Obstetric Consultant, Dr B

District Health Board

Midwife, RM C

A Report by the

Deputy Health and Disability Commissioner

(Case 16HDC00911)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Table of contents

Executive summary

1. In 2016, at approximately 9am, Mrs A arrived at the delivery unit at a public hospital in established labour at term. Mrs A was cared for by her midwife lead maternity carer, RM C.

2. At 1.20pm, owing to a lack of progress, maternal tiring, and fetal distress in the second stage, Dr E, a registrar, recommended an instrumental delivery. The obstetric consultant, Dr B, agreed with the recommendation. Dr E documented that at 2pm, after performing a pudendal block[1] and an episiotomy,[2] Dr B carried out a ventouse extraction. It took three pulls to deliver the head, and there was moderate shoulder dystocia.

Repair of tear

3. Immediately following the delivery, Dr B left the room to attend to another patient. Dr E remained in the room and began to repair the tear. Dr E queried the tear as being a fourth-degree tear[3] and discussed her concerns with a senior registrar, Dr D. Dr D then examined Mrs A, decided that the tear was second degree[4] only, and began repairing the tear. Dr D cannot recall whether she had closed the vaginal mucosa in its entirety when she became concerned that "the tear to the skin possibly involved the anal mucosa". Dr D said that she left the room and discussed her concerns with Dr B, and then left the repair as she had to go to theatre to attend to another patient.

4. Dr B documented that she examined Mrs A in the lithotomy position and repaired the episiotomy tear. Dr B recorded that the tear was to the anal margin but did not involve the sphincter, and that the per rectum examination post-suturing was normal with no sutures felt.

Postnatal care

5. On 10 Month1,[5] day one post-partum, RM C visited Mrs A and documented that Mrs A had not opened her bowels, and that her perineum was "normal" but tender. RM C did not view Mrs A's perineum.

6. RM C visited Mrs A and her baby in NICU on 12 Month1. Mrs A told HDC that she advised RM C that she had faecal discharge at the front of her underwear. RM C told HDC that she carried out a verbal assessment, and that there were no indications for her to undertake a physical examination. She stated that she considered the minor faecal leakage reported by Mrs A to be normal in the immediate postnatal period and she did not consider that a physical examination was indicated at that time.

7. On 15 Month1, at six days post-partum, RM C carried out a third postnatal visit at NICU. Mrs A told HDC that again she reported faecal discharge on the front of her underwear.

[1] Local anaesthesia used to provide analgesia to the vulva and anus during a vaginal birth and any subsequent repair that may be required.
[2] A surgical cut made at the opening of the vagina during childbirth, to aid a difficult delivery and prevent rupture of tissues.
[3] A fourth-degree tear involves injury to the perineum including the anal sphincter complex and anorectal mucosa.
[4] A second-degree tear involves injury to the perineum including the perineal muscles but not involving the anal sphincter.
[5] The relevant month is referred to as Month1 to protect privacy.

However, RM C told HDC that Mrs A did not report any faecal leakage on that occasion, but did report loose bowel motions.

8. On 19 Month1, at 10 days post-partum, another midwife, RM F, visited Mrs A and documented that Mrs A reported that the "perineal pain" was improving and that "no physical concerns were voiced". RM F recorded that Mrs A reported that her bowels and perineum were normal.

9. RM C carried out another postnatal visit on 25 Month1, at 16 days post-partum. Mrs A reported pain and faecal discharge, and RM C examined Mrs A's perineum. RM C documented that Mrs A had had light faecal leakage after bowel motions for the past 10 days. RM C queried an infected perineum and requested an obstetric registrar review.

Findings

10. Criticism was made that, considering the concerns raised by two registrars, Dr B, as a consultant, did not identify that the tear was more significant. Accordingly, Dr B did not provide Mrs A with an appropriate standard of care and breached Right 4(1) of the Code.

11. It was accepted that the policies that applied to the care provided by Dr B to Mrs A were adequate, and that the district health board (DHB) had taken reasonably practicable steps to prevent the error from occurring. Accordingly, the DHB was found not to be vicariously liable for Dr B's breach of the Code.

12. It was found that RM C's failure to carry out a visual perineal examination prior to 25 Month1 was unacceptable. Accordingly, RM C did not provide Mrs A with an appropriate standard of care and breached Right 4(1) of the Code.

Recommendations

13. It was recommended that RM C provide a written apology to Mrs A, and provide evidence to HDC confirming attendance or enrolment at a course relating to perineal tears.

14. It was recommended that Dr B provide a written apology to Mrs A. It was also recommended that Dr B audit the outcome of deliveries in which she has been involved over the previous three months, and provide HDC with a copy of the audit report.

15. It was recommended that the Midwifery Council of New Zealand consider undertaking a review of RM C's competence.

16. It was recommended that the Medical Council of New Zealand review this report, as proposed in its letter of 27 February 2018 to Dr B.

Complaint and investigation

17. The Commissioner received a complaint from Mrs A about the services provided at the DHB. The following issues were identified for investigation:

- *Whether the DHB provided Mrs A with an appropriate standard of care in 2016.*
- *Whether Dr B provided Mrs A with an appropriate standard of care in 2016.*
- *Whether RM C provided Mrs A with an appropriate standard of care in 2016.*

18. This report is the opinion of Rose Wall, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

19. The parties directly involved in the investigation were:

Mrs A	Consumer
Dr B	Obstetric consultant
RM C	Lead Maternity Carer/registered midwife
The district health board	

Also mentioned in this report:

RM F	Midwife
Dr G	Obstetric consultant

20. Information was also reviewed from:

Dr D	Registrar
Dr E	Registrar
ACC	

21. Independent expert advice was obtained from an obstetric consultant, Dr Sornalatha Vasan (**Appendix A**), and a registered midwife (RM), Alison Andrews (**Appendix B**).

Information gathered during investigation

Background

22. In 2015, Mrs A, aged 31 years at the time of events, approached a maternity service for assistance with her second pregnancy. Mrs A's first child had been born by Caesarean section. She stated that the Caesarean section had been necessary because of the "failure to progress at 7cm" and because the umbilical cord had been wrapped around her baby's arm.

23. Mrs A engaged a community-based registered midwife, RM C, as her Lead Maternity Carer (LMC). RM C referred Mrs A to a clinic at the DHB for an antenatal discussion of the delivery options available to her. RM C documented Mrs A's expected due date.

24. Mrs A was reviewed at the public hospital at 22 weeks and 4 days' gestation and again at 36 weeks and 4 days' gestation. Following these consultations, it was decided that a trial of a vaginal birth was reasonable.

25. RM C and Mrs A completed a birth plan, which included Mrs A having a vaginal birth with the option of transferring to hospital for an epidural[6] if required. RM C provided HDC with a copy of a birthplan document, which had been given to Mrs A.

Delivery

26. At approximately 9am, two days past her expected due date, Mrs A arrived at the delivery unit at the public hospital in established labour with a cervical dilation of 7cm. A cardiotocograph (CTG) showed a normal fetal heart rate (FHR), and an intravenous infusion was instigated. At 10am, RM C documented that she had discussed the findings with Mrs A. RM C recorded the treatment plan as: "[N]otify team of patient — continue CTG."

27. At 10.40am, Mrs A was reviewed by an obstetrics and gynaecology registrar, Dr D, who documented that Mrs A was expected to be "fully dilated by 12.30pm".

28. At 11am, RM C assessed Mrs A and recorded her observations. At this time, Mrs A requested an epidural, but an anaesthetist was not available immediately and so an epidural could not be administered. At 11.30am, RM C documented that Mrs A was "getting distressed" and that Entonox (an analgesic) was provided.

29. At 11.39am, a hospital midwife took over the care of Mrs A to give RM C a meal break. The midwife commenced a CTG to check the fetal heart rate. She documented: "Reassuring — Baseline 130bpm Accelerations present, variability between 6–25bpm."

30. At approximately 12.15pm, Mrs A "experienced a desire to push", and a vaginal examination was carried out. It is documented that cervical dilation was at 9cm, and that the FHR had decelerated to 60bpm. RM C was called back to the room.

