CAS-14539-Z0Y9V4
9 June 2026

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Care provided by plastic surgeon after breast-reduction surgery and a postoperative haematoma

Executive summary

1. Mrs A underwent breast-reduction surgery in May 2022 and experienced a postoperative haematoma (collection of blood trapped under the skin). In her complaint to the Health and Disability Commissioner (HDC) in October 2022, Mrs A raised concerns about the management of the haematoma and subsequent post-surgical care and follow-up provided by Dr B at a private surgical facility. These concerns have been the focus of this investigation.

2. I find Dr B in breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) for his decision not to admit Mrs A to hospital for further observation, for his failure to follow up when she did not attend her six-week check, and for the standard of his documentation relating to Mrs A's post-surgical care.

Recommendations

3. Dr B has told HDC that he and the private surgical facility have made a number of changes to their practice since Mrs A's complaint, including:

- Considering an upgrade of his patient record and management system.
- Ensuring his practice contacts patients on the same day as a missed appointment.
- Requesting that the anaesthetist returns to administer anaesthetic in similar situations.
- Giving patients the option to stay the night in hospital.
- Updated the policies relating to postoperative complications and bleeding to be in line with 'Standards New Zealand: Day-stay Surgery and Procedures Standard' (NZS 8164:2005).
- Made improvements to note-taking and records for procedures, including separate operation notes.
- Instituted automatic backup of call phone messages and photographs.
- Updated the privacy policy.

4. In considering the changes made by Dr B and that a competency assessment has been completed by the Medical Council of New Zealand, I recommend that he:

- provide HDC with a written apology for the deficiencies in care identified in this report for forwarding to Mrs A within three weeks of the date of this report;
- provide HDC with an update on the implementation of the new patient management system within three months of the date of this report.

Background

5. Mrs A had an initial consultation with Dr B on 16 July 2021, which included a discussion with a practice nurse. She signed the consent for surgery on that day. The clinical record indicates that Mrs A had undergone previous plastic surgery, that no second and/or preoperative consultation was planned, and that motel options were discussed because the surgery was planned as a day-stay case. Dr B has told HDC that he performs 98–99% of similar surgeries as day cases.

6. The surgery was delayed until 23 May 2022 because of the COVID-19 pandemic. On this day, Mrs A attended Dr B's practice at the private surgical facility for breast-reduction surgery. COVID-19 restrictions were in place, so Mrs A attended alone while her partner waited nearby.

7. Dr B's postoperative note states that he performed a superomedial breast reduction[1] and closed the surgical sites using '1 Vicryl, 2-0/3-0 Rapide stitches' (synthetic, braided sutures designed for rapid absorption). Documentation shows that Mrs A was in the operating theatre for approximately one hour, between 12.20pm and 1.19pm, and that the surgery was completed within 35 minutes. While in recovery, approximately 40 minutes after the surgery, Mrs A's left breast swelled up. The postoperative note indicates that Dr B evacuated a haematoma in the recovery area and that the local anaesthetic was still active.

8. Mrs A told HDC that this was a traumatic procedure completed while she was awake and that blood spurted onto Dr B's face. Dr B told HDC that he discussed with Mrs A the option to return to the operating theatre under general anaesthetic or to be admitted to a local hospital but advised her that delaying surgery could result in additional challenges with recovery and healing.

9. In contrast, Mrs A told HDC that Dr B told her the operating theatre was closed, the anaesthetist had left for the day and, as such, it was not possible to return to theatre.

10. There is limited clinical documentation regarding this procedure and no evidence of what was discussed. Dr B also told HDC that, as Mrs A had eaten and taken fluid orally since the surgery, he believed that the anaesthetist would be reluctant to proceed with general anaesthetic. It is documented on the post-anaesthetic care unit chart that Mrs A had consumed some water and an ice block.

11. The consultant anaesthetist, Dr C, told HDC that it was his usual practice to remain onsite for at least one hour after an operation; however, given the passing of time, he cannot state when he left the private surgical facility on 23 May 2022. He said his criteria for leaving the centre after surgery include that the patient has stable observations and is rousable and that the recovery nurse is happy with the overall patient condition. Dr C advised that Dr B did not contact him after he had left the surgery that day but that he was available at home and would have returned immediately if necessary.

[1] A surgical technique that moves the nipple–areola complex to a higher position using a tissue flap (pedicle) based in the superior medial (top inner) area of the chest.

12. The clinical record indicates that Mrs A was discharged from the post-anaesthetic care unit at 4.45pm. Mrs A told HDC that she had been recommended a motel nearby to continue her recovery; however, she felt she was not ready to be discharged and believes she should have been admitted to hospital that night. Dr B told HDC that he believes there was no danger in discharging Mrs A, as the active bleeding had been controlled and she was physiologically stable. He has stated retrospectively that, given Mrs A and her partner's high levels of anxiety, he would now admit her to hospital overnight.

