# Obstetrician and Gynaecologist, Dr B

# Southland District Health Board

## A Report by the

## Health and Disability Commissioner

## (Case 06HDC12769)

Health and Disability Commissioner
*Te Toihau Hauora, Hauātanga*

## Parties involved

| | |
|---|---|
| Ms A | Complainant/Consumer |
| Mr A | Ms A's partner/Baby A's father |
| Baby A | Consumer |
| Dr B | Obstetrician and gynaecologist/Provider |
| Dr C | Obstetrician and gynaecologist |
| Dr D | Obstetrician and gynaecologist |
| Ms E | Midwife and Lead Maternity Carer |
| Ms F | Nurse |
| Dr G | Obstetric registrar |
| Dr H | Paediatric registrar |
| Dr I | Paediatrician |
| Dr J | Paediatrician |
| Southland District Health Board | Provider |

## Complaint

On 25 August 2006 the Health and Disability Commissioner (HDC) received a complaint from Ms A about the services provided by Dr B and Southland District Health Board (Southland DHB) in mid-2006. The following issues were identified for investigation:

- *The appropriateness of care provided by Dr B to Ms A.*
- *The appropriateness of care provided by Dr B to Baby A.*
- *The appropriateness of care provided by Southland DHB to Baby A.*

An investigation was commenced on 22 February 2007.

The investigation has taken over 18 months because of the complexity of the issues and the involvement of United States personnel.



*Names have been removed (except Southland Hospital/DHB, Dunedin Hospital) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.*

## Information reviewed

Information was received from:

- Ms A
- Mr A
- Dr B
- Ms E
- Dr G
- Ms F
- The Invercargill Coroner
- Accident Compensation Corporation of New Zealand (ACC)
- Medical Council of New Zealand (Medical Council)
- Southland District Health Board
- Otago District Health Board

Independent expert advice was obtained from obstetrician Dr Anil Sharma (see Appendix 1).

## Information gathered during investigation

### Overview

This investigation concerns the care of two consumers — Ms A and her daughter, Baby A.

Midwife Ms E induced Ms A's labour. Later that day, Ms A was referred to Southland Hospital and attempted a normal vaginal delivery with the assistance of Ms E and registered nurse Ms F. Ms E felt that the delivery was not progressing and sought the assistance of obstetric registrar Dr G. Dr G made two unsuccessful attempts to perform a ventouse-assisted[1] delivery then called for the assistance of the on-call obstetric consultant, Dr B.

Witnesses to the events reported that Dr B treated Ms A in a disrespectful manner and did not fully explain the delivery options available to her.

[1] Ventouse or vacuum extraction is a method of delivery where a cup is placed over the fetal skull, and vacuum pressure is applied to the cup so that it adheres to the fetal scalp. A cord attached to the cup can then be pulled to deliver the baby.

Dr B initially advised Dr G to make preparations for a Caesarean section but then decided to attempt another ventouse-assisted delivery. Dr B delivered the baby's head with the next contraction. After delivering the head, Dr B passed responsibility for the rest of the delivery to Ms E. Ms E found that the umbilical cord was around the baby's neck and attempted to lift it over her head without success. According to Ms E, Dr B then intervened and attempted to manually lift it over the baby's head, causing avulsion (tearing) of the cord at the point where it joined the baby. In contrast, Dr B reported that the force of Ms A's next push caused the avulsion of the cord.

Baby A was delivered at 7.00pm. Dr B and Dr G stopped the bleeding from Baby A's torn umbilicus, and she was transferred to the neonatal unit. Meanwhile, Dr B delegated the repair of Ms A's vaginal lacerations (tears) to Ms E. She examined Ms A and found the tears to be beyond her (Ms E's) scope of practice to repair. Ms E then asked Dr B to re-assess Ms A's vaginal lacerations, and Dr B subsequently repaired the lacerations with the assistance of Dr G.

Baby A received paediatric care in the neonatal unit but her condition deteriorated. Clinicians suspected a subgaleal haemorrhage[2] and, the following day, Baby A was transferred to Dunedin Hospital by helicopter. Despite intensive care Baby A died shortly afterwards.

Ms A complained that Dr B failed to provide her and Baby A with adequate care. In addition, Ms A feels that Dr B treated her disrespectfully and did not give her the opportunity to make an informed choice about the delivery options available to her.

## Background

Dr B trained and worked in obstetrics and gynaecology in the United States for over 20 years. He registered with the Medical Council of New Zealand within a special purpose scope of practice and was permitted to work as a locum tenens in a specialist position in obstetrics and gynaecology at Southland DHB. Dr B was employed by Southland DHB on a 24-month contract from 15 August 2005.

*Dr B's recruitment*

On 10 June 2005, an international medical recruitment agency forwarded Dr B's curriculum vitae to the human resources coordinator at Southland DHB. Dr B detailed his qualifications, and indicated that he had 20 years' experience in obstetrics and gynaecology. He also included contact details for five referees, three of whom had provided written references. The human resources coordinator forwarded this information to the Clinical Director of obstetrics and gynaecology, Dr C.

Dr C and a paediatrician first interviewed Dr B by telephone. During this interview, Dr B disclosed that he had been the subject of malpractice claims in the United States

[2] "Subgaleal haemorrhaging" describes bleeding into the potential space between the skull and inner layer of the scalp. Because the potential space covers the entire skull, blood loss can be very significant.

and discussed the nature of these claims, confirming that none had been substantiated. He was made an offer of employment that was subject to satisfactory reference checks and Medical Council registration.