31. At 12.25pm, Mrs A was reviewed by the DHB Charge Midwife, who confirmed that FHR "variable decelerations were occurring, but with quick recovery to a baseline of 130bpm and rate variability of 3 to 5 bpm". At 12.30pm, Mrs A was fully dilated. Registrar Dr E reviewed Mrs A and a decision was made to allow pushing for 20 minutes. The DHB told HDC that at the time of events, Dr E was a junior registrar.

32. At 1pm, staff documented: "Pushing with nil visible progress." At 1.10pm, Mrs A was reviewed by obstetric consultant Dr B and Dr E. Full dilation was confirmed, along with "descent of the fetal head to station +1cm between contractions and +2cm with pushing during contractions". Further pushing was encouraged.

33. At 1.20pm, owing to maternal tiring, fetal distress, and no further progress, an instrumental birth was recommended by Dr E, and Dr B[7] agreed with the recommendation. Dr B

[6] An injection of local anaesthetic into the spinal region of the lower back to produce loss of sensation, especially in the abdomen or pelvic region.

[7] Dr B has held a vocational scope of practice in obstetrics and gynaecology with the Medical Council of New Zealand since 2011 and has been a fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) since 2011.

documented that Mrs A consented to this verbally. However, Mrs A told HDC: "I did not have adequate information to consent to having instrumental — ventouse delivery."

34. Dr B told HDC:

> "My routine practice is to obtain verbal consent for instrumental delivery, and while I cannot remember the details of the consent process with [Mrs A], I would always explain that instrumental delivery involves either the use of a metal (ventouse) cup on the fetal head or the use of Neville-Barnes forceps."

35. Dr B stated that she would "routinely outline the risks including: the possible need for episiotomy and repair of the perineal tear, bruising of the baby's head, and in the case of ventouse, bleeding under the scalp".

36. RM C documented that Baby A was born at 1.41pm weighing 3,180 grams. At one minute and nine seconds, Baby A had an APGAR score[8] of 6 and, at five minutes, a score of nine.

37. At 2pm, Dr E documented that the ventouse birth had been conducted successfully by Dr B following appropriate positioning and preparation, and that it had taken three pulls. Dr E recorded that the "McRoberts Manoeuvre"[9] had been utilised for shoulder dystocia,[10] and that Mrs A had been given a pudendal block[11] and an episiotomy.[12] Dr B left the room immediately following the delivery to attend to another patient, and Dr E remained in the room.

38. Dr B told HDC that no excessive force was used, and that, as a safeguard, if excessive force is used with ventouse instruments they are designed to detach, and this did not occur.

Identification and repair of tear

39. Following the delivery, Dr E delivered the placenta, provided Mrs A with local anaesthetic, and began to repair a perineal tear. Dr E told HDC:

> "I infiltrated the perineum with local anaesthetic and started with a few sutures, but stopped because the tear was felt to be complicated. The anal tone felt poor and I was able to insert [three] digits into the anal canal. Given these findings, I called the delivery suite registrar, [Dr D] to assess the tear."

40. Dr E documented in Mrs A's clinical notes that she queried the tear as being a fourth-degree tear.

[8] An index used to evaluate the condition of a newborn infant based on a rating of 0, 1, or 2 for each of the five characteristics of colour, heart rate, response to stimulation of the sole of the foot, muscle tone, and respiration, with 10 being a perfect score.
[9] An obstetric manoeuver used in childbirth.
[10] Shoulder dystocia is when the baby's head has been born but one of the shoulders becomes stuck behind the mother's pubic bone, delaying the birth of the baby's body. It is diagnosed when the shoulders fail to deliver shortly after the head. Shoulder dystocia is an obstetric emergency.
[11] Local anaesthesia used to provide analgesia to the vulva and anus during a vaginal birth and any subsequent repair that may be required.
[12] A surgical cut made at the opening of the vagina during childbirth, to aid a difficult delivery and prevent rupture of tissues.

41. At the time of events, Dr D had seven years' experience as an obstetric and gynaecology registrar. Dr D told HDC that Dr E discussed her concerns that Mrs A's tear was a fourth-degree tear.[13] Dr D told HDC that she examined Mrs A and considered that it was not a fourth-degree tear, so she decided to repair the tear herself. She redirected Dr E to a task outside of the delivery room, as the delivery suite was busy.

42. Dr D told HDC that her initial assessment of the tear was that it was a second-degree tear, and she began repairing the tear by identifying the vaginal apex of the tear and closing the vaginal mucosa. Dr D cannot recall whether she had closed the vaginal mucosa in its entirety when she became concerned that "the tear to the skin possibly involved the anal mucosa". Dr D said that she left the room and discussed her concerns with Dr B, and then left the repair as she had to go to theatre to attend to another patient.

43. Dr D advised HDC that having assessed the anal tone, she did not believe the tear to be a third- or fourth-degree tear, but rather wanted to ensure that the repair was anatomically correct. Dr D said that she was not present in the delivery room when Dr B carried out the repair. Dr D did not document any of her actions in the clinical notes.

44. Dr B documented in the clinical notes that she was "called for suturing as DU reg called away", and advised HDC that "it was not the difficulty of the repair, but the fact that [Dr D] was needed elsewhere, that meant I was asked to complete the repair". Dr B also told the DHB: "The registrars asked for my assistance due to the complex nature of the vaginal tear. I asked [Dr D] to attend to other emergencies in the delivery unit when she called for my assistance."

45. Dr B documented that she examined Mrs A in the lithotomy position and repaired the episiotomy tear. Dr B recorded that the tear was to the anal margin but did not involve the sphincter, and that the per rectum examination post-suturing was normal with no sutures felt.

46. Dr B told HDC:

> "Ideally, I would have preferred to have assessed and repaired [Mrs A's] tear in theatre with regional or general anaesthesia, however this option was not available due to unavailability of theatre(s)."

47. Dr B recorded that Mrs A could be transferred to a postnatal facility. Mrs A was discharged to the care of her LMC, RM C, for postnatal care.

Communication between Dr B and Dr E

48. Mrs A told HDC that Dr B was speaking inappropriately to her registrar, Dr E. Mrs A said that Dr B did not give her team the chance to speak up. In a later meeting between the DHB and Mrs A, the DHB told Mrs A that Dr E left the room crying, as there was a "communication issue" between Dr B and Dr E, which has since been resolved. RM C, who

[13] A first-degree tear involves injury to perineal skin and/or vaginal mucosa. A second-degree tear involves injury to the perineum involving perineal muscles but not involving the anal sphincter. A third-degree tear involves injury to the perineum involving the anal sphincter complex. A fourth-degree tear involves injury to perineum involving the anal sphincter complex and anorectal mucosa.

was in the room at the time, told HDC that Dr B told Dr E to stop looking so "scared about an instrumental birth" and told her to "look happier".

49. Dr B stated:

> "I acknowledge that communication between [Dr E] and I could have been better … On a personal level, as soon as I was made aware of [Dr E's] reaction to the events in the delivery room, I approached her and apologised for the distress caused to her."

50. Dr B told HDC:

> "Since the issue of my communication on this day with [Dr E] was raised, I attended a Senior Medical Officer meeting … which included a workshop on the issue of bullying, in which I participated, and education about [the values of the DHB]."

Postnatal care

51. On 10 Month1, day one post-partum, RM C visited Mrs A and documented that Mrs A had not opened her bowels, and that her perineum was "normal" but tender. RM C did not view the perineum.

52. On 12 Month1 (three days post-partum), Baby A became unwell and was transferred to the Neonatal Intensive Care Unit (NICU) for subsequent care. The DHB told HDC: "Initial postnatal recovery seemed uneventful, though the baby required intensive care because of development of Group B streptococcal meningitis."

53. RM C visited Mrs A and her baby in NICU on 12 Month1. Mrs A told HDC that she advised RM C that she had faecal discharge at the front of her underwear, but RM C did not ask her any questions relating to her symptoms or perform a "clinical" examination.

54. RM C told HDC that she carried out a verbal assessment, and that there were no indications for her to undertake a physical examination. She stated that she considered the minor faecal leakage reported by Mrs A to be normal in the immediate postnatal period, and she did not consider that a physical examination was indicated at that time.

55. RM C stated: "If she had reported heavier faecal leakage, then I would have done a physical examination and checked her pad." The detail of this assessment was not documented, and RM C acknowledged that her documentation of the 12 Month1 postnatal visit was inadequate.