13. Mrs A has consistently refuted Dr B's assertions that she was an anxious patient. There is no documented evidence of this concern within Dr B's contemporaneous notes or within her general practitioner (GP) record.

14. Mrs A reported that the bleeding had become uncontrollable by 6pm so she returned to the surgery, where Dr B applied fresh bandages and additional local anaesthetic. Dr B told HDC that there was no active bleeding but that blood-stained local anaesthetic was leaking from the breast. Mrs A reports that, when she returned to the motel, the bleeding continued and she began to vomit. Dr B told HDC he was aware of the anxiety Mrs A and her partner were presenting with and so attended the motel at 9pm. While there, he ceased one of her painkillers, OxyNorm (an opioid), to help reduce her nausea. Dr B told HDC that local anaesthetic leaking from the surgical site was to be expected.

15. There is no clinical documentation regarding Mrs A's subsequent attendance at the private surgical facility, Dr B's visit to the motel that evening, or the routine review that took place the following morning (24 May 2022).

16. Mrs A was seen again by Dr B on 30 May 2022 for a postoperative review. He documented that everything was settling well. However, the following day, Mrs A called the surgery because she was concerned she had an infection. She sent photos to Dr B and was advised that her wounds did not show signs of infection, but she was prescribed a seven-day course of flucloxacillin (an antibiotic).

17. On 13 June 2022, Mrs A attended the private surgical facility for her sutures (stitches) to be removed. Dr B documented a few small holes on the left breast and that Mrs A 'seem[ed] to be doing very well.' The nursing note states that the left breast had 'suture site irritation and breakdown.' Dr B told HDC that the wound was not infected but that Mrs A was having a reaction to the sutures, which he had removed, and – as such – he did not feel she required further antibiotics when she requested them.

18. Mrs A returned to the practice on 15 June 2022 for an unplanned appointment as she was continuing to feel unwell and remained concerned about the healing of her wounds. Mrs A told HDC that she was 'distressed, sick and crying' during this appointment. The nursing note documented that Mrs A was 'concerned of her wound getting worse … red and inflamed … assurance ++.' In his file note, Dr B recorded that the vertical scar on her left breast had opened up and was raw. Dr B told HDC that he did not take a wound swab at this time as he did not believe there was an infection. He documented that it would heal nicely but does not reference Mrs A's distressed presentation in his file note. Mrs A told HDC that, during her assessment with Dr B he spoke to her in an abrupt tone and raised his voice.

19. Mrs A remained concerned about a potential infection, so she attended an out-of-hours clinic on 16 June 2022. The GP documented purulence (pus) with redness and prescribed a further five-day course of flucloxacillin.

20. Mrs A saw a locum GP at her usual health centre on 21 June 2022. The GP documented 'no erythema [redness], no fluctuant abscess palpable [identifiable pocket of pus under the skin], not hot to touch.' The absence of these symptoms would suggest that infection was not present at this time. However, the GP took a swab of the wound and prescribed a 10-day course of cefalexin as an alternative antibiotic.

21. The wound swab identified methicillin-resistant *staphylococcus aureus* (MRSA)[2] on 22 June 2022. Cefalexin appeared to clear the infection; however, Mrs A reports that pus returned within a day of finishing the course, on 1 July 2022. Mrs A had been prescribed co-trimoxazole (an antibiotic that can treat MRSA) as a precaution if the wounds did not heal, and she reports she started taking these antibiotics on 1 July 2022. Mrs A attended another after-hours clinic on 2 July 2022; at this visit, the presence of an infection was confirmed and she was prescribed a further month of co-trimoxazole. Mrs A continued to attend her GP practice one to two times a week for ongoing wound review and dressings, a journey that took at least 2.5 hours each way. Her last wound care appointment was 22 July 2022, after which Mrs A managed her own dressings until 7 August 2022 (10 weeks post-surgery).

22. The clinical notes provided by Mrs A's GP surgery include discussion of the MRSA infection potentially being commensal (meaning it was already living on Mrs A's skin without causing harm) and note that she appeared to be allergic to the medical tape on her skin, which caused further redness.

23. Mrs A had a six-week follow-up appointment scheduled with Dr B on 4 July 2022, which she did not attend. She reports that she would have informed the practice nurse of this via text and that the only subsequent follow-up she received was a text message on 5 July 2022 and an email on 14 July. In response to the email on 14 July 2022, she informed the practice nurse of the ongoing infection and need for dressing changes at her GP. The nurse stated that she would pass this on to Dr B, but no follow-up is documented. The content of text messages cannot be evidenced because the private surgical facility's phone was damaged.