Dr C telephoned two of the referees on 21 June 2005. Both of these referees had also provided written references. Verbal transcripts of these telephone calls were recorded, to support Dr B's application for registration with the Medical Council. The written and verbal references described Dr B positively in terms of both his personal and professional character. In response to the question about Dr B's weaknesses or limitations, one referee noted that Dr B could get "tense under pressure". Neither referee was aware of any malpractice claims against him.

**Medical Council registration process**

Dr B submitted two registration applications to the Medical Council. His first application was for registration within a special purpose scope of practice (locum specialist). His second application was for registration within a vocational scope of practice in obstetrics and gynaecology.

*(a) Dr B's special purpose scope of practice (locum specialist) registration*
On 23 June 2005, the international medical recruitment agency submitted Dr B's application for registration within a special purpose scope of practice to the Medical Council on his behalf. The application form was accompanied by a number of supporting documents, including the transcripts of Dr C's two verbal reference checks.

On the Medical Council's application form, Dr B answered "yes" to the question whether he was currently or had been the subject of civil proceedings related to competence or negligence issues. He also answered "yes" to the question whether he had ever been refused medical indemnity insurance cover or had his premiums raised because of professional conduct, competence or negligence-related claims. He submitted a letter to the Medical Council outlining four malpractice claims — two settled and two open. These are *Cases 1*, *2*, *3* and *4* described below.

On 19 July 2005, the Medical Council's Registration Administrator contacted the recruitment agency to seek further information necessary to complete Dr B's application. In particular, the Registration Administrator requested:

- Certificates of good standing from the medical boards in any state where Dr B had practised in the last three years.

- Additional information relating to the four malpractice claims Dr B had disclosed including court documentation for all cases, and a letter from his defence attorney outlining Dr B's position in relation to the two open cases.

- A comprehensive curriculum vitae describing Dr B's practice history from his graduation in 1980 until the present day. The Registration Administrator noted that the Medical Council required an explanation for gaps in employment longer than three months.

- Written references to substantiate the recommendations of the other referees provided or a further "more robust reference check completed on a current colleague". The Registration Administrator explained that the Medical Council required this additional information because Dr C's verbal transcripts did not give any specific information about Dr B's clinical ability.

The Registration Administrator also advised the recruitment agency that Dr B's disclosures about civil proceedings placed the application "outside policy" and it therefore needed to be considered by the Registrar.

Dr B submitted current licence verification documents from three states.[3] Dr B described these as being equivalent to certificates of good standing.

On 22 and 28 July 2005, Dr B's attorney sent two letters to the Medical Council on instructions from Dr B. These letters confirmed information previously provided by Dr B and also provided the Medical Council with a significant amount of additional information regarding his malpractice claim history.

Dr B and his attorney explained that the first case, *Case 1*, concerned a birth in May 1985 and was settled in September 1991. Dr B was named in this case but was not the delivering doctor. The allegation was a failure to diagnose ruptured membranes. Dr B saw the baby's mother one month before the birth for a routine obstetric consultation. At this consultation, Dr B believed she was doing well and there was no evidence of ruptured membranes. The mother later presented to the hospital with a "several day history" of ruptured membranes and thick meconium. She delivered the baby, who developed cerebral palsy. In September 1991 this case was settled and $US47,500 was paid to the plaintiff on Dr B's behalf by his insurance company. Dr B's attorney provided a copy of the settlement agreement, and the Court's approval of the settlement, to the Medical Council.

In the second case, *Case 2*, the plaintiff claimed that Dr B erroneously failed to perform a Caesarean section in February 2000. At the time, Dr B was in solo practice and he provided all of the plaintiff's obstetric care. She had previously delivered an 8½lb baby. On this occasion, the plaintiff presented for prenatal care late in her pregnancy. Dr B said that a glucola examination was performed but the specimen was lost and the examination was not repeated because of the plaintiff's advanced

[3] Dr B explained that although he held a licence to practise in one of the states, he had never practised in that state.

gestation. She had a rapid labour and encountered a shoulder dystocia[4] which responded to obstetric manoeuvres. The baby was delivered within 90 seconds of the delivery of the head. However, the baby developed Erb's palsy[5]. In April 2003 this case was settled and $US360,000 was paid to the plaintiff on Dr B's behalf by his insurance company.

Dr B and his attorney also provided information about two open cases involving Dr B. His attorney advised that the first open case, *Case 3*, "boiled down" to a factual dispute between the plaintiff and Dr B as to whether a Caesarean section was ever provided as an option and whether it was requested.

The plaintiff was a 26-year-old woman whose first baby had weighed 10lb 8oz at birth, had shoulder dystocia and suffered Erb's palsy. The estimated fetal weight was greater than the 90th percentile after an ultrasound scan at 37 weeks and one day's gestation. Dr B gave evidence that he explained the risk of a repeat shoulder dystocia and advised that Caesarean section was the safest mode of delivery. In the plaintiff's clinical notes, Dr B recorded:

> "I had a long discussion with the patient and she understands very clearly the risks of a shoulder dystocia as she has been through it. She understands that permanent injury and death … may result from it. We also discussed a c-section which she understands that it has risks. I discussed with her the modes of delivery and we agreed to talk in one week and make a final decision."