56. On 15 Month1, at six days post-partum, RM C carried out a third postnatal visit at NICU. Mrs A told HDC that again she reported faecal discharge on the front of her underwear, and again RM C did not ask her about her symptoms or examine her. However, RM C told HDC that Mrs A did not report any faecal leakage on that occasion, but did report loose bowel motions.

57. RM C stated that she considered the loose bowel motions to be the result of the analgesics Mrs A was taking, and said that she would have come to this conclusion following her assessment of Mrs A. RM C documented that Mrs A was having loose bowel motions that were likely secondary to nonsteroidal anti-inflammatory drugs (often used to treat pain and

inflammation caused by injury). RM C did not view Mrs A's perineum but did document: "[P]erineum more comfortable today."

58. On 19 Month1, at 10 days post-partum, another midwife, RM F, visited Mrs A and documented that Mrs A reported that the "perineal pain" was improving and that "no physical concerns were voiced". RM F recorded that Mrs A reported that her bowels and perineum were normal.

59. The following day, RM F visited Mrs A in NICU as a support person at a family meeting concerning "non reassuring MRI findings" in relation to Mrs A's baby. No postnatal assessment was carried out.

60. RM C carried out another postnatal visit on 25 Month1, at 16 days post-partum. Mrs A reported pain and faecal discharge, and RM C examined Mrs A's perineum. RM C documented:

> "[I]nfected perineum ?fistula forming. Episiotomy. Has had light faecal leakage post bowel motions for past 10 days. Viewed by [LMC] at parent rooms (NICU). Very sore and lots of pus/inflammation."

Re-admission to the public hospital

61. RM C requested an obstetric registrar review, and Mrs A was readmitted to the public hospital.

62. Mrs A was reviewed by an obstetric consultant who identified that the perineal body was absent, the external anal sphincter was not intact, and that there was an ano-vaginal fistula of approximately 1cm. The consultant documented that there might be "a short length of intact internal sphincter higher in the anal canal as the anal tone did not feel completely absent".

63. On 26 Month1, the colorectal team at the DHB recommended a defunctioning colostomy,[14] and advised that it would need to remain for at least three to four months. The surgery was performed on 28 Month1 by a colorectal surgeon. Examination prior to the colostomy revealed "an almost finger sized defect between the posterior vaginal wall and the lower rectum and anus" and loss of anterior anal sphincter muscle.

64. No issues were identified with the care provided following the identification of the ano-vaginal fistula.

Further information

Consent to carry out ventouse extraction

65. At a meeting held at the DHB with Mrs A, Mrs A's husband, RM C and another LMC support person, and the DHB staff including Dr B, Dr E, and Dr D, Mrs A said that she felt that she had not been given a choice about the mode of birth, and that given the choice she likely would not have chosen to have a ventouse extraction. Mrs A was advised that the day of Baby A's birth was a very busy day, and the obstetricians were prioritising patients

[14] A surgical procedure that brings one end of the large intestine out through the abdominal wall. During the procedure, one end of the colon is diverted through an incision in the abdominal wall to create a stoma (an opening in the skin where a pouch for collecting faeces is attached).

according to need; they knew Mrs A's history of a previous Caesarean section, and were mindful of that during the assessment for her suitability for a ventouse delivery.

66. Mrs A was informed that ventouse was deemed to be the appropriate method of delivery because, although the head was delivered successfully, the baby's shoulders were stuck, so an episiotomy was performed and a technique called McRoberts (a method of opening up the pelvis to deliver the shoulders) was used to assist the baby out. Mrs A was told that often a ventouse is the preferred option because it is the least invasive method for both the mother and baby — it does not cause birth canal trauma as it does not come into contact with the mother's birth canal, and there is a safety mechanism for the baby in that if too much force is applied, or if it is on the wrong angle, then the cup comes off automatically.

67. Mrs A was further advised that an instrumental birth was deemed more appropriate than a Caesarean birth because potentially a Caesarean section in the second stage of labour (after the cervix is fully dilated) can be more traumatic because the baby has already descended into the birth canal, and pulling it back up the canal for a Caesarean section can cause more trauma for the baby and more bleeding for the mother.

Management of perineal trauma

68. The DHB policy in place at the time of events, "Perineal tears, third and fourth degree", states:

> "Up to 30% of 3rd/4th degree tears go unrecognised at delivery. All skin tears that extend to the anal margin are 3rd degree tears until proven otherwise by the charge midwife. If in doubt examine in lithotomy and do a rectal exam to ascertain the extent.
>
> - Repairs should be performed by/under supervision of a consultant or senior registrar.
>
> - All repairs must be conducted in the operating room where there is access to good lighting, appropriate equipment and aseptic conditions."

69. The DHB told HDC that Dr B performed an examination with Mrs A in the lithotomy position, and "the fact that the perineal damage was assessed as a second degree tear only, did not trigger the need for transfer of [Mrs A] to the operating theatre".

70. The DHB stated:

> "The skills required to assess and repair perineal trauma, including 3rd and 4th degree tears are considered core competencies for all obstetricians practicing obstetrics. As outlined in the job description, an essential qualification required for all Obstetric Consultant roles is that they are [Royal Australian and New Zealand College of Obstetricians and Gynaecologists] (or equivalent) qualified and that they are registered as specialists in [New Zealand]."

71. The DHB said that it does not have a requirement for obstetricians to complete the Obstetric Anal Sphincter Injury Workshop (OASIS) training, but that the training is an option available to obstetricians at the DHB. In a Rapid Multidisciplinary Morbidity review of this event carried out in August 2016, the DHB noted that the clinical leader would follow up with Dr B on when she last attended an OASIS workshop. The review also noted that the

clinical repair form had not been completed by Dr B, and recommended that the repair form be amended to state clearly that it is to be completed by the person who performs the repair.

72. Dr B submitted:

> "The literature shows that up to a third of all women will sustain an unrecognised anal sphincter injury after their first vaginal birth (see below), with respect I do not agree that it is reasonable to find that it is a serious deviation to have missed the sphincter injury."

73. Dr B also submitted a clinical opinion provided by an obstetric consultant, Dr G. Dr G stated:

> "[Mrs A] was examined in the lithotomy position. Both rectal examinations ([Dr D] and [Dr B]) revealed normal anal tone and no defect in the rectal mucosa. With this information I am unsure what the indication for taking [Mrs A] to theatre would have been."

74. Dr G further advised:

> "This has been a tragic outcome for [Mrs A] but whether this is a result of [Dr B] showing a serious deviation from accepted practice is debatable. A senior registrar felt that this was a second (degree) tear as did [Dr B] … She, and a senior registrar, both performed rectal examinations, which did not detect sphincter damage or a rectal mucosa defect."

75. Dr B also told HDC:

> "After a difficult instrumental delivery, my preference would have been for [Mrs A] to be admitted to the postnatal ward for observation. However due to a shortage of available postnatal beds at the public hospital, [Mrs A] was discharged to a [primary postnatal facility] under the care of her self-employed midwife lead maternity carer (LMC)."

Changes to practice

76. Dr B told HDC that she completed the public hospital's PROMPT (Practical Obstetric Multi-Professional Training) course. The course provides training in obstetric emergencies, and improves knowledge, clinical skills, and team work. Dr B also enrolled in, and completed, an OASIS (obstetric anal sphincter injury) workshop. Dr B said that she had completed the course previously during her specialist training.

77. Dr B also said that this was her first shift at the DHB. She stated:

> "With time, I have become more familiar with the processes at [the DHB], and I have strategies to manage periods where there is heavy workload. In the Women's Health Directorate within the past year, policies have been developed to clarify escalation processes when a second acute theatre is required and when there is a bed shortage.
>
> I have continued to participate in the Delivery Unit consultant on-call roster at the public hospital, including supervising and performing instrumental deliveries and

perineal tear repairs. To my knowledge, there have not been any complications arising from any of the deliveries."

78. RM C stated:

> "In hindsight I absolutely wish I had inspected [Mrs A's] perineum and I will apologise to her for not doing so. However, I can honestly say that warning bells were not triggered for me at that time as being abnormal for the following reasons:
>
> - A diagnosis of a second-degree tear at delivery
> - My lack of clinical experience of anal-vaginal fistula which I understand to also be very rare in maternity care in developed countries
> - Further non-reporting of symptoms from [Mrs A] likely attributable to her caring for her sick baby."