Analysis

24. To assist with my assessment of this complaint, expert advice was sought from Dr Marcus Bisson, consultant plastic and reconstructive surgeon (see appendix A).

Dr B – Breach

Management of the postoperative bleed and decision to discharge

25. Dr Bisson advised that, where significant and rapid swelling occurs after surgery, standard practice and the safest, most effective option would be to conduct the evacuation and washout (surgery to evacuate haematoma) with Mrs A under general anaesthetic. He disagreed that an anaesthetist would be reluctant to use general anaesthesia in this situation because water and an ice block would constitute clear fluids and so the 'six-hour rule' (where solid food should not be consumed within six hours before surgery) would not

[2] Bacteria that can cause serious infection and is resistant to many common antibiotics.

have applied. In his advice, Dr Bisson recognised mitigating factors, including Dr B's concern about a delay in transferring Mrs A to a hospital or arranging further general anaesthesia and that it was technically possible to perform the washout while Mrs A was awake with good local anaesthetic.

26. I am concerned that no anaesthetist was onsite so shortly after surgery; however, I accept Dr C's statement that he was available and would have returned had he been contacted. I consider that it would have been reasonable for Dr B to have consulted with Dr C to ascertain whether further general anaesthesia would have been appropriate to manage the haematoma, and I am critical that he did not do so.

27. Dr Bisson advised that a longer period of observation would typically be required after an acute haematoma, and admission to hospital would be accepted practice. Dr B did not believe there were any concerns discharging Mrs A to a motel, although I note that she did not feel ready for discharge, and there is no evidence that the potential to be admitted to a private hospital was discussed. Further, as Dr B believed Mrs A to be anxious (noting the lack of evidence for this), I would have expected him to demonstrate additional precaution to reassure his patient.

28. I accept the advice of Dr Bisson that this represented a moderate departure from the standard of care and am critical of the decision not to admit Mrs A to a hospital for further observation.

Follow-up care and management of infection

29. Mrs A attended Dr B's surgery for three follow-up appointments but did not attend her six-week post-surgical check as she had lost confidence in Dr B's care and was receiving treatment for the postoperative infection from her GP. Dr B has apologised for raising his voice and being abrupt. However, he caveats this by stating that he does not believe he presented this way and offered a nurse to provide testimony. While I cannot make a finding on what occurred during this consultation as I am reliant on two conflicting accounts and evidence is lacking, I do not consider that Dr B's statement of disbelief that he acted this way reflects acceptance of the concerns that led to Mrs A's loss of confidence in the care she had been receiving.

30. In addition, I am critical that, after Mrs A did not attend the six-week check, follow-up by Dr B's practice with Mrs A or her GP was very limited despite the known wound-healing problems and a postoperative complication. Dr Bisson advises that most clinicians would have processes in place to investigate a nonattendance in this situation and considered this to be a mild departure from accepted practice. I agree.

31. Mrs A raised her concerns about infection with Dr B several times, but the clinical notes do not indicate suspicion of infection during his consultations and refer to inflammation and a potential reaction to the sutures. I accept the advice of Dr Bisson that the prescription of flucloxacillin as a broad-spectrum antibiotic on 30 May 2022 was appropriate and that it may also have been appropriate not to prescribe antibiotics on the 15 June 2022 consultation.

32. Although it is not possible to know with certainty, I note that MRSA may have been present as a commensal bacterium that grew as the flucloxacillin killed other susceptible bacteria (MRSA is resistant to flucloxacillin) and returned a positive result from the swab taken on 21 June 2022. The alternative antibiotic, cefalexin, prescribed by Mrs A's GP is also ineffective against MRSA, and it was not until her wounds reopened on 1 July that Mrs A began a suitable course of antibiotics. This would have contributed to the delayed wound healing and caused additional distress to Mrs A.

Documentation

33. I am critical of Dr B's post-surgical documentation. Dr Bisson stated that 'the surgical operation note is brief and lacks detail,' which has limited his assessment of Dr B's surgical technique as he has not detailed the technical aspects of the closure of the wound, which may have had an impact on Mrs A's recovery.

34. Dr B has acknowledged that he did not dictate a separate operation note detailing how the haematoma was managed. Dr Bisson notes that it is standard practice to seek verbal consent in the context of an awake washout of haematoma; however, I note there is no documented evidence of what was discussed with Mrs A and what consent she gave. This is a particular concern given that Mrs A was still recovering from general anaesthesia and does not recall being given the option of transferring to another hospital.