The plaintiff then telephoned Dr B after discussing delivery options with her husband. She informed Dr B that she did not wish to have a Caesarean section.

Dr B's attorney said that Dr B has given evidence that when the plaintiff arrived at the hospital, he again discussed the mode of delivery with the plaintiff but she refused a Caesarean section. Since the fetus was never distressed, they proceeded with a vaginal delivery. The baby was infected at birth and suffered an Erb's palsy.

According to Dr B's attorney, the defence's position in this case was that Dr B properly advised the plaintiff of the risks of shoulder dystocia and Caesarean section. He claims that the plaintiff was fully aware of the risks of a vaginal delivery because she had a child with an Erb's palsy but simply refused to have a Caesarean section on this occasion. His attorney noted that "[s]ince there was no emergent problem with the fetus, Dr B could not have committed a battery on this patient by forcing a c-section

4 Shoulder dystocia is a complication in labour caused by the baby's shoulder becoming impacted behind the mother's pubic bone.

5 Erb's Palsy is a partial paralysis of the arm caused by injury to a baby's brachial plexus during birth.

absent any medical emergency". Dr B advised that the plaintiff continued to consult him regularly over the next two years. Her last consultation with him was in July 2000. The plaintiff filed proceedings against Dr B in July 2003.

Dr B's attorney advised the Medical Council that *Case 3* was set down for trial on 25–28 October 2005.[6]

The second open case, *Case 4*, involved a birth in May 2000. The plaintiff was a 28-year-old woman with a history of gestational diabetes. She was managed in conjunction with the Department of Maternal Fetal Medicine at a Medical School. The plaintiff had a vacuum-assisted spontaneous vaginal delivery and the baby suffered a brachial plexus[7] injury.

In October 2003, the plaintiff filed proceedings claiming that Dr B erroneously failed to perform a Caesarean section and that the baby's injury was a result of poor care during the delivery.

Dr B gave evidence that this was an uneventful delivery and that the baby never presented with shoulder dystocia. An episiotomy[8] was not required and an X-ray showed that there was no fracture of the clavicle.[9] According to Dr B's attorney, the defence's experts were expected to give evidence that Dr B's care during the delivery was appropriate and that the duration of the delivery would not have allowed a shoulder dystocia to have occurred. Dr B and his attorney also said that the clinical records do not show shoulder dystocia or a clavicular fracture.

Dr B's attorney advised the Medical Council that this case was set down for trial on 15–18 November 2005.[10]

Dr B and his attorney informed the Medical Council that the same attorney represented the plaintiffs in *Cases 2*, *3* and *4*.

[6] The case was subsequently tried by jury in court on 26 May 2006. The jury unanimously found in favour of the plaintiff and awarded $US275,000 in damages against Dr B and his company (a joint defendant). In a final order on 13 July 2006, the Court accepted the jury's verdict. Dr B and his company paid the amount awarded in damages.

[7] The brachial plexus is a network of nerves, arising from the spine at the base of the neck, from which arise the nerves supplying the arm, forearm and hand, and parts of the shoulder girdle.

[8] An episiotomy is an incision into the opening of the vagina during a difficult birth, at the stage when the baby's head has partly emerged through the opening of the birth passage. The aim is to enlarge the opening in a controlled manner so as to make delivery easier and to avoid extensive tearing of adjacent tissue.

[9] Commonly referred to as the collar bone.

[10] The court subsequently dismissed this case and no trial took place.

Dr B also instructed his attorney to inform the Medical Council that he knew he had been named in other previously filed proceedings that *may* have contained allegations of negligence. His attorney explained to the Medical Council:

> "We used the term 'may' because those suits were never served, dismissed or withdrawn without ever being prosecuted against [Dr B]. To [Dr B's] knowledge, no experts were ever designated against him in those cases and they have all been dismissed. Unfortunately, under [state] law, until very recently, a plaintiff did not have to certify they have retained an expert witness who was willing to testify that there was a violation of the standard of care before filing the lawsuit. Accordingly, it is not uncommon that lawsuits are filed naming physicians and then subsequently dismissed or withdrawn without ever designating an expert witness to testify. The four cases that [Dr B] named are the only malpractice claims that have been actively prosecuted against him. (Of course two of the four are being contested and tried this fall.)"

In addition, Dr B's attorney advised the Medical Council that it was their understanding from court website records that there were two other pending cases in which Dr B was named as a defendant. However, Dr B had never been served with these proceedings, nor had he been provided with copies of the court documents relating to these cases. Accordingly, the attorney advised that Dr B had no knowledge of "the specifics of the allegations". He said that the plaintiffs had not taken any steps to pursue the claims and had not given Dr B the opportunity to provide an adequate defence as required by state law. The attorney said that Dr B wished to bring these peripheral claims to the Medical Council's attention "out of an abundance of caution" and in order to be "fully responsive" to its enquiry about his malpractice claim history.

Later in the process, the Registration Administrator also asked Dr B to provide documentation from his former insurance provider outlining why he had been refused insurance. In response, Dr B explained that he had not been refused insurance; rather, he had declined to renew his insurance because the premium was unaffordable. He noted that the state had a medical malpractice crisis and premiums were generally very high. His premium increased after one lawyer filed three similar malpractice claims against him within a relatively short period of time. Dr B explained that he was sure he could defend these claims, but nonetheless declined to renew his insurance on the basis of cost.