79. RM C further stated that she has learnt "so much from this case" and that she is "devastated at the outcome for [Mrs A]". RM C has completed a documentation study day and intends to enrol in a perineal repair course. RM C said that, with the woman's consent, she will now inspect all perineums that have undergone trauma, and will undertake a thorough visual inspection whenever faecal matter on a pad is reported.

Responses to provisional opinion

80. Mrs A was provided with an opportunity to respond to the "information gathered" section of the provisional opinion. She outlined her concerns about the care, attention, and level of support provided to her.

81. Dr B was provided with an opportunity to respond to the relevant sections of the provisional opinion. She made submissions and provided copies of reference letters and other correspondence with the Medical Council of New Zealand, which have been considered carefully. The Council had considered concerns received from HDC in February 2018 and resolved to take no further action at that time. However, the Council encouraged Dr B to attend an OASIS course in March 2018, and advised that it would review the final HDC report to see if any new concerns had been raised.

82. Dr B submitted that the evidence does not support a conclusion that she failed to recognise a fourth-degree tear. In her submissions, Dr B advised that she does not believe that she failed to recognise a third- or fourth-degree tear, and said that a recto-vaginal fistula may occur in the recto-vaginal septum in the absence of a fourth-degree tear. Dr B advised that the ano-vaginal fistula was not identified until Mrs A was assessed by a doctor 16 days postpartum, and that infection may have caused the breakdown of the episiotomy wound.

83. Dr B provided a submission from an obstetric consultant, the admitting doctor following RM C's referral. The consultant advised that her "opinion was (and still is) that the most likely cause of this patient's severe injury was an untreated infection of a second degree perineal laceration, rather than an undiagnosed third degree tear". Although Dr B agrees that damage to the sphincter could have occurred at the time of delivery, she stated that it is important to note that there was a 16-day delay between the delivery and referral to medical staff. Dr B resubmitted the advice she obtained from Dr G, who stated: "[O]n the basis of

probability it is likely that the sphincter was damaged at the time of delivery. The time frame of faecal incontinence appearing so quickly after delivery makes it unlikely that infection resulted in the fistula or the disruption of the sphincter."

84. Dr B noted that Dr G further advised: "I would disagree that [Dr B] seriously deviated from acceptable practice. Although it became evident that a fourth degree tear had occurred, in my opinion [Dr B] made a reasonable effort to rule that out at the time of suturing the tear."

85. The DHB was provided with an opportunity to respond to the relevant sections of the provisional opinion. The DHB told HDC: "[The DHB] is committed to a culture of excellence and on-going quality improvement. We believe that we do have robust systems to monitor quality and safety, and will undertake to consider any further improvement work that can be done in this area."

86. RM C was provided an opportunity to respond to the relevant sections of the provisional opinion. She stated that she accepts the opinion and the recommendations.

Opinion: Dr B — breach

Method of delivery

87. Expert advice was obtained from an obstetric consultant, Dr Sornalatha Vasan. Dr Vasan advised HDC that the decision to perform a ventouse delivery was appropriate in the circumstances. She further advised that usually ventouse delivery is less painful than forceps delivery, and that the pudendal block is "an accepted practice for Ventouse delivery to hasten delivery in second stage although Epidural block is ideal."

88. I do not have concerns about the use of the pudendal block, as an epidural was not available.

89. Dr B told HDC that she cannot recall the consent process in relation to the care she provided to Mrs A. However, Dr B did document that Mrs A provided verbal consent.

90. From the recollections of the parties involved, I am unable to determine what information was provided to Mrs A before she gave her verbal consent to undergo a ventouse instrumental delivery.

Identification and repair of tear

91. Dr E assessed Mrs A, began repairing the perineal tear, and then stopped and contacted a more experienced registrar, Dr D, owing to concern that Mrs A had a fourth-degree tear. Dr E documented her concern in the clinical notes. Dr D then commenced suturing the tear, before Dr B took over the repair.

92. Dr D advised HDC that she did not believe the tear to be a third- or fourth-degree tear, but wanted a consultant involved to ensure that the repair was anatomically correct. Dr D said that she became concerned that "the tear to the skin possibly involved the anal mucosa" and that she left the room and discussed her concerns with Dr B, and then left the repair as she

had to go to theatre to attend to another patient. In her response to Mrs A's complaint to the DHB, Dr B stated: "The registrars asked for my assistance due to the complex nature of the vaginal tear. I asked [Dr D] to attend other emergencies in the delivery unit when she called for my assistance." Dr B further stated to HDC: "My notes record I was asked to complete the tear as [Dr D] was called away to another case. It was not the difficulty of the repair, but the fact that she was needed elsewhere, that meant I was asked to complete the repair."

93. I acknowledge Dr B's submissions that she does not believe that she failed to recognise a third- or fourth-degree tear but that this could be the case, and also that a recto-vaginal fistula may occur in the recto-vaginal septum in the absence of a fourth-degree tear, and that infection may have caused the breakdown of the episiotomy wound. I note that Dr Vasan advised that at the time of repair, it was likely that there was a fourth-degree tear. Dr Vasan noted:

> "Fistula can occur even after adequate repair but they do not occur in the absence of injury to sphincter or rectal mucosa. Infection occurs from inside bowel to perineum leading to dehiscence which does not occur with intact rectal mucosa."

94. In addition, Dr B submitted a clinical opinion provided by obstetric consultant Dr G stating that on the basis of probability it is likely that the sphincter was damaged at the time of delivery. Dr G noted that the time frame of faecal incontinence appearing so quickly after delivery makes it unlikely that infection resulted in the fistula or the disruption in the sphincter. I accept the advice that it is likely that at the time of repair, it was a fourth-degree tear.

95. Dr B further submitted:

> "The literature shows that up to a third of all women will sustain an unrecognised anal sphincter injury after their first vaginal birth, with respect I do not agree that it is reasonable to find that it is a serious deviation to have missed the sphincter injury."

96. Dr Vasan noted that Mrs A had known risk factors for anal sphincter injury, including undergoing an instrumental delivery, shoulder dystocia, and her race, and advised that while anal sphincter injuries could be missed, fourth-degree tears are less commonly missed if the patient is examined appropriately. Dr Vasan considered that as two registrars had raised concerns about the nature of Mrs A's perineal injury, it would have been prudent to examine her under adequate analgesia in theatre before suturing.

97. Dr G noted that Mrs A was examined in the lithotomy position, and advised that as both Dr D's and Dr B's assessments revealed normal anal tone and no defect in the rectal mucosa, there was, in his view, no indication to take Mrs A to theatre.

98. I acknowledge that the senior registrar also assessed Mrs A and identified the tear as a complex second-degree tear rather than a third- or fourth-degree tear, and I accept that it was reasonable for the repair to take place in the delivery suite, based on Dr B's understanding that she was managing a second-degree tear.

99. Dr Vasan has advised me that Dr B's failure to identify the fourth-degree tear in these circumstances is a serious deviation from accepted practice. Dr G advised: "This has been a

tragic outcome for [Mrs A] but whether this is a result of [Dr B] showing a serious deviation from accepted practice is debatable."

100. While I acknowledge Dr B's submissions and I respect Dr G's view that it is debatable as to whether this was a serious departure, I remain critical that considering the concerns raised by two registrars, Dr B, as a consultant, did not identify that the tear was more significant. Accordingly, Dr B did not provide Mrs A with an appropriate standard of care and breached Right 4(1) of the Code.

101. I note that Dr B appropriately undertook further training at an OASIS (obstetric anal sphincter injury) workshop.

Communication

102. It is apparent that the manner in which Dr B interacted with Dr E was distressing to Mrs A and Dr E. This was inappropriate, and caused additional distress for Mrs A. I note that since these events Dr B has appropriately completed courses on communication.

Opinion: District health board — no breach

103. As a healthcare provider, the DHB is responsible for providing services in accordance with the Code. In this case, I consider that the errors that occurred did not indicate broader systems or organisational issues at the clinic. Therefore I consider that the DHB did not breach the Code directly.

