Child's death from postoperative haemorrhage after tonsillectomy (01HDC15000, 21 May 2003)

Surgeon ~ Anaesthetist ~ Ambulance service ~ Private hospital ~ Tonsillectomy ~ Standard of care ~ Information about treatment options ~ Postoperative risks ~ Rights 4(1), 4(2), 6(1)(a), 6(1)(b), 6(4)

A complaint was made by parents about the care and services provided to their two-year-old twins by a surgeon, an anaesthetist and an ambulance service. The complaint was that:

1 the surgeon made an appointment for bilateral myringotomy and insertion of ventilation tubes and adenotonsillectomy on the twins without reviewing their notes, offering alternatives to surgery, providing any information about risks, or providing any literature on tonsillectomies; in addition, the surgeon did not see the twins again prior to surgery and did not adequately assess their condition following the operation;
2 the anaesthetist consulted with the parents only briefly prior to the surgery and did not discuss the twins' medication, condition, allergies, previous health problems and recent poor health; and
3 when one of the twins haemorrhaged after discharge from hospital, the ambulance officers took 16 minutes to arrive at the house, and a further 18 minutes before leaving for the hospital.

The Commissioner reasoned that it would have been prudent for the surgeon to provide an information sheet about the tonsillectomy at the initial consultation, and to have met with the twins and their parents on the day of surgery to make sure there were no further issues to discuss. The generally reported risk of significant bleeding after a tonsillectomy (in approximately 2% of cases) was certainly not too remote to discuss.

It was held that the surgeon:

1 breached Right 6(1) by failing to discuss the risk of post-tonsillectomy bleeding with the twins' parents at the initial consultation;
2 did not breach Right 4(2) and complied with professional standards in the preoperative assessment because the surgeon was satisfied with the detailed history provided by the twins' parents and his own examination;
3 did not breach Right 6(4) in omitting to provide written information on tonsillectomy as there is no evidence that the twins' parents requested a written summary; and
4 did not breach Right 4(1) because in the immediate postoperative period the assessment of the twins' condition was appropriate.

The anaesthetist did not breach Rights 6(1)(a) or 6(1)(b) because he reviewed the pre-anaesthetic assessment with the twins' parents on the morning of the operation, and an opportunity was provided to express concerns or ask questions. The ambulance service did not breach the Code because the response time was within the accepted limits and the ambulance officers acted appropriately when confronted by an "awful clinical scenario".