Dr B modified his curriculum vitae and explained that he discontinued his practice for five months in 2005 for personal reasons and provided a satisfactory explanation to the Medical Council about these reasons. Dr B advised that he had been working as a locum while awaiting his New Zealand registration. He provided the details of three colleagues who could attest to his clinical abilities — a referring practitioner and two obstetrician and gynaecologists. All of these referees gave very positive feedback

about Dr B's clinical competence and manner, supporting his application for registration.

On 28 July 2005, the Registration Administrator requested a reference from one of the recent locums Dr B had completed. Dr B advised that he was unable to obtain a reference from an obstetrician and gynaecologist for his locum over June and July 2005 because he was the only obstetrician and gynaecologist working at the hospital at that time. However, he said that he had full hospital privileges and asked whether it would be appropriate for him to obtain a reference from the anaesthesiologist who saw him operate. He then arranged for a practitioner to provide a reference to the Medical Council by 2 August 2005. However, the Medical Council did not receive this reference.

On 1 August 2005, the Registration Administrator submitted Dr B's application to the Registrar of the Medical Council for approval. The Registration Administrator advised the Registrar:

> "[Dr B] and his attorney have provided sufficient information on the civil proceedings cases and the reason for not renewing his insurance policy to assure Council that these circumstances do not affect his fitness or registration. [Dr B] has furnished the appropriate certificates of good standing and provided very supportive references."

On 2 August 2005, the Registrar approved Dr B's special purpose registration subject to his supervisor, Dr C, being made aware of the nature of the open malpractice cases against him.[11] With Dr B's consent, the Registration Administrator then sent all of the information pertaining to the civil proceedings that Dr B has been involved in to Southland DHB. In this email, the Registration Administrator also advised that she would send confirmation of Dr B's eligibility for registration shortly.

By letter dated 3 August 2005, the Medical Council confirmed that Dr B had met the requirements for registration within a special purpose scope of practice in obstetrics and gynaecology. The Medical Council also explained that he was required to attend an interview to confirm his identity, sight his original documents, confirm his practice intentions, and pay the practising certificate fee.

On 5 September 2005, the Registration Administrator advised Southland DHB that the Medical Council had granted Dr B registration within a special purpose scope of practice to work in obstetrics and gynaecology at Southland DHB under Dr C's supervision. Dr B's name was included on the New Zealand Register of Medical Practitioners with effect from 10 August 2005.

*(b) Dr B's registration within a vocational scope of practice*

[11] Registrars are able to approve special purpose registrations if there are no issues arising out of the application.

Dr B's application for registration within a vocational scope of practice in obstetrics and gynaecology was received by the Medical Council on 28 July 2005.

On 4 August 2005, the Medical Council Vocational Registration Administrator acknowledged Dr B's application for vocational registration. She also recorded the following in a filenote:

> "[Dr B] has made a disclosure in his voc application — however, he has also made the same disclosure in his special purpose scope application. The Registrar (…) has viewed the disclosure and signed it off as OK — please refer to special purpose scope application."

The Vocational Registration Administrator sought Medical Council referees' reports from the three referees whom Dr B put forward in support of his special purpose registration. She received reports from two of the three referees. However, on 5 August 2005, Dr B's third referee advised that he was unable to provide a reference for Dr B. He explained:

> "It has been several years since I have had direct contact or knowledge of [Dr B's] clinical practice of medicine. I was favourably impressed with his academic knowledge. Nonetheless, I do not have sufficient knowledge of how he translates this knowledge into clinical practice to be comfortable attesting to his current qualifications."

On 6 August 2005, Dr B put forward an alternative referee. In total, three referees completed referees' reports.

The first referee, an obstetrician and gynaecologist and university Associate Professor, had known and worked with Dr B for over 20 years. He provided a positive reference for Dr B.

The second referee, an obstetrician and gynaecologist, had known and worked with Dr B for 24 years. When asked, "To the best of your knowledge, are there any current or past disciplinary action or legal proceedings against the applicant?", this referee answered, "Yes, specific case not known." When asked what he would describe as Dr B's weaknesses/limitations, he said, "Can be impatient under stress." Otherwise, this referee advised that Dr B was "very good" in all other areas.

The third referee was a doctor of medicine who had known Dr B for over 11 years but had never worked with him. His primary knowledge of Dr B was as a specialist to whom he referred patients. This referee described Dr B as excellent in almost all areas. He noted, "I have referred to [Dr B] over 1100 patients (ObGyn) without a single complaint."

On 21 September 2005, the Medical Council advised that Dr B's application for vocational registration was complete and that it would be forwarded to the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) for assessment.

After an interview with Dr B, and a satisfactory reference from Dr D (one of Dr B's current colleagues in obstetrics and gynaecology at Southland DHB), RANZCOG advised the Medical Council that Dr B had the qualifications, training and experience comparable to a medical practitioner vocationally trained in New Zealand. It recommended that vocational registration would be appropriate after 12 months' supervised practice and on receipt of satisfactory supervisor's reports.

The Registrar subsequently confirmed Dr B's eligibility for registration within the provisional vocational scope of obstetrics and gynaecology.

**Appointment of Dr B**
On 15 August 2005, Dr B commenced his employment at Southland Hospital.

**Southland DHB's consideration of Dr B's malpractice claim history**
During Dr B's application process, Dr C specifically confirmed the nature of the malpractice claims Dr B had disclosed. He discussed his views with his colleagues at the time — two vocationally registered obstetric and gynaecology consultants. These consultants agreed that Dr B's malpractice claim history did not constitute a barrier to his employment.