104. In addition to any direct liability for a breach of the Code, under section 72(2) of the Health and Disability Commissioner Act 1994 (the Act), an employing authority is vicariously liable for any acts or omissions of its employees. A defence is available to the employing authority of an employee under section 72(5) if it can prove that it took such steps as were reasonably practicable to prevent the acts or omissions.

105. At the time of events, Dr B was an employee of the DHB. Accordingly, the DHB is an employing authority for the purposes of the Act. As set out above, I have found that Dr B breached Right 4(1) of the Code for her failure to identify that the tear was more significant.

106. The DHB provided a copy of the policy in place at the DHB during the time of events. The "Perineal tears, third and fourth degree" policy was provided to Dr Vasan for review and comment. Dr Vasan advised that the policy is adequate and up to date. The DHB also provided a copy of the orientation policy that related to the recruitment and commencement of employment at the DHB for senior medical officers. Dr Vasan advised that the policy is adequate.

107. The DHB also told HDC:

> "The skills required to assess and repair perineal trauma, including 3rd and 4th degree tears are considered core competencies for all obstetricians practicing obstetrics. As outlined in the job description, an essential qualification required for all Obstetric

> Consultant roles is that they are [Royal Australian and New Zealand College of Obstetricians and Gynaecologists] (or equivalent) qualified and that they are registered as specialists in [New Zealand]."

108. I note that Dr B has been registered as Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists since 2011. The DHB also told HDC that while it does not require OASIS training, it is training that is available to its obstetricians.

109. I accept that the policies that applied to the care provided by Dr B to Mrs A were adequate. I am satisfied that the DHB took reasonably practicable steps to prevent this error occurring and I am not critical of the systems in place. Accordingly, I do not find the DHB vicariously liable for Dr B's breach of the Code.

110. I further note that the DHB carried out a review of this event to ensure that learning occurred. In the review, the DHB appropriately identified further training for Dr B and a change to the perineal repair form to ensure that it is completed by the person who performs the repair.

111. I have consulted with the Deputy Chair of the National Maternity Monitoring Group (NMMG) on the management of perineal tears. She advised that this event highlights the importance of senior medical officers being encouraged and supported to self-reflect on whether or not they are fully up to date with all aspects of their core competencies. I agree, and I also consider it to be important that DHBs develop a culture that is supportive of reflective conversations between senior medical officers and clinical leaders.

112. Dr B told HDC:

> "Since the issue of my communication on this day with [Dr E] was raised, I attended a Senior Medical Officer meeting [at the DHB] … which included a workshop on the issue of bullying, in which I participated, and education about [the DHB's values]."

113. This was an appropriate course offered by the DHB, and I take this opportunity to reiterate the importance of DHBs taking responsibility at a management level to ensure that workplace bullying does not occur, and that when it does, it is not accepted.

Opinion: RM C — breach

114. Mrs A told HDC that during the second postnatal visit on 12 Month1 she reported faecal leakage to RM C, but RM C did not carry out an assessment or ask any questions about the leakage.

115. While RM C did not document an assessment, she stated that she did do one and was aware that Mrs A had "minor faecal leakage", but considered that there was no indication for a physical examination.

116. Expert advice was obtained from RM Alison Andrews. RM Andrews advised:

> "LMC [RM C] is responsible for assessing the health and wellbeing of the woman throughout the postnatal period. This would include perineal examination to observe for healing of sutures. Furthermore, a visual examination of the sutures would identify [whether] the presence of faecal matter were due to poor hygiene … or whether there were another cause that may or may not require referral."

117. I am of the opinion that in the circumstances RM C should have carried out a perineal examination on 12 Month1.

118. On 15 Month1, RM C visited Mrs A. Mrs A told HDC that again she reported faecal discharge on the front of her underwear, and again RM C did not ask her about her symptoms and did not examine her. However, RM C documented that Mrs A was having loose bowel motions that were likely secondary to NSAIDS, and that her perineum was more comfortable that day. RM C told HDC that she did not carry out a visual inspection of the perineum at that visit, and Mrs A made no mention of faecal leakage.

119. On 19 Month1, at 10 days post-partum, RM F visited Mrs A and documented that Mrs A had reported that her bowels and perineum were normal. RM C carried out Mrs A's next postnatal visit on 25 Month1, at 16 days post-partum. RM C documented that Mrs A reported perineal discomfort and faecal discharge on her pad after bowel motions, and RM C visually examined Mrs A's perineum and appropriately referred her for obstetric review.

120. RM Andrews advised that not only would it be reasonable to expect that an LMC would undertake a visual inspection of the perineum to check for healing at least once during the first week post-partum, but that not undertaking a visual inspection of the perineum prior to 16 days post-partum in a woman who has undergone a complex repair of the perineum and reported faecal matter on her pad at three days post-partum was a significant departure from accepted practice.

121. RM C stated: "[I]n hindsight I absolutely wish I had inspected [Mrs A's] perineum." While I acknowledge RM C's reasons for not having been concerned, including the diagnosis of a second-degree tear at delivery, I am of the opinion that in the circumstances RM C's failure to carry out a visual perineal examination prior to 25 Month1 was unacceptable. Accordingly, RM C did not provide Mrs A with an appropriate standard of care and breached Right 4(1) of the Code.

Recommendations

122. I recommend that RM C:

a) Provide a written apology to Mrs A for her breach of the Code. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mrs A.

b) Provide evidence to this Office, within three weeks of the date of this report, confirming her attendance or enrolment at a course relating to perineal tears.

123. I recommend that Dr B:

a) Provide a written apology to Mrs A for her breach of the Code. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mrs A.

b) Audit the outcome of deliveries in which she has been involved over the previous three months. A copy of the audit report is to be provided to this Office within four months of the date of this report.

124. I recommend that the Midwifery Council of New Zealand consider whether a review of RM C's competence is warranted.

125. I recommend that the Medical Council of New Zealand review this report, as proposed in its letter of 27 February 2018 to Dr B.

Follow-up actions

126. A copy of this report with details identifying the parties removed, except the experts who advised on this case, will be sent to the Medical Council of New Zealand, and it will be advised of Dr B's name.

127. A copy of this report with details identifying the parties removed, except the experts who advised on this case, will be sent to the Midwifery Council of New Zealand, and it will be advised of RM C's name.

128. A copy of this report with details identifying the parties removed, except the experts who advised on this case, will be sent to the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, the National Maternity Monitoring Group, and the New Zealand College of Midwives, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

129. I will be writing to DHBs and the National Maternity Monitoring Group highlighting the importance of senior medical officers being encouraged and supported to self-reflect regularly on whether or not they are fully up to date with all aspects of their core competencies, and asking how such a culture of self-reflection on upskilling can be developed.

Appendix A: Independent expert advice to the Commissioner

The following expert advice was obtained from obstetric consultant Dr Sornalatha Vasan:

"02.11.2016

I Dr Sornalatha Vasan have been asked to give opinion C16HDC00911 Expert advice request.

I am a Fellow of the Australian and New Zealand College of Obstetricians and Gynaecologists and am on their Expert Witness Register as well as fellow of college of Obstetricians and Gynaecologists in South Africa from where I qualified as an Obstetrician and Gynaecologist in 1998.

I work as a general O&G Specialist and I am an examiner for RANZCOG and supervisor for ITP trainees in New Zealand.

I have no personal or professional conflict in this case.

I have read the following documents you provided:

Complaint from [Mrs A]
Response from [the DHB]
Clinical notes from [the DHB]

SUMMARY OF EVENTS:

[Mrs A] 31 yrs. old G2 P1 presented to Delivery Suite in active labour on 9th [Month1] at 9 am. She was cared by LMC in current pregnancy. First baby was born by emergency CS […] for foetal distress.

She was reviewed in secondary clinic in [the public] hospital and planned to have VBAC (vaginal delivery after CS); no other maternal or foetal concerns reported.

On arrival she was assessed to be 7 cm dilated; normal CTG and having regular strong contractions.

At 10.40 reviewed by Registrar [Dr D] as coping well; normal CTG advised for continuous CTG; Epidural if wanted and to reassess at 12.30 — should be fully dilated.

At 11 hrs. anaesthetist contacted; at 11.30 patient was getting distressed with pain, Entonox was provided. At 11.39 care taken over by core staff since LMC left to have lunch.