35. Further, there is no contemporaneous documentation of the two post-discharge contacts Dr B had with Mrs A on the evening of 23 May 2022. Given Dr B's assertion that Mrs A was anxious and that a clinician treating a patient in a motel room is an unusual situation, I would have expected a clear recording of the visits to protect both the consumer and the practitioner.

Suture choice – other comment

36. Dr Bisson advised that the use of '2-0/3-0 Rapide' stitches represented a mild departure from the accepted standard of care, as they are fast dissolving and may not provide the required tensile strength for wound healing, although he mitigates this by acknowledging that choice of suture is up to the individual surgeon and notes that Dr B reports generally good outcomes. I accept Dr Bisson's advice in this respect, and I encourage Dr B to reflect on Dr Bisson's comments about the suitability of the sutures used.

Conclusion

37. For the reasons outlined above, I find Dr B in breach of Right 4(1) of the Code for his decision not to admit Mrs A to hospital for further observation, for his failure to follow up when she did not attend her six-week check, and for the standard of his documentation relating to Mrs A's post-surgical care.

Distribution

38. A copy of this report will be sent to the Medical Council of New Zealand.

39. A copy of this report with details identifying the parties removed, except the independent clinical advisor, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Vanessa Caldwell
Deputy Health & Disability Commissioner

Appendix A: Independent clinical advice to the Commissioner

The following independent advice was obtained from Dr Marcus Bisson, consultant plastic and reconstructive surgeon.

Independent clinical advice to Health and Disability Commissioner

Complaint:	**Mrs [A] /Dr [B]**
Our ref:	**C22HDC02484**
Independent advisor:	**Dr Marcus Bisson**

I have been asked to provide clinical advice to HDC on case number **C22HDC02484**. I have read and agree to follow HDC's Guidelines for Independent Advisors.

I am not aware of any personal or professional conflicts of interest with any of the parties involved in this complaint.

I am aware that my report should use simple and clear language and explain complex or technical medical terms.

Qualifications, training and experience relevant to the area of expertise involved:	BM, BS, FRCS(Plast), MD Consultant Plastic and Reconstructive Surgeon Vocationally Registered in Plastic and Reconstructive Surgery Mixed Public and Private Plastic Surgery Practice
Documents provided by HDC:	1. Letter of complaint dated 6 October 2022. 2. Dr [B]'s response dated 30 January 2023. 3. Clinical records from Dr [B] covering the period July 2021 to October 2022. 4. Clinical records from [the private surgical facility] covering the period 7 July 2021 to May 2022.
Referral instructions from HDC:	Dr [B] 1. Whether it was consistent with accepted practice to perform [Mrs A]'s surgery as a day-stay case. 2. Whether there was any obvious deficiency in the manner in which the initial surgery was undertaken. 3. Please comment on [Dr B]'s management of [Mrs A]'s postoperative bleeding, including the consenting process to re-exploration under local anaesthetic and the decision to discharge [Mrs A] to a motel the same day. 4. Please comment on the standard and appropriateness of [Mrs A]'s subsequent postoperative care, in particular whether wound swabbing or further antibiotic treatment was indicated at the review on 15 June 2022.

	5. Any additional comments regarding [Dr B]'s management of [Mrs A].

Factual summary of clinical care provided complaint:

Brief summary of clinical events:	The complaint raised is of circumstances surrounding the management of a postoperative haematoma after a breast reduction and the subsequent discharge to a motel. The level of care and ability to be safely managed is questioned. There is a concern regarding the assessment and management of postoperative wound breakdown and infection, and – finally – complaint about the final result The clinical notes indicate that, on Monday 23 May 2022, Mrs [A] underwent a bilateral breast reduction under general anaesthetic with local anaesthetic and adrenaline solution infiltration. The surgery was carried out by [Dr B] at [a private surgical facility], commencing at approximately 12.30pm. A brief operation note details the surgical technique and closure sutures. The patient was in recovery by 1.20pm, but 40 minutes later was noted to have acute swelling of the left breast. This was detailed in the recovery paperwork, being noted at 1.55pm. An acute postoperative bleed and haematoma was diagnosed, and this was evacuated in recovery under local anaesthetic with a bleeding vessel reported to be tied off. [Dr B]'s response stresses the perceived difficulties with returning the patient to theatre, highlighting that the patient had eaten and drunk, preventing a safe anaesthetic for six hours and that no anaesthetist or anaesthetic tech remained in the surgical centre. His view was that it was safe and appropriate to proceed with evacuation and washout in the recovery area, topping up the existing local anaesthetic cover with additional infiltration. The provider detailed communication to the patient and verbal consent. He appreciated there may have been a feeling of pressure during the procedure but did not believe this was painful. The complainant's perception was very different, and she states that she asked about general anaesthetic but was told this was not possible. She found the experience of awake drainage traumatic, with copious blood, and wondered if the conditions contributed to later infection. After this and a further period of time in the recovery unit, the patient was discharged to a motel, continuing to follow the original operative plan of day-case breast-reduction surgery. This occurred