Southland DHB was also aware that the Medical Council would look into Dr B's malpractice history, which assured Dr C that his own assessment of Dr B would be "double-checked" prior to his registration.

Southland DHB considered that these types of claims were reasonably common obstetric and gynaecology adverse event complaints — for example, shoulder dystocia. It was also considered that over a 20-year practice period, four malpractice cases was not unreasonable, given the medical malpractice litigation environment in the United States of America. Southland DHB also noted that there appeared to have been no actual findings of negligence on the part of Dr B. Furthermore, Southland DHB said that "it is well known that insurance companies often settle cases, for economic reasons, to avoid high litigation costs in the USA and thus a limited amount of weight could be placed upon the settlements as an indication of negligence".

Southland DHB explained that the usual supervisory systems were put in place for Dr B, and no additional supervision was considered to be necessary in light of his malpractice claim history. Southland DHB advised that Dr C had almost daily contact with Dr B although no more so than any other consultant he had supervised. Dr C was aware that the Medical Council had satisfied itself in relation to Dr B's malpractice claim background and that, accordingly, the proposed supervisory arrangement had been approved by the Council with full knowledge. In Southland DHB's view, "there

certainly was no suggestion of [Dr B] requiring an extraordinary level of supervision" over and above that required by the Medical Council.

**Supervisors' reviews**

Dr C was approved by the Medical Council to supervise Dr B for the term of his employment. On 9 March 2006, Dr D took over Dr B's supervision. The Medical Council approved the new supervision arrangements on 23 March 2006.

Dr B was required to have three-monthly supervisor's reports as a condition of his continued provisional registration within the vocational scope of obstetrics and gynaecology and as a prerequisite to his registration within this vocational scope.

Dr C completed two supervisor's reports. His first report was for the period between 10 August 2005 and 10 November 2005, and was dated 11 November 2005. Dr C's second report was for the period between 10 November 2005 and 10 February 2006. It was signed by Dr C on 9 February 2006 and by Dr B on 2 March 2006. Dr C's reports indicated that Dr B was performing at a level that was "above expectation" or "exceptional" in all competencies.

Having taken over supervision of Dr B on 9 March 2006, Dr D completed one supervisor's report for the period between 10 February 2006 and 10 May 2006. This report was completed on the day Baby A died.[12] Dr D reported that Dr B's performance was "above expectation" with regard to clinical knowledge and skills, and that he was meeting or exceeding expected standards in all other competencies, except in emergency situations, and when dealing with midwives. Dr D noted "overreaction even in not high risk situations", and Dr B commented, "I have been trying to improve my relations with midwives."

**Treatment provided to Ms A and Baby A**

*Induction*

The antenatal period of Ms A's pregnancy was uneventful. It was her first pregnancy.

Because her pregnancy had reached 41 weeks and one day, Ms A's Lead Maternity Carer[13] midwife, Ms E, decided to induce the labour.

Ms A attended Southland Hospital with her partner. Prostaglandin[14] was administered by Ms E at 9.20am. Ms A experienced prostin tightenings[15] immediately, and a

[12] I note that this date was incorrectly noted in my provisional opinion. For the sake of clarity, Dr D's adverse comments in Dr B's performance review were not made until after Baby A's birth.

[13] "Lead Maternity Carer" refers to the general practitioner, midwife or obstetric specialist who has been selected by the woman to provide her complete maternity care, including the management of her labour and birth.

cardiotocograph (CTG)[16] showed a reactive and variable fetal heart rate (FHR).[17] After an hour of satisfactory monitoring, Ms A returned home to await active labour. She was advised by Ms E to return at 3.00pm, or earlier if necessary.

*Labour*

Ms A and Mr A returned to Southland Hospital at 3.00pm, and another CTG was performed, with a good FHR noted. Ms E administered a further dose of prostaglandin at 3.15pm, and labour was established at about 4.30pm. Ms A was in a birthing pool for pain relief when her membranes spontaneously ruptured at 5.00pm.

At 5.30pm, pain relief (pethidine) was administered, and Ms A requested an epidural at 5.40pm. She said that her request "was ignored". Ms E responded that "[Ms A] wanted an epidural but was fully dilated and pushing. An epidural at this time may or may not be best clinical practice. I needed a second opinion on this." Ms A commenced pushing at 5.42pm.

At 6.20pm, Ms E requested assistance from registered nurse Ms F to get Ms A into the lithotomy position[18] to assist pushing. Ms A was not comfortable using lithotomy poles, so Ms E and Ms F allowed her to brace her feet against their hips while pushing. However, this did not progress Ms A's labour.

At 6.25pm, Ms E called obstetric registrar Dr G to assist, because Ms A's pushing was not effective. Dr G examined Ms A, and decided to attempt a ventouse-assisted delivery. Between 6.25pm and 6.35pm, Dr G applied the ventouse cup three times, and pulled with Ms A's contractions twice. However, Dr G was unable to deliver the baby, and left the room at about 6.35pm to call for assistance from the on-call obstetric consultant, Dr B.

Dr B agreed to come to assess Ms A. In his response to this investigation, Dr B stated that on his arrival, "management of the case was not turned over to [him]". Nonetheless, Dr B advised Dr G to make preparations for a Caesarean section. Dr G booked an operating theatre, and returned to draw blood samples from Ms A and insert an IV line.