At 12.15 LMC was called back since patient had strong urge to push. VE — 9cm dilated; AROM (rupture of membranes) — moderate meconium stained liquor drained; FHR dropped to 60 bpm.

At 12.30 reviewed by SMO assessed patient as fully dilated; ROT station 1+ no caput moulding CTG — variable decelerations, no accelerations, decreased variability and advised to allow pushing for 20 mts and review.

13.10 assessed by [different SMO] and discussed ventouse delivery due to maternal exhaustion and non-reassuring CTG.

At 14.00 O&G registrar writes in retrospect: ventouse delivery by SMO after Pudendal block; Head delivered with 3 pulls (OA); McRoberts for shoulder dystocia . Active 3rd stage and placenta delivered. Perineum inspected — assessed as 2nd degree tear; infiltrated 10 mls LA but suspected 4th degree tear and called senior registrar to review.

No notes by SR; but reported in DHB response that SR found the tear complicated and called SMO to review.

14.40 SMO records — called for suturing as DU Reg called away. Episiotomy repair completed — anal sphincter not involved. PR normal tone and no sutures felt. Recommended routine care and discharge.

Two weeks after birth [Mrs A] was readmitted with faecal incontinence (noted 4 days after birth). Examined by duty SMO and diagnosed ano vaginal fistula.

Subsequently assessed by Colo rectal Surgeon and Urogynaecologist who confirmed full thickness deficient perineum and absent anterior anal sphincter. She underwent defunctioning colostomy and planned for re-anastomosis after 3 to 4 months.

You have requested me to comment on the following issues:

1. Whether decision to perform Ventouse delivery was appropriate in the clinical circumstances

Yes. Accepted practice

She was fully dilated with head below spines which is suitable for instrumental delivery. FHR was raising and mother was getting exhausted from lack of adequate pain relief. Under these circumstances ventouse is better instrument than forceps which needs strong (dense) analgesia i.e. Epidural/Spinal block.

2. Was [Mrs A] given adequate analgesia for ventouse delivery? Vacuum-assisted delivery is usually less painful than forceps delivery.

Pudendal block is an **accepted practice** for Ventouse delivery to hasten delivery in second stage although Epidural block is ideal.

3. [Dr B's] overall management of perineal tear including whether the ano vaginal fistula that resulted is a known complication (if so at what rates?)

All women having a vaginal delivery are at risk of sustaining OASIS (Obstetric anal sphincter injury) or isolated rectal buttonhole tears. They should therefore be examined systematically, including a digital rectal examination, to assess the severity of damage, particularly prior to suturing — **The Management of Third- and Fourth-Degree Perineal Tears — Green-top Guideline No. 29 June 2015.**

When two registrars had raised concerns about nature of Perineal injury, it is prudent to examine the patient appropriately under adequate analgesia in theatre before suturing.

Instrumental delivery, shoulder dystocia, Asian race are known risk factors for anal sphincter injury.

Although delivery was accomplished under Pudendal block, assessment and repair of complicated tear should have been done in theatre under Spinal or General anaesthesia.

Serious deviation from accepted practice.

[Dr B] failed to recognise 4th degree tear and inadequate repair led to development of ano-vaginal fistula. Fistula can occur even after adequate repair but they do not occur in the absence of injury to sphincter or rectal mucosa. Infection occurs from inside bowel in to perineum leading to dehiscence which does not occur with intact rectal mucosa.

Obstetricians who are appropriately trained are more likely to provide a consistent, high standard of anal sphincter repair and contribute to reducing the extent of morbidity and litigation associated with anal sphincter injury — **Andrews V, Shelmeridine S, Sultan AH, Thakar R. Anal and urinary incontinence 4 years after a vaginal delivery.** *Int Urogynecol J2013;24:55* **60**.

The overall incidence of ano/recto-vaginal fistula in the UK is 2.9% (range 0 8%), with an incidence of 6.1% in primiparae compared with 1.7% in multiparae.

4. Whether [Mrs A] was provided adequate information about the episiotomy, perineal repair, the potential for complication and any advice on seeking further care if complications should ensue

As accepted by the team who cared for [Mrs A], care was fragmented due to lack of cohesiveness/communication within the team.

Since major perineal trauma was not diagnosed adequate information and further advice regarding complication and follow up were not provided.

Serious deviation from accepted practice.

References:

The Management of Third- and Fourth-Degree Perineal Tears Green-top Guideline No. 29 June 2015

Third degree obstetric anal sphincter tears: risk factors and outcome of primary repair

A H Sultan, MA Kamm, C N Hudson, C I Bartram **Obstetric perineal trauma: An audit of training**

A. H. Sultan St Bartholomew's and St Mark's Hospitals, London, M. A. Kamm St Bartholomew's and St Mark's Hospitals, London & C. N. Hudson St Bartholomew's and St Mark's Hospitals, London

Comment:

Error in clinical judgement can happen in the early years of Clinicians' practice.

In [Dr B's] response she has informed that she has acknowledged breakdown in communication with Junior staff and she has attended necessary courses for communication and in-service performance.

She needs to do OASIS and audit her complications regularly.

29th January 2017

In your recent mail you had requested to clarify the following:

1. [Dr B] failed to recognise 4th degree tear and inadequate repair led to development of rectovaginal fistula.

   Please clarify the basis for which you determined that this was 4th degree tear as opposed to 2nd or 3rd degree tear.

   Would your opinion be different if the extent of the tear remained an open question?

1st Registrar who started suturing suspected 4th degree tear which is tear of rectal/anal mucosa.

Senior registrar could not repair the tear since she felt it was complicated.

[Dr B] has written that Episiotomy repair completed — anal sphincter not involved. PR normal tone and no sutures felt. Recommended routine care and discharge.

Two weeks after birth [Mrs A] was readmitted with faecal incontinence (noted 4 days after birth). Examined by duty SMO and diagnosed ano vaginal fistula.

Subsequently assessed by Colo rectal Surgeon and Urogynaecologist who confirmed full thickness deficient perineum and absent anterior anal sphincter. She underwent defunctioning colostomy and planned for reanastomosis after 3 to 4 months.

[Dr B] did not record if she had performed rectal examination before suturing. Without rectal examination 3rd or 4th degree tear can be missed. In the light that two registrars raised concerns of possibility of complicated tear it is important to assess the patient adequately before repairing. Accepted and recommended practice for repair of complicated perineal tear is to examine under adequate analgesia and repair in theatre which was not undertaken. Patient developed faecal incontinence 4 days after birth of the baby.

Recto vaginal fistula can only occur in the event of injury or tumor or inflammation secondary to radiation involving rectal mucosa. With no other cause in this patient trauma i.e. 4th degree tear which is perineal tear involving rectal mucosa can only be the cause for recto vaginal fistula.

Please refer to colorectal surgeon's notes clearly stating that the patient had full thickness dehiscence of perineum involving anal sphincter and rectal mucosa — [Dr B] had written anal sphincter was not involved.

It is unquestionable that the tear was 4th degree and not 2nd degree with above information and therefore extent of the tear cannot be considered an open question.

18/09/2017

Dr Sornalatha Vasan
MBBS FCOG FRANZCOG
Senior specialist Obstetrician and Gynecologist
Hutt Valley DHB
Lower Hutt

I am a Fellow of the Australian and New Zealand College of Obstetricians and Gynecologists and am on their Expert Witness Register as well as fellow of college of Obstetricians and Gynecologists in South Africa from where I qualified as an Obstetrician and Gynecologist in 1998.

I work as a general O&G Specialist and I am an examiner for RANZCOG and supervisor for ITP trainees in New Zealand.

I have no personal or professional conflict in this case.

I have received and read the following documents sent from your office on 15/09/17:

> Request for further expert advice on care provided to [Mrs A] —1611DC00911— [Mrs A]/[the DHB]/[Dr B].
>
> Further documents received (31 August 2017):
>
> [Dr B's] response dated 24 August 2017
>
> [DHB] responses dated 21 August 2017 and 11 August 2017.
>
> Hospital, clinical notes relating to [Mrs A's] delivery.

Further advice requested to review above document and advise whether care provided to [Mrs A] at [the DHB] was reasonable in the circumstances and why.

