Dr O /
Midwife, Ms G / Midwife, Mr D / and others**

Opinion – Case 97HDC6074, continued

**Response by
Consultant
Obstetrician
and
Gynaecologist,
Dr L continued**

iv) ***He should have insisted on further CTG***
In accordance with our standard policy for women with ruptured membranes and not in labour, I considered it appropriate for her to be transferred to the Antenatal Ward on the understanding that the midwifery staff will follow the protocol and take regular observations including a CTG. Although the CTG done in Delivery Suite shows reduced variability, it would be passed as normal in accordance with the RNZCOG Guidelines for Intrapartum Interpretation of CTG's ... [I note the protocol referred to was not in place at that time].

v) ***He should have considered an Ultrasound scan in these circumstances***
Special investigations in any field of medicine have indications and I did not feel that an ultrasound scan was indicated in [Ms A's] case when I saw her.

The information received by me at the take over round was not that of uncertainty over the presenting part. If that had been the case, I would have performed an ultrasound scan at that time. In retrospect I regret not having examined [Ms A] at this point, but at the time the situation perceived by me was of an uncomplicated case of ruptured membranes at term with a cephalic presentation.”

**Crown Health Enterprises / Consultant Obstetrician and
Gynaecologist, Dr L / House Surgeon, Dr O /
Midwife, Ms G / Midwife, Mr D / and others**

Opinion – Case 97HDC6074, continued

Opinion: Right 4(2)

Breach

House

Surgeon, Dr O

In my opinion House Surgeon, Dr O, breached the Code. It is documented on the complainant, Ms A's, medical records that Dr O saw Ms A while she was on the antenatal ward and that she was contracting 1:30 minutes.

Dr O did not record the time of the examination which from the notes is known to have occurred between 8:40am and 1:30pm. In my opinion Dr O breached Right 4(2) by not meeting a standard medical practice of recording the time of the assessment.

Opinion:

No Breach

Consultant

Obstetrician

and

Gynaecologist,

Dr I

Rights 4(2) and 4(4)

In my opinion the consultant obstetrician and gynaecologist, Dr I, did not breach Right 4(2) or Right 4(4) of the Code.

An ultrasound scan on 12 February 1997 showed the breech presentation and an increased amount of amniotic fluid. Dr I's involvement finished at the antenatal visit on 26 February 1997. At that antenatal visit Dr I felt certain that the presentation of the baby was cephalic. The advisor noted that "*given the excess amount of liquor it is not too surprising that the foetus was more than averagely mobile, perhaps unstable, at this stage of the pregnancy*". The ability to assess the presentation at this stage is significantly reduced by maternal body weight. Likewise the effectiveness of an ultrasound is affected by abdominal fat thickness. I accept the opinion of my obstetrician and gynaecologist advisor that a ultrasound scan on this occasion, given the instability of the lie would not have given any more information to help the situation at the time of admission.

**Crown Health Enterprises / Consultant Obstetrician and
Gynaecologist, Dr L / House Surgeon, Dr O /
Midwife, Ms G / Midwife, Mr D / and others**

Opinion – Case 97HDC6074, continued

Opinion: Right 4(2)

No Breach

**Senior House
Officer, Dr J**

In my opinion the senior house officer, Dr J, did not breach Right 4(2) of the Code.

I accept the advice of my obstetrician and gynaecologist advisor that Dr J clearly and adequately documented the problems in assessing the complainant, Ms A, and left clear comments about how she felt Ms A should be managed before she went off duty.

Opinion: Right 4(2)

No Breach

**Registrar,
Dr H**

Dr H was the overnight registrar and responsible for the handover of the complainant, Ms A, to the next shift. Dr H reviewed the senior house officer, Dr J's, notes which advised that there was some uncertainty as to the presentation of Ms A's baby. Dr H, on examination of Ms A, considered the presentation to be cephalic, noted CTG reduced variability, requested continued monitoring and fully documented the case so details were available. Responsibility for Ms A's care was then transferred to the next shift. In my opinion Dr H carried out her duties in accordance with professional standards.

Opinion:

No Breach

**Registrar,
Dr K**

In my opinion the registrar, Dr K, did not breach the Code. She saw the complainant, Ms A, briefly with the senior consultant, Dr L, and it was Dr L's responsibility to ensure an appropriate assessment occurred.

**Crown Health Enterprises / Consultant Obstetrician and
Gynaecologist, Dr L / House Surgeon, Dr O /
Midwife, Ms G / Midwife, Mr D / and others**

Opinion – Case 97HDC6074, continued

**Opinion:
No Breach
Registrar,
Dr M**

Right 4(2) and Right 4(4)

In my opinion the registrar, Dr M, did not breach the Code and dealt with the situation appropriately.

In terms of the recording by Dr M of the complainant, Ms A's, medical notes in my opinion there was not a breach of the Code as there was an emergency and there was no time for notes to be written immediately.

**Opinion:
No Breach
Anaesthetist,
Dr N**

Right 4(4)

In my opinion the anaesthetist, Dr N, did not breach the Code. Dr N was presented with an exceptionally urgent Caesarean Section with no existing intravenous access. In my opinion gaining intravenous access was complicated by the obesity of the complainant, Ms A. The fact that it took Dr N three attempts to gain access did not significantly delay the delivery.