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[14] Prostaglandins may be administered to ripen (soften) the cervix, so that dilation and uterine contractions can begin.

[15] Prostin tightenings are the initial uterine contractions that precede active labour.

[16] A cardiotocograph is the external electronic monitoring of the fetal heart rate. A CTG can indicate abnormalities in the fetal heart rhythm, which may indicate fetal distress. The Doppler unit converts fetal heart movements into audible beeping sounds and records this on graph paper.

[17] Fetal heart rate variability is considered to be one of the most reliable indicators of fetal well-being. Baseline variability (the normal variation of the FHR within normal range) increases when the fetus is stimulated, and slows when the fetus sleeps. If no variability is present, it indicates that the natural pacemaker activity of the fetal heart has been affected. Decreasing variability indicates the development of fetal distress. Absent variability is considered a severe sign, indicating fetal compromise.

[18] A birthing position whereby the woman lies on her back, with her legs raised vertically and knees at a 90° angle.

Ms E stated that she, Ms A and Mr A were unaware that Dr B had asked for theatre preparations to be made. Ms E believes that, had this information been conveyed to her, Ms A or Mr A, Ms A "would have been prepared for theatre, if she could have stopped pushing her baby out".

While Dr G was away, Ms A moved to a standing position and continued to push. Ms E believed that the labour was progressing well and the birth was imminent. She informed Dr G of this when she returned at approximately 6.45pm, and advised that a Caesarean section would not be required. Ms E also advised Dr G that an IV line was unnecessary because Ms A was well hydrated.

*Dr B's manner towards Ms A*
Immediately afterwards, Dr B arrived and assessed Ms A. He recalls that he introduced himself to Ms A and asked for permission to take care of her.

There is conflicting evidence about the manner in which Dr B asked Ms A to refrain from making excessive noise during her contractions. Ms A, Mr A, Ms F and Ms E recall that Dr B did not talk to Ms A in an appropriate way.

Ms F stated:

> "[Ms A] was making noises with each contraction, and [Dr B] asked her to focus, look at him, be quiet, put her lips together and push, and said she was making too much noise and wasting energy."

Ms A reported that Dr B told her that she "[had] to stop using [her] words and use [her] energy to push [Baby A] out". She felt Dr B was "rude in the way he was saying it".

Ms E stated: "[Dr B] was so rude telling her to shut her mouth."

Mr A said he did not recall exactly what Dr B said to Ms A when he asked her to reduce her noise but "the way he said it was pretty much 'shut up and push'".

Dr G recalls that Dr B "instructed [Ms A] to bear down properly, to stop yelling and push down". Dr G said that Dr B was "a little stressed, but was not rude to anyone" and explained that he "just had a loud voice".

Dr B responded that he was always polite and was never "rude" to Ms A. Dr B acknowledged that he speaks very loudly and waves his hands when he speaks. He explained that this manner is ingrained in him from his background. In Dr B's words, "to quiet, restrained New Zealanders, this may at times appear intimidating".

*Discussion of delivery options and consent*

There are conflicting accounts of the discussion Dr B had with Ms A about her options for delivery and the risks involved with each. Dr B stated:

> "I explained that a Caesarean was clearly indicated, due to a failed attempt at [ventouse]. [Ms A] and [Ms E] refused ... I offered to make one attempt to deliver with the [ventouse] ... I explained that the baby's head was already [o]edematous[19] ... and there was a significant danger of injuring the child ..."

In another statement, Dr B said:

> "I discussed a Caesarean delivery, stated it was the best choice, and a repeat attempt at vacuum extraction with [Ms A] and her husband, clearly informing them of the risks of each. She understood and stressed again that she did not want a Caesarean."

Dr B also recalls that he explained to Ms A that if another attempt at ventouse-assisted delivery did not succeed, "we would have no option for the sake of her baby but to perform a Caesarean delivery". According to Dr B, Ms A understood and agreed. Later, at 7.15pm, Dr B recorded the statement "informed consent, risks described for [vacuum] extraction" in Ms A's clinical notes. A typewritten summary of the events by Dr B in the clinical notes contains the statement: "I obtained informed consent and did a vacuum extraction through one contraction."

In his response to Ms A's complaint, Dr B stated that "it should be up to her midwife to advise [Ms A of] the safest mode of delivery — a Caesarean. Instead, Ms A was advised [by Ms E] to refuse a Caesarean."

In response to my provisional opinion, Dr B provided further comment on the discussion of delivery options and consent. He said:

> "As soon as I evaluated [Ms A], I clearly told her that the only acceptable mode of delivery was by Caesarean section. Her answer was immediate, and clear 'I do not want a Caesarean'. As the same time, [Ms E] stated that a Caesarean was not necessary, and [Dr G] reminded me that [Ms A] had already refused a Caesarean and I.V.
>
> The above statement arguably constitutes a refusal of the operation, Caesarean section. I knew that the baby needed to be delivered. I was left with no option. I have never abandoned a patient, even when they refuse appropriate treatment. Both [Ms A] and [Ms E] requested that I try a vacuum extraction again. I explained the risk and delivered the baby."

[19] Oedema is a collection of fluid below the skin. While moderate scalp oedema and bruising is usual with ventouse delivery, further attempts at ventouse delivery are contraindicated where oedema is present.