In particular comment on:

- Whether information provided by [Dr B] alters my previous opinion in any way.

SUMMARY OF EVENTS:

[Mrs A] 31 yrs old G2 P1 presented to Delivery Suite in active labour on 9th [Month1] at 9 am. She was cared by LMC in current pregnancy. First baby was born by emergency CS […] for foetal distress.

She was reviewed in secondary clinic in [the public hospital] and planned to have VBAC (vaginal delivery after CS); no other maternal or foetal concerns reported.

On arrival she was assessed to be 7 cm dilated; normal CTG and having regular strong contractions.

At 10.40 reviewed by Registrar [Dr D] as coping well; normal CTG advised for continuous CTG; Epidural if wanted and to reassess at 12.30 — should be fully dilated.

At 11 hrs anesthetist contacted; at 11.30 patient was getting distressed with pain, entonox was provided. At 11.39 care taken over by core staff since LMC left to have lunch.

At 12.15 LMC was called back since patient had strong urge to push. VE — 9cm dilated; AROM (rupture of membranes) — moderate meconium stained liquor drained; FHR dropped to 60 bpm.

At 12.30 reviewed by SMO assessed patient as fully dilated ; ROT station 1+ no caput moulding CTG — variable decelerations, no accelerations, decreased variability and advised to allow pushing for 20 mts and review.

13.10 assessed by [different SMO] and discussed ventouse delivery due to maternal exhaustion and non-reassuring CTG.

At 14.00 O&G registrar writes in retrospect: ventouse delivery by SMO after Pudendal block; Head delivered with 3 pulls (OA); McRoberts for shoulder dystocia. Active 3rd stage and placenta delivered. Perineum inspected — assessed as 2nd degree tear; infiltrated 10 mis LA but suspected 4th degree tear and called senior registrar to review.

No notes by Senior Registrar; but reported in DHB response that SR found the tear complicated and called SMO to review.

14.40 SMO records — called for suturing as DU Reg called away. Episiotomy repair completed — anal sphincter not involved. PR normal tone and no sutures felt.

Recommended routine care and discharged.

Two weeks after birth [Mrs A] was readmitted with faecal incontinence (noted 4 days after birth). Examined by duty SMO and diagnosed ano vaginal fistula.

Subsequently assessed by Colorectal Surgeon and Urogynaecologist who confirmed full thickness deficient perineum and absent anterior anal sphincter. She underwent defunctioning colostomy and planned for reanastomosis after 3 to 4 months.

[DHB] response: Appendix 1 — Statement — [Dr D] 4 August 2017

Page 5 Recollection of assessment of [Mrs A's] tear:

Paragraph 3

My assessment of the tear was that it was a second degree tear. I repaired the tear by identifying the vaginal apex of the tear closing the vaginal mucosa moving towards the introitus. My usual practice is to perform this with 2-0 vicryl rapid suture in a continuous locking technique. I cannot recall if I had closed the vaginal mucosa in its entirety when I became concerned that tear extended to the skin possibly involved anal mucosa. At that point I recall leaving the room to explain my concerns to [Dr B] who was present on Delivery Unit

Recollection of events when [Dr B] repaired the tear

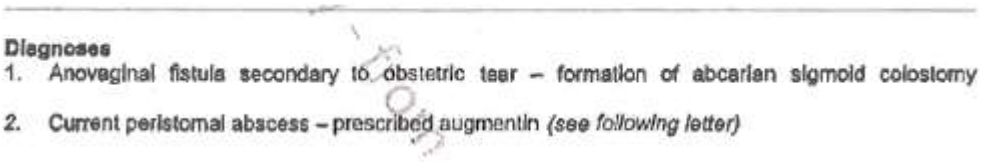
I discussed my concerns with [Dr B] and we decided that in view of this and …

Family meeting [the DHB] 24/05/16

9. Things would have been better if other registrars or LMC had spoken up when [Dr B] was doing something odd.

[Dr B] responds:

I was not 'doing something odd'. The registrars asked for my assistance due to the complex nature of the vaginal tear. I asked [Dr D] to attend to other emergencies in the Delivery Unit when she called for my assistance.



Diagnoses
1. Anovaginal fistula secondary to obstetric tear – formation of abcarian sigmoid colostomy
2. Current peristomal abscess – prescribed augmentin *(see following letter)*

It is very evident that both registrars had raised concerns about severity of perineal injury and asked for assistance.

Detailed findings recorded in the notes by Colorectal Surgeon clearly report the fistula secondary to Obstetric tear.

[Dr B] did record performing rectal examination and clearly documents the tears as second degree tear. She failed to recognize 4th degree tear which in this incident led to ano-vaginal fistula and not due to other factors alluded in all references provided by [Dr B] and [Dr G]. [Dr G] in his report mentions 'On the basis of probability it is likely that the sphincter was damaged at the time of delivery. The timeframe of fecal incontinence appearing so quickly after delivery makes it unlikely that infection resulted in the fistula …

Sphincter injuries could be missed but 4th degree tears are less commonly missed if examined appropriately. The recommendation is to examine these patients under adequate analgesia, light and assistance in operating theatre so 3rd and 4th degree tears are diagnosed and repaired adequately. ([The DHB's] policy on 3rd/4th degree tear explains this clearly.)

Adequate repair of 4th degree tear also has increased risk of fistula formation. Specific measures are taken after 3rd/4th degree perineal tear as described in [the DHB's] policy on 3rd/4th degree perineal tear. Hence not giving adequate information regarding complications from 4th degree tear led to patient presenting 2 weeks after discharge although noticed fecal discharge per vaginum from as early as Day four following delivery. I agree with [Dr B] that she could not give appropriate advice since she did not recognize 4th degree tear.

Ano vaginal fistula is the most serious Obstetric complication and significant public health issue with profound long term sequelae. It is very apparent and obvious that [Mrs A] sustained 4th degree perineal tear at the time of her recent instrumental delivery which was not recognized and not repaired accordingly leading to

development of large ano vaginal fistula. The patient has to have multiple surgical procedures with potential long term consequences.

Information provided by [Dr B] does not alter my previous opinion.

- Adequacy of policies in place at [the DHB] relating to the repair of perineal tears

Policies on Perineal tears are adequate and up-to-date.

- Adequacy of orientation policy in place at [the DHB] for Senior Medical Officers.

Orientation policy is adequate."

Appendix B: Independent expert advice to the Commissioner

The following expert advice was obtained from Midwife Alison Andrews:

"**Advisor Response for Complaint C16HDC00911 [24 November 2017]**

Introduction:

I, Alison Andrews have been asked to provide an opinion to the Commissioner on case number C16HDC00911. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

I have been a Midwife for 25 years and originally registered in the UK in 1992. I also completed a Diploma of Midwifery (1993) and an MSc in Reproduction and Health (2002).

I registered as a New Zealand Midwife in 2010 and have worked as a Core Midwife in a secondary care maternity unit, a Lead Maternity Carer (LMC) and Charge Midwife Manager of a secondary care maternity unit. I also undertake competency reviews for Midwifery Council of New Zealand.

Following a review of the documents provided by the Commissioner I have been asked to consider if the care provided to [Mrs A] between 9 [Month1] and 25 [Month1] by LMC [RM C] was reasonable in the circumstances, and why.

Regarding the care provided by [RM C], I have been asked to comment on:

1. The reasonableness of the care provided by [RM C] in relation to [Mrs A's] reporting of faecal leakage four days post partum following the repair of the tear.
2. Any other matters I consider warrant comment.

For each question I have been asked to advise:

a) What is the standard of care/accepted practice?
b) If there has been a departure from the standard of care or accepted practice, how significant a departure I consider this to be?
c) How it would be viewed by my peers?
d) Recommendations for improvement that may help prevent a similar occurrence in the future.

If there are different versions of events in the information provided I have been asked to provide advice in the alternative. For example whether the care was appropriate based on scenario (a), and whether it was appropriate based on scenario (b).

Information Reviewed:

1. Health and Disability Commissioner's letter dated 14 November 2017.
2. [RM C's] response dated 30th June 2016
3. [RM C's] response dated 10th October 2016
4. [RM C's] postnatal documentation
5. [Mrs A's] clinical records from [the DHB]
6. Case review summary and meeting notes from [the DHB]

7. Midwifery Council of New Zealand (2007) Competencies for Entry to the Register for Midwives.
8. New Zealand College of Midwives (2008) Decision points for midwifery care. Midwives Handbook for Practice, page 41.