Crown Health Enterprises / Consultant Obstetrician and Gynaecologist, Dr L / House Surgeon, Dr O / Midwife, Ms G / Midwife, Mr D / and others

Opinion – Case 97HDC6074, continued

Opinion: Rights 4(3) and 1(3)

Breach

Crown Health Enterprises

In my opinion Crown Health Enterprises breached Right 4(3) and Right 1(3) of the Code. While Crown Health Enterprises placed the complainant, Ms A, in a single room in the postnatal ward, she was able to hear babies crying. I agree that this would have caused overwhelming distress for Ms A and did not meet her cultural needs. Ms A's distress was so great that she asked to have her baby taken out of the room.

In my opinion there must be a room made available which is more sensitive to the needs of a bereaving mother.

Right 4(5)

In my opinion Crown Health Enterprises breached Right 4(5) of the Code of Health and Disability Services Consumers' Rights.

No person was responsible for the continuing ongoing care of Ms A. The hand over process is paramount in the continuing management of patients and the degree of failure in communication at hand over had an effect on the outcome of this case. Uncertainty about the presentation of the baby and the need to further monitor the foetal heart rate were not communicated effectively during the hand over process.

Right 10(6)

In my opinion Crown Health Enterprises breached Right 10(6)(b) of the Code as it has shown no evidence that they informed Ms A about the Health and Disability Commissioner advocacy services.

Rights 4(2) and 4(4)

Under s72(2) of the Health and Disability Commissioner Act 1994 Crown Health Enterprises is vicariously liable for the acts and omissions of its employees whether or not they were done with the knowledge or approval of Crown Health Enterprises.

Continued on next page

Crown Health Enterprises / Consultant Obstetrician and Gynaecologist, Dr L / House Surgeon, Dr O / Midwife, Ms G / Midwife, Mr D / and others

Opinion – Case 97HDC6074, continued

Opinion: Rights 4(2) and 4(4)

Breach

**Crown
Health
Enterprises**
continued

Under s72(2) of the Health and Disability Commissioner Act 1994 Crown Health Enterprises is vicariously liable for the acts and omissions of its employees whether or not they were done with the knowledge or approval of Crown Health Enterprises.

Crown Health Enterprises must ensure that its consultants take prime responsibility and review the actions of other staff. In this case there was no appropriate foetal heart monitoring between 8:00am and 3:30pm. In fact no satisfactory foetal heart traces were obtained from the time of admission. Once Ms A was transferred to the 'waiting area' there should have been some instructions to closely monitor foetal heart, as the trace in the Delivery Suite was not normal. Having just been reviewed by a consultant, ward staff were entitled to assume the maternal and foetal conditions were satisfactory, particularly as there were no instructions for further monitoring. At the time there was no protocol in place to repeat the trace immediately (or at least within four hours of being transferred to the ward) and the actions of the consultant ought to have been able to be relied on. I note that as the result of the internal review undertaken, Crown Health Enterprises now carry out an ultrasound where there is uncertainty about the presenting part.

After extended communication with Crown Health Enterprises the guidelines in place at the time were made available. In my opinion these guidelines were not appropriate and have now been replaced by a protocol.

**Crown Health Enterprises / Consultant Obstetrician and
Gynaecologist, Dr L / House Surgeon, Dr O /
Midwife, Ms G / Midwife, Mr D / and others**

Opinion – Case 97HDC6074, continued

**Opinion:
No Breach
Crown
Health
Enterprises**

In my opinion Crown Health Enterprises did not breach Right 1(3) of the Code of Health and Disability Services Consumers' Rights.

On 6 March 1997 a cultural worker visited the complainant, Ms A, and reported that Ms A did not require any follow up from the Cultural Resources Unit. The complainant's whanau advised the Commissioner that their complaint related only to that first day. The support worker who came that evening and the following day, after Ms A lost her baby, was described as wonderful.

However I note that there is no evidence the Cultural Support worker adequately discussed issues with Ms A. Certainly the notes recording this visit simply record "ok" and these should be reviewed and attended to.

Right 1(2)

In regard to the provision of a single room, in my opinion there was no breach of the Code regarding the antenatal care. There are constraints on the number of single rooms available. Ms A was not a patient requiring special care and was not in established labour, it was therefore appropriate to accommodate her in a shared room.