Ms F recalls that Dr B explained the two available delivery options (ventouse-assisted delivery and Caesarean section) and the risks associated with each to Ms A. In another statement, Ms F reported that Dr B "explained that the options were Caesarean or another attempt at ventouse, and said both of these held risks for the baby". According to Ms F, Ms A indicated that she preferred another attempt with the ventouse and would rather not have a Caesarean section. She reported that Ms A "was not really adamant about not having a [Caesarean section]" but preferred another attempt at ventouse delivery before a Caesarean section.

According to Ms E, prior to Dr B's arrival she advised Dr G that a Caesarean section was not necessary because birth was imminent. Dr G's summary of events at 6.25pm in Ms A's clinical notes contains the statement "came back to inform them of the need for CS [Caesarean section] but LMC suggested to continue pushing as she feels the head has come down and does not need CS".

Ms E also advised Dr B that "the baby was coming". Ms E recalls that Dr B said to Ms A he would "try the ventouse once as there is a risk to the baby delivering either this way or [by Caesarean section]". Later, at 10.51pm, Ms E recorded in a summary of events in Ms A's clinical notes: "informed consent obtained and options for Caesarean section and ventouse. Ventouse option decided upon." This summary of events was also signed by Dr B.

According to Ms A, Dr B warned her that "if [she] didn't push [Baby A] out in two goes he would take [Ms A] upstairs and cut [Baby A] out of [her]". Ms A recalls that a Caesarean section was never discussed with her, and that "at no time was I told of risk via ventouse or C-section". Ms A and Mr A said that Ms E decided Dr B should proceed with another attempt at ventouse and that she communicated this decision to Dr B without consulting them. They insist that "we were never asked or consulted about [a Caesarean section]". They also refute Dr B's claim that Ms A requested another attempt with the ventouse.

Dr G does not recall Dr B explaining the delivery options and associated risks to Ms A. According to Dr G, Dr B performed the vaginal examination and told Ms A that he would attempt to deliver the baby using the ventouse, otherwise a Caesarean section would be necessary.

*Ms A's request to discontinue the ventouse delivery*
As he was applying the ventouse cup, Ms A asked Dr B to stop. Dr B did not stop, and Ms E noted:

> "[It] was more of a pain response than a demand to stop."

Ms A refuted this:

"I wanted them to stop what they were doing and I was completely ignored."

*Delivery of the baby's head*

Dr B delivered the baby's head with the next contraction. Dr B described a "repeat, gentle vacuum extraction" and reported that he "easily [delivered] the foetal head". However, other witnesses recall that significant force was applied. Mr A stated that Dr B pulled "a number of times, very hard" and that Dr B "was pulling a lot harder than [Dr G]". Dr G reported that Dr B climbed onto the bed to gain maximum leverage for his pull. She was so concerned about Dr B's technique that she later reported it to her superior, and Dr B's supervisor, Dr D.[20]

Dr B denies that excessive force was used. He pointed out that the vacuum releases if pulled too hard and noted that observers cannot judge the tension applied. Dr B explained that as Ms A moved, he placed his knee on the bed to manoeuvre the back of the baby's head upward.

*Transfer of care mid-delivery*

After delivering the head, Dr B passed responsibility for the rest of the delivery to Ms E. Ms E stated that Dr B "turned to [her] and sarcastically said 'well, are you not going to do the rest?'". However, Dr B described the transfer of care as a "gesture of trust and goodwill". Dr B said that he thought that Ms E was "happy to suture the lacerations". He believes he was always polite and never sarcastic to Ms E.

For her part, Ms E said, "At no time have I ever been unprofessional to [Dr B]."

*Tearing of the umbilicus*

Ms E found that the umbilical cord was around the baby's neck and attempted to lift it over the head. She could not release the cord, and called for clamps and scissors, so that she could cut it instead.

Ms E stated that Dr B then intervened and attempted to manually lift the umbilical cord over the baby's head. There was a "snapping" sound and bleeding occurred. Baby A was delivered immediately, and it became obvious that the cord had been torn. In contrast, Dr B reports that he asked Ms A not to push, but she did so before the umbilical cord could be released, and the force of delivery caused the cord to be torn at the end attached to the baby.

Although no other participants witnessed the tearing of the cord, Dr G and Ms F stated that they did not hear Dr B say anything to Ms A after Ms E called for the clamps. Dr G said that Dr B apologised to the family for "pulling the cord off" after Baby A was transferred to the neonatal unit (see below).

Baby A was delivered at 7.00pm.

[20] Although Dr G's report was not documented, Dr D referred to "concerns expressed by attending staff" in later correspondence to SDHB.

*Post-delivery management of the avulsed umbilicus*
At birth, Baby A was bleeding from her torn umbilicus. Dr B applied pressure with his hand and transferred Baby A to a resuscitation table so that the blood loss could be controlled. The paediatric registrar, Dr H, was paged and Ms F assisted Dr G and Dr B to attend Baby A. Dr B and Dr G stopped the bleeding by suturing the torn artery, and Baby A was transferred to the neonatal unit. Her Apgar[21] scores were six at one minute, and seven at five and ten minutes.

*Care of Ms A after Baby A's birth*
Ms E clamped the maternal end of the umbilical cord, and delivered the placenta at 7.05pm. Because of the large amount of blood in the bed, Ms A was briefly moved to an armchair, while Ms E replaced the linen.