Summary of events leading to complaint:

On 9 [Month1], [Mrs A] gave birth to a baby girl by a ventouse (instrumental) delivery; an episiotomy (a cut to the perineum) was performed. Post delivery, two Obstetric Registrars reviewed [Mrs A's] perineum and thought the episiotomy had extended and may be a complex repair. A senior Obstetrician was contacted and repaired the tear.

Following the perineal repair [Mrs A] was discharged to a primary birth care facility under the care of her LMC [RM C].

On the 15th [Month1] it is recorded that [Mrs A] reported faecal incontinence to [RM C]. This was documented as likely to be secondary to the analgesia [Mrs A] was taking for her perineal pain. On 25th [Month1] [RM C] requested an urgent review of [Mrs A] at [the public hospital] to assess her for an infected perineum and possible fistula.

The care provided by [RM C]

1. *The reasonableness of the care provided by [RM C] in relation to [Mrs A's] reporting of faecal leakage four days post partum following the repair of the tear.*

Paragraph 12 of [RM C's] response dated 30th June 2016 states:

'*[Mrs A] started to report some light faecal leakage at day 3 postpartum, her perineal pain was reported to be getting better in the first week post-partum and she was afebrile however faecal incontinence became worse and pain started to get worse and on clinical exam on 25 [Month1] I sent her to [clinic] for what looked like a fistula formation.'*

This would mean that [Mrs A] first reported faecal leakage on the 12th [Month1]. However, the postnatal documentation regarding the mother's details for this date is blank indicating that no clinical assessment was carried out at this stage despite the apparent reporting of an abnormal clinical symptom.

The documentation for this date appears to show that contact was via telephone. It would be reasonable to expect that if [Mrs A] had reported faecal leaking at that stage, [RM C] would have undertaken a face-to-face clinical assessment. On the other hand if faecal leakage were not reported during that telephone contact it would however, be accepted practice to document any discussions and assessments made, as this is a requirement of Competency Two, Performance Criteria 2.16 (Midwifery Council of New Zealand 2007).

If there were reporting of faecal leakage by [Mrs A], which was not clinically assessed by [RM C], it is my view this would be a significant departure from accepted practice, which would be viewed with significant disapproval by my peers. However, if there were no reporting of faecal leakage, and a telephone assessment of [Mrs A] did take

place but was not documented it is my view this would be a moderate departure from accepted practice, which would be viewed with moderate disapproval by my peers.

The next postnatal contact is dated 15th [Month1] and states '*[Mrs A] reports loose bowel motions likely secondary to NSIDS'*. [Mrs A] was 6 days postpartum at this point. Analgesics such as Non-Steroidal Anti Inflammatory Drugs (NSAID) may cause gastro-intestinal symptoms such as diarrhoea, however, there is no information documented that details what type of assessment was made in order to come to this conclusion.

It would be reasonable to expect that following a report of loose bowel motions there would be an assessment in the form of questioning to determine whether it was a side effect of the medication or if there was possibly another cause. Such questioning would include when the symptoms started, the frequency, whether this only occurred following a bowel motion or at other times, the approximate amount and consistency of the faecal matter, whether there was any pain, have any other family members had diarrhoea?

It would also be reasonable to expect that the LMC would undertake a visual inspection of the perineum to check for healing at least once during the first week post partum, as per the New Zealand College of Midwives recommendations regarding postnatal examination (NZCOM, 2008). There is no documentation in the postnatal record to evidence a visual inspection of the perineum being undertaken by [RM C] prior to the 25th [Month1]; when [Mrs A] was 16 days post partum.

If an assessment was undertaken to determine the possible nature of the loose bowel motions, but this was not documented, it is my view this would be a moderate departure from the accepted standard of care. Moreover, if a visual inspection of the perineum had been carried out prior to the 25th [Month1], but not documented it is my view this would be a moderate departure from the accepted standard of care that would be viewed with moderate disapproval by my peers.

However, if an assessment to determine the possible nature of the loose bowel motions were not undertaken it is my view this would be a significant departure from the standard of accepted care. Likewise, if a visual inspection of the perineum had not been undertaken prior to the 25th [Month1] it is my view this would be a significant departure from the accepted standard of care, which would be met with significant disapproval by my peers.

Recommendations for improvement:
Undertake a detailed assessment to determine the possible cause of abnormal clinical symptoms, such as loose stools/diarrhoea/faecal leakage.

Undertake a visual inspection of the perineum at least once in the first post partum week for women who have undergone perineal repair.

Improve standard of record keeping by ensuring more detail is included in documentation, with particular regard to assessments, discussions and decisions made in relation to the care provided.

Alison Andrews 1st December 2017"

"Advisor Response to Letter From [RM C] dated 21 December 2017

Ref C16HDC00911

2. The reasonableness of the care provided by [RM C] in relation to [Mrs A's] reporting of faecal leakage four days post partum following the repair of the tear.

[RM C's] letter states that [Mrs A] first reported faecal matter on her pad on 12 [Month1]. [RM C] confirms the assessment was face-to-face but verbal. She did not undertake a physical examination of [Mrs A] as she considered there were no indications for her to do so. [RM C] did not document this verbal assessment. [RM C] goes on to state she did not carry out an assessment of the perineum prior to the 25th [Month1].

The presence of faecal matter on a woman's sanitary pad is not normal. Faecal matter contains bacteria and is a source of infection. Infection can lead to dehiscence (splitting open) of an episiotomy repair. deBeche-Adams and Bohl (2010) cite infection as one of the causes of fistula formation. Moreover, not only can dehiscence of an episiotomy be caused by infection but dehiscence can be also be caused by a fistula, which can be evident by 3 or 4 days after the delivery (Women's Health and Education Center 2009).

As stated in my report, given [Mrs A's] reporting of an abnormal symptom it would be accepted practice to undertake a clinical assessment to investigate the cause. As the LMC [RM C] is responsible for assessing the health and wellbeing of the woman throughout the postnatal period. This would include perineal examination to observe for healing of sutures as per the NZCOM (2008) recommendation cited in the report. Furthermore, a visual examination of the sutures would identify if the presence of faecal matter were due to poor hygiene (and therefore advising on this), or whether there were another cause that may or may not require referral, as per Competency 2 Performance Criteria 2.12 (Midwifery Council of New Zealand 2007).

The Advisor recognises that examining the perineum can be distressing and embarrassing for women. However, as the LMC [RM C] has had an on-going relationship with [Mrs A] and has provided care throughout her pregnancy, labour and birth. Therefore, she should be able to discuss, gain consent and undertake the assessment in a sensitive and respectful manner.

Regarding the postnatal assessment on the 15 [Month1] [RM C's] letter states:

'As my notes indicate, I considered that the loose bowel motions were the result of analgesics. I would have come to this conclusion following an assessment of [Mrs A] on that date, although the details of this assessment are not recorded in my documentation. I would have asked [Mrs A] when the loose bowel motions started; how frequent she was defecating; and what was the consistency of the stools.'

Despite [RM C's] claim to have carried out a more detailed assessment, this is not evidenced in her documentation, which she admits. I advised this is a moderate departure from the accepted standard of care, i.e. moderate as in modest or slight, and therefore do not consider this to be a severe judgment.

My opinion that the failure to undertake a visual inspection of the perineum prior to 16 days postpartum in a woman who has

(a) undergone a complex repair of the perineum
(b) reported faecal matter on her pad at 3 days postpartum

is a significant departure from accepted practice remains unchanged.

In addition to the recommendations already made I also advise [RM C] updates her knowledge in regard to the causes of rectovaginal fistula formation

Alison Andrews 12 January 2018

References

deBeche-Adams, T. H., & Bohl, J. L. (2010). Rectovaginal Fistulas. *Clinics in Colon and Rectal Surgery*, *23*(2), 99–103. http://doi.org/10.1055/s-0030-1254296

Women's Health and Education Center (2009) Obstetrical Fistulae, Rectovaginal Fistula and Fecal Incontinence. WHEC Published 23 July 2009. Accessed 11 Jan 2018 www.womenshealthsection.com."