	at around 4.30pm but by 6pm there were concerns regarding ongoing or further bleeding, and the patient returned to the clinic with dressings being changed and a report of further local anaesthetic infiltration with adrenaline to control bleeding. The provider's response details this review and the feeling that there was no ongoing active bleeding but leakage of blood-stained fluid. The patient felt there was ongoing bleeding. There are no clinical notes for this interaction. The patient returned to the motel. Further concerns were raised by the patient later that evening at 9pm, stimulating a motel visit by [Dr B]. Further dressings, reassurance and advice to discontinue OxyNorm analgesia were provided, given that the patient was feeling unwell with nausea and vomiting. There is no documentation of this review, but the provider's response indicates that he was not concerned regarding the safety of the patient or the level of bleeding and felt this was an expected discharge of blood-stained local anaesthetic infiltration fluid. The complainant's response indicates ongoing concerns regarding the level and extent of leakage and bleeding with contamination of dressings and motel sheets and towels. I cannot find documentation of a review the following day, but this was considered normal. One week after surgery, a wound check was carried out, with clinical records detailing that things were progressing as expected, but two days later the patient re-contacted the clinic with concerns. Photos were sent and a prescription for flucloxacillin antibiotics was sent. No notes are available regarding this. The provider's response indicated that he felt this empirical use of flucloxacillin was appropriate although there was no definite cellulitis. At the three-week check, planned for suture removal, the nursing notes describe areas of wound breakdown, especially on the vertical limb, and suture abscess formation on the left breast, with two spots on the right. [Dr B] noted a good result with a few small holes. The provider's response was that he felt there were areas of suture reaction that should settle after sutures had been removed, whereas the patient viewed these as areas of infection querying antibiotics. A further check two days later on 15 June was carried out as the patient was concerned regarding redness and inflammation and wound fragility on the left breast horizontal scar line. Ongoing reassurance and dressing advice with steroid ointment and

	request for photo update the following week. A comment stating no signs of infection or need for antibiotics is detailed in the clinical notes. The provider's response indicated he did not feel there was invasive infection, although the patient was distressed and the wound had opened. The complainant's view was that she had pus in her wounds with distressing opening of the left breast. She felt the provider to be abrupt and failed to listen to her concerns regarding infection and had travelled a long way to be reviewed given the level of concern. There is no further contact noted in the clinic record until an email on 14 July to the practice manager indicating ongoing intensive dressing with her GP and ongoing open wounds. GP records from 16 June indicate concerns regarding infection and discharge. I presume from subsequent notes that flucloxacillin was again prescribed. A wound swab result from 22 June and further GP notes indicated ongoing concerns re infection, wound breakdown, and purulent discharge. A change in antibiotics to cefalexin was carried out, and the wound swab showed MRSA. It is not clear if the MRSA was sensitive to cefalexin or if this was subsequently changed. No other clinical records are available to me from primary care, but the patient details multiple ongoing visits for dressing changes. The complainant's view is that she did indeed have ongoing infection and in fact had a delay to diagnosis of an MRSA infection with no wound swabs being taken. She felt poorly cared for and not listened to. The provider did not feel there was invasive infection present on their final clinical review on 15 June but noted that wounds are often slow to heal with MRSA colonisation or infection. There has been no direct provider review since this time. The complainant details a significantly delayed healing and a poor result. There is no clinical documentation of the result or postoperative photographs, and therefore it is not possible to comment except that the complainant perceives her scarring to be severe, with uneven breast size and nipple position. I am unable to comment further on this aspect.

Question 1: Whether it was consistent with accepted practice to perform [Mrs A]'s surgery as a day-stay case.	
List any sources of information reviewed other than the documents provided by HDC:	Kalus A. Breast reduction as a day case. Ambul Surg. 1996;4:35–39
Advisor's opinion:	This is not practiced in all areas and may not be commonplace in New Zealand except in certain practices; however, it is a well-documented and accepted practice in many areas of the world.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	There are no standards or recommendations I am aware of.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	No departure.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	Would be acceptable if appropriate safety netting and care pathways were in place.
Please outline any factors that may limit your assessment of the events.	None.
Recommendations for improvement that may help to prevent a similar occurrence in future.	Considering patient factors, such as anxiety, comorbidity and other risk factors meaning day-case surgery was more vulnerable.
Question 2: Whether there was any obvious deficiency in the manner in which the initial surgery was undertaken.	
List any sources of information reviewed other than the documents provided by HDC:	Documents provided only.
Advisor's opinion:	The surgical operation note is brief and lacks detail. The technique described of a superior-medial pedicle-