Crown Health Enterprises / Consultant Obstetrician and Gynaecologist, Dr L / House Surgeon, Dr O / Midwife, Ms G / Midwife, Mr D / and others

Opinion – Case 97HDC6074, continued

**Actions:
Midwife, Mr D**

I recommend that:

- Mr D apologises for his breach of Ms A's rights. This apology is to be sent to the Commissioner's Office which will forward it to Ms A.
 - Undertakes a peer review with the New Zealand College of Midwives should he return to New Zealand to practice.
-

**Actions:
Consultant
Obstetrician
and
Gynaecologist,
Dr L**

I recommend that:

- Dr L apologises for his breach of Ms A's rights.
 - Reads Crown Health Enterprises' protocols and procedures for treatment of consumers who present with spontaneous rupture of membranes.
 - Ensures that he takes appropriate care to read consumer's historical notes and acquire information from colleagues about a patient's condition during handover.
 - Undertakes an appropriate medical professional education program in consultation with the Royal New Zealand College of Obstetricians and Gynaecologists and in accordance with section 45(f) of the Act. This matter in respect to Dr L will also be referred to the Director of Proceedings for the purpose of deciding whether any action should be taken.
-

Crown Health Enterprises / Consultant Obstetrician and Gynaecologist, Dr L / House Surgeon, Dr O / Midwife, Ms G / Midwife, Mr D / and others

Opinion – Case 97HDC6074, continued

Actions:

**Crown
Health
Enterprises**

I recommend that Crown Health Enterprises takes the following actions:

- Apologises to Ms A for its breach of Ms A's rights. This apology is to be sent to the Commissioner's Office which will forward it to Ms A.
- Reviews its amended protocols for women who are admitted full term with spontaneously ruptured membranes to ensure that:
 - i) where there is uncertainty as to the presentation of the baby on admission a scan is carried out;
 - ii) the foetal heart rate is carefully monitored;
 - iii) where a CTG is not satisfactory this is clearly recorded and instructions for further monitoring are passed on; and
 - iv) in circumstances where a woman has a stillborn child they are given the option of not returning to the antenatal ward.
- Improves the quality of hand over reporting between staff.
- Ensures that its complaints procedure incorporates the need to advise the complainant about the office of the Health Advocate and the Health and Disability Commissioner.
- Takes steps to ensure that staff are aware of protocols and that they are being complied with.
- Ensures women with stillborn babies in postnatal deaths are not placed in a postnatal ward and that their cultural and counselling needs are met.
- Reviews the support and note taking by cultural advisors to ensure appropriate support is being given and recorded.
- Amends its major incident quality review to ensure a quality team approach occurs by all clinical disciplines. Such reviews must involve total end to end service including documentation of requirements to improve future services and follows up actions assigned to specific staff.

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Crown Health Enterprises / Consultant Obstetrician and Gynaecologist, Dr L / House Surgeon, Dr O / Midwife, Ms G / Midwife, Mr D / and others

Opinion – Case 97HDC6074, continued

Actions:
Crown Health Enterprises
continued

The Commissioner wishes to mediate a solution between Crown Health Enterprises and Ms A. If this is not successful, in accordance with section 45(f) of the Act, this matter in respect to Crown Health Enterprises will also be referred to the Director of Proceedings for the purpose of deciding if any action should be taken before the Complaints Review Tribunal.

Actions Taken:
Crown Health Enterprises

Crown Health Enterprises advised the following actions have been taken:

- A protocol has been put in place since this incident took place relating to the management of patients with ruptured membranes at term. It should be noted however that these are simply guidelines (which are reviewed annually), and that their application will depend upon the circumstances of each case. The guidelines for patients with ruptured membranes at term does not include a specific reference to the performance of an ultrasound scan when the presentation of the baby is uncertain, as this is standard clinical practice.
- Crown Health Enterprises accepts that it is always possible to improve processes and that the hand-over process is no exception. A full time consultant is now on duty in the delivery suite and acute gynaecology department between 8:00am and 5:00pm Monday to Friday, who has no other responsibilities at this time. The introduction of this role has enhanced the effectiveness of hand-over for all levels of staff in these areas.
- Crown Health Enterprises has a patients' rights pamphlet which is available to all patients upon request. Visual displays of the pamphlet in poster form are on all wards in the public hospital.
- The wards within Women's Health cater for both antenatal and postnatal women. Crown Health Enterprises advises it will continue to ensure women with stillborn babies are placed in single rooms. Crown Health Enterprises attempts to ensure that the cultural and counselling needs of such patients are met and I note that Ms A was visited by the bereavement team and cultural advisors and was offered counselling and support.

Crown Health Enterprises / Consultant Obstetrician and Gynaecologist, Dr L / House Surgeon, Dr O / Midwife, Ms G / Midwife, Mr D / and others

Opinion – Case 97HDC6074, continued

Actions Taken:
Crown Health Enterprises
continued

- Crown Health Enterprises' major incident quality review procedures have been reviewed since the incident took place. The Women's Health Service now has a quality plan which is reviewed annually and a structure which ensures appropriate monitoring of adverse events, complaints and incidents. Currently, this quality plan involves practice groups which report to a Quality of Service Committee. The quality procedures attempt to ensure a total end to end service, including documentation of requirements to improve future services and follow up actions assigned to specific staff.
- Crown Health Enterprises is happy to mediate a resolution of this matter with Ms A. It did in fact meet with Ms A and her whanau soon after this incident took place, but unfortunately, these meetings were unsuccessful in resolving the matter.

Other Actions

A copy of this opinion will be sent to the New Zealand Medical Council, the Nursing Council of New Zealand, the New Zealand College of Midwives and the Royal New Zealand College of Obstetricians and Gynaecologists.