	wise pattern breast reduction is a standard approach and used widely in New Zealand and worldwide. However, the suture choice for closure, in my view, is atypical. While a 1 Vicryl for pillar closure is not unreasonable. 2/0 and 3/0 Rapide suggests the rest of the wound closure was done with fast-dissolving sutures and would not be a routine choice. In my opinion, these provide limited tensile strength for the required length of time, particularly if tension or swelling are present. This type of suture, if external and left in for the described 3 weeks, may also have propensity in my view to cause reaction and suture inflammation, as was seen here. The provider indicates he performs many breast-reduction surgeries but does not state whether he uses a standard technique and suture choice on all cases but indicates a low documented complication rate.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	At the time of the events, most surgeons would have chosen a layered closure of a longer-lasting suture, both intradermally and as a subcuticular closure for the skin. I accept some surgeons might consider using a thinner-gauge Vicryl Rapide for the nipple areolar inset.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	My opinion is that this would represent at least a mild departure from more widespread routine practice and is mitigated by the provider's assertion that results in general are good, with low complication rates, using this atypical choice of suture material.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	My peers would view the surgical approach and technique as routine standard of care, but the suture choice would not be viewed as routine practice. I have neither seen nor used this suture choice in multiple units I trained or practiced in across the world. This was confirmed by canvassing opinions of public hospital departmental peers.

Please outline any factors that may limit your assessment of the events.	Factors limiting the assessment are the brevity and lack of detail in the operation note itself, which – except for the pillar closure – does not describe where and in which layer of the tissues the sutures are used. The dressings are not detailed.
Recommendations for improvement that may help to prevent a similar occurrence in future.	My opinion is that an alternative suture closure choice would be appropriate. This could mitigate suture spitting and inflammation in future patients. While longer-lasting sutures do not prevent wound breakdown, which is a recognised complication risk in breast reduction, these may maintain tensile strength for longer than Vicryl Rapide in a swollen breast or with a tight closure, as in this case. An operation note that includes somewhat more detail may be valuable in understanding the manner in which the procedure has been undertaken.
Question 3: Please comment on [Dr B]'s management of [Mrs A]'s postoperative bleeding, including the consenting process to re-exploration under local anaesthetic and the decision to discharge [Mrs A] to a motel the same day.	
List any sources of information reviewed other than the documents provided by HDC:	None referred to
Advisor's opinion:	The complication of postoperative bleeding and a haematoma was identified in recovery in a timely fashion. With a rapid expanding haematoma and active bleeding, there is some priority to evacuate the blood and control the bleeding. As per the provider's response, this can compromise the closure and the blood supply to the nipple. The decision to proceed with this awake in recovery under local anaesthetic is challenging. The assertion that transfer to a different facility or public hospital for evacuation and haemorrhage control would have taken a lengthy period is true. In these circumstances, with an anaesthetised field, a limited washout may have been appropriate particularly in the "heat of the moment." However, in my view, with a rapid, expanding bleed in a patient whose original surgery was under general anaesthetic, the most effective and safest way to

	complete such surgery is also under a general anaesthetic. The provider does not comment that the patient requested a general anaesthetic, but this is the patient's assertion. I find it unusual that at 2pm on a Monday afternoon there was no anaesthetic staff available and that they had left for the day. I do not agree with the assertion that general anaesthesia would only be reluctantly considered if food and drink had been consumed within six hours. In the face of acute haemorrhage, while riskier, general anaesthetic can be considered for emergent situations. I also interpret from the recovery record that the patient had not eaten by the time the haematoma was diagnosed and had only tolerated water and an ice block, both counting as clear fluids and not needing adherence to the six-hour rule. This is inconsistent with the provider's response. Second, commenting on the consent process, in this set of circumstances with an urgent local anaesthetic washout, verbal consent may have been entirely appropriate as long as suitable discussion had been undertaken. The effectiveness of this can depend on the patient's level of recovery and cognition post anaesthesia. However, there is no adequate documentation of this, either in the contemporaneous notes provided or the operation note, which includes only a brief description of this happening and of a large bleeder being tied off. Finally, commenting on the decision to still discharge [Mrs A] to a motel the same day. My view is that this is an unusual decision and that having had an early acute bleed in an anxious patient with potential for ongoing oozing or recurrent bleeding, the safest approach would have been admission to a ward/hospital or facility for a higher level of nursing care and observation. It is not clear if this was even discussed as there are no notes on this. It is not clear if there are mitigating factors such as cost or patient or surgeon factors that drove this decision.

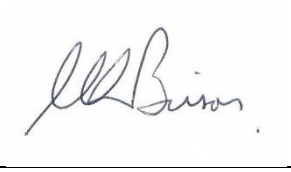
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	There are no standards; however, my view is that, in the circumstances of a significant rapid acute swelling, standard practice would have been a general anaesthetic evacuation and washout. Consent and a consent form would have been routine had a further general anaesthetic procedure been completed; however, in the situation of an awake local anaesthesia washout, verbal consent would not have been unusual although requiring discussion. Caution would normally dictate a longer period of observation and monitoring after an acute haematoma post breast reduction. Hospital admission would be accepted practice.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	Moderate departure from normal standards or accepted practice for management of an acute postoperative haematoma for breast reduction and for the decision to then discharge the patient to a motel. No departure from the standard of care for verbal consent.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	Normal practice would be general anaesthetic evacuation, washout, and control of haemorrhage followed by admission for observation.
Please outline any factors that may limit your assessment of the events.	Mitigating factors such as the pressure of the initial situation and the perceived difficulties in organising and expediting a further general anaesthetic procedure. Also, the technical possibility, given good anaesthesia, to wash out the breast while awake under local anaesthesia, clearly at the time made it feel like an appropriate management pathway. There may be unclear drivers in the circumstances that pushed continued same-day discharge to a motel after the haematoma. Costs, patient, convenience, facilities, and surgeon factors can all play into this decision-making and judgement.
Recommendations for improvement that may help to prevent a similar occurrence in future.	Clear policies about management of postoperative haematomas or bleeding would be valuable. These should include the circumstances and capacity to call back anaesthetic staff in an urgent situation, which

	should be a duty of care for management of a post general anaesthetic patient, especially within an hour of surgery. Further consideration should be given to day-case surgery such as this and flexibility to change a plan or seek support or a higher level of care if patient factors dictate or if an early complication is evident. A policy or guideline about when to admit such a patient and how this will be completed if a different private hospital is required, should be clear.
Question 4: Please comment on the standard and appropriateness of [Mrs A]'s subsequent postoperative care, in particular whether wound swabbing or further antibiotic treatment was indicated at the review of 15 June 2022.	
List any sources of information reviewed other than the documents provided by HDC:	Only documents provided by HDC.
Advisor's opinion:	The ongoing standard of postoperative care was adequate for the visits that were undertaken. The initial empiric prescription of flucloxacillin would have been a standard and common response if photos were sent. There was clearly wound inflammation and breakdown that was then noted at subsequent visits at the three-week mark for removal of sutures and then at the point two days later on 15 June. This is a recognised risk/complication of breast-reduction surgery and would have been a higher risk in the setting of a postoperative haematoma and swelling. Antibiotics are not indicated for all wound breakdown circumstances and should generally be reserved for evidence of invasive infection. The photos provided in the documents from 15 June do not clearly show any spreading redness or cellulitis. I would also not necessarily have commenced antibiotics. In terms of whether a wound swab was indicated, this is a difficult question to give a definitive answer to. Many practitioners would have swabbed the wound but not have commenced antibiotics. Open wounds such as this are nearly always colonised by bacteria. A wound swab can guide antibiotic usage if infection then develops. MRSA may not have been diagnosed at this time. A further course of flucloxacillin was

	subsequently prescribed in primary care, which could also have selected out a resistant strain of *Staphylococcus aureus* such that the MRSA was then present on the wound swab from 22 June. The GP had changed antibiotics to cephalexin; however, MRSA is often resistant to this, and I have no notes detailing a change to a different antibiotic at any time. Ongoing discharge can be fat necrosis and liquifying haematoma as well as frankly infected purulent material. I cannot make a determination based on the photos. Regular and intensive dressing as were then done in primary care are fully appropriate for such issues and typically take an extended period to heal with wound breakdown such as that seen here.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	Regular wound dressing and nursing care would be the accepted standard of care. Wound swabs may have been undertaken but antibiotics would not necessarily have been commenced based on the photos I can see from 15 June.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	No departure.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	Consistent with most practice. Many practitioners might consider wound swab.
Please outline any factors that may limit your assessment of the events.	None
Recommendations for improvement that may help to prevent a similar occurrence in future.	None except more careful consideration in an open wound if a wound swab would be valuable to guide antibiotic choice in the face of deterioration.

Question 5: Any additional comments regarding [Dr B]'s management of [Mrs A].	
List any sources of information reviewed other than the documents provided by HDC:	None.
Advisor's opinion:	[Dr B] and [Mrs A]'s perceptions of the clinical events surrounding the haematoma and subsequent care with wound breakdown are clearly disparate. I believe that [Dr B] did make decisions that he believed were in the best interests of the patient in terms of the decision to wash out the haematoma but perhaps did not recognise the level of anxiety and stress this would and did cause. The decision to continue discharge planning as a day case to an unsupported motel environment compounded this, where the patient felt unsupported despite further reviews later that day in the clinic and then at the motel itself. This could all have been mitigated if admission was undertaken. Subsequent wound breakdown was managed in a mixed fashion with returns to the clinic and subsequent primary care management, which became the patient's preferred strategy. This is particularly given the distance from the surgical clinic and the seeming loss of confidence [Mrs A] developed in the provider's care. It is notable that, despite knowing there were wound-healing problems and an initial postoperative complication, there was still not recognition in the clinic or documentation that the patient had not attended for further follow-up and that attempts were not made to contact her or the GP.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	Most clinicians would have processes in place to confirm follow-up and investigate a non-attendance, especially when there is a known adverse event and healing issues.
Was there a departure from the standard of care or accepted practice? • No departure;	Mild departure.

• Mild departure; • Moderate departure; or • Severe departure.	
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	Careful and diligent follow-up of patients with complications is the norm, or assistance in referral to another practitioner if the patient prefers or has lost confidence in the provider.
Please outline any factors that may limit your assessment of the events.	None.
Recommendations for improvement that may help to prevent a similar occurrence in future.	Documentation and practice alerts for important patients missing follow-up.

By signing this report, I agree to HDC correcting any formatting, spelling, or grammar issues on the proviso that the substance of the report and any quoted material remains unchanged.
Signature: 
Name: Dr Marcus Bisson
Date of Advice: 31 May 2025

Further response to [Dr B]'s comments and further feedback

Ref: 22HDC02484
Response to investigation for [Mrs A] with further information and reply

I have read and reflected upon [Dr B]'s response to the review. I have the following comments.

1) The response from [Dr B] highlights the difficult circumstances any surgeon would find themselves in when faced with an early postoperative complication that clearly requires further intervention to remedy, and in this case halt bleeding and manage a haematoma. Mitigating factors are the difficulties in transfer to another facility and the time this might take to allow further surgical intervention. I can see a circumstance where, in the face of adequate local anaesthetic field cover, the wounds could be opened in recovery as initial urgent management. However, as in this case, this could be difficult in an anxious or distressed patient and lead to a negative experience and poor perception of a procedure intended to expedite best care.

It is reassuring to understand that [Dr B] has subsequently involved early anaesthetist call back and involvement, should a similar situation arise, and support for the patient and surgeon in such a way can only be of value. A shared decision about the best way forward for managing a problem would always be considered best practice.

My view is that I would still not have considered discharge after such an episode and would have found a way of admitting the patient for observation, wherever was appropriate. [Dr B] reports he has also considered this in subsequent patients and has changed practice for those who are anxious or have limited support.

2) Documentation practices have been improved subsequent to this episode, which will support the patient and protect the surgeon.
3) I am in full agreement that suture choice is an individual surgeon's personal preference. I still remain unsure as to the type of closure undertaken and if this has been layered as would be standard practice in all units I have worked and trained in. [Dr B] has not detailed these technical aspects of the closure. [Dr B]'s assertion of good general results can be taken at face value, and indeed patients can react to any suture material; however, I do not share [Dr B]'s assertions regarding more problems with a monofilament closure.
4) I agree with [Dr B] that it can be very difficult to contact and encourage some patients to return to the practice for further reviews if they are not motivated to do so. I am reassured that there has been a process change to proactively make contact, especially in patients recognised to have a more difficult recovery. This is a positive outcome. In the cohort where no contact is possible but a problem has been identified, careful documentation and contact with the GP is a way of

supporting a patient, even in the event of a loss of confidence in the therapeutic relationship and demonstrates ongoing appropriate action from the provider to try and resolve issues or provide alternative avenues of help.

Overall, my conclusions in the initial response remain similar.

I find mild departures in points 3 and 4 but am encouraged by changes in practice that will improve ongoing or future care.

Point 1 is difficult as there are likely to be significant circumstantial reasons why events unfolded in the way they did. The patient and surgeon expectations of day-case surgery and perhaps a feeling of pressure to continue this plan may have blinkered all to the alternatives. The changes in subsequent practice detailed in [Dr B]'s reply again reflect a positive change.

A moderate to mild departure at the time of the events has been mitigated by subsequent reflection and changes in practice.

Dr Marcus Bisson

2 April 2026