After Baby A was transferred to the neonatal unit, Dr B asked Ms E if she had delivered the placenta. She said that she had, but had not yet examined Ms A to determine whether suturing was necessary. Ms A was transferred back to the bed, and Dr B told Ms E that she could perform the suturing, or get Dr G to do it.

*Dr B's apology*
Ms F, Ms E and Mr A all reported that Dr B apologised to Ms A and Mr A as he left the room, saying he was embarrassed by the events that occurred because nothing like this had happened to him before. Ms E thought that he was referring to the avulsion of the umbilical cord.

Dr B explained his apology as follows:

> "Afterward, I apologised to [Ms A]; it was not an admission of wrongdoing. It is true that it is the only avulsed cord that I have seen. I was sad for the outcome and being sympathetic to her."

*Vaginal lacerations*
Ms E examined Ms A and found extensive vaginal tears, involving the cervix, and significant bleeding. She found Dr B and asked him to re-assess Ms A as the injuries were beyond her scope of practice to repair. Dr B re-assessed Ms A and administered a local anaesthetic. He began to suture Ms A in the birthing room, but soon decided to complete the repair in theatre under general anaesthetic.

Dr G assisted Dr B with the surgery. She stated that Ms A's tearing and blood loss was "excessive", taking an hour to repair and requiring two units of transfused blood.

[21] An Apgar score is used to ascertain and record the condition of the baby, looking at the colour, respiratory effort, heart rate, muscle tone and reflex response, with a maximum/optimal score of 10.

*Clinical records*

Dr G reported that after the delivery, she returned to the Nurses Station and saw Dr B reading Ms A's folder. She stated that Dr B asked her to "come and write down that [he] was able to do the delivery in one easy pull", then stayed until Dr G had written the statement down. Her clinical notes for Ms A contain the statement "Kiwi cup applied and delivery went well without difficulty on single contraction". Dr G explained that she recorded this statement because she was "afraid of [Dr B] and was also very busy and just wanted him to go away". Dr G gave consistent evidence on this matter in her statement to the Coroner and when interviewed by HDC.

Prior to his departure, Dr B dictated a summary of events to Ms E. Ms E reported that when she came to record the cause of the avulsion of Baby A's umbilicus, she noted that Dr B had avulsed the umbilicus. According to Ms E, Dr B told her "not to write that" because "we don't want to attribute blame". Ms E obliged and the cause of the avulsion of the umbilicus was omitted from her record of events. Ms E gave consistent evidence on this matter in her statement to the Coroner and in her response to HDC.

Dr B has not commented on either of the above incidents concerning the clinical notes described by Dr G or Ms E.

Dr B's handwritten summary of the events in Ms A's clinical notes contains the following entry at 7.15pm:

> "Informed consent, risks described for vac [vacuum] extraction. Instrumental vac. extraction performed — fetal head delivered on single contraction. Nuchal cord, cord snapped, infant delivered & compression over stump of cord."

As noted above, Dr B recorded in a second, typewritten summary of events in Ms A's clinical notes:

> "I obtained informed consent and did a vacuum extraction delivery through one contraction."

*Paediatric care*

Dr H attended Baby A in the birthing room and assessed her after her umbilicus had been sutured. He found her to be pale and floppy, but crying spontaneously and responsive to touch, with mild swelling of her scalp. Dr H took Baby A to the neonatal unit, inserted an IV line and began administering fluids and antibiotics. He drew blood samples, which he personally delivered to the laboratory, before telephoning the on-call paediatrician, Dr I, to inform him of the new admission. Baby A's oxygen saturation, blood pressure, heart and respiratory rates were satisfactory. Although Dr H noted a "boggy" haematoma on her scalp, he thought this to be a cephalatoma.[22]

Dr H left the ward briefly to write retrospective notes and, at 8.30pm, Baby A stopped breathing while being held by her father. Her oxygen saturation was low, but she was intubated and ventilated to good effect. Dr I was asked to assess Baby A, and noticed that the swelling on her scalp was increasing. He documented "?? Subgaleal haemorrhage" in the clinical notes.

Dr I arrived at 9.00pm, and took over Baby A's care. Dr I called Dr J, a paediatrician at Dunedin Hospital, to discuss Baby A's care. Both agreed that subgaleal haemorrhage was likely, and that large volumes of blood products would be needed. Transfer to Dunedin Hospital was discussed, but it was decided that appropriate care could be provided at Southland Hospital. Baby A's head was bandaged, and intraosseous (within bone) access for fluids was established.

Throughout the night, Baby A received large volumes of whole blood, plasma and saline, but continued to deteriorate. At 2.24am the following day, Dr I discussed Baby A's deteriorating condition with Dr J, and helicopter transfer to Dunedin Hospital was arranged.

At 5.00am, Dr J arrived at Southland Hospital and took over Baby A's care. He noted an "obvious tense boggy swelling on [Baby A's] scalp", that seizure activity had been observed, and that she was minimally responsive. Baby A was immediately transferred by helicopter to Dunedin Hospital, accompanied by her father. Ms A was transferred to Dunedin Hospital later that day.

Despite intensive care Baby A died shortly afterwards.

[22] Cephalatoma occurs when blood accumulates under the periosteum, a membrane that covers each skull bone. Blood loss is confined to the affected skull bone, so is rarely significant.

## Follow-up actions by Southland DHB

On the day of Baby A's death, Dr B's supervisor, Dr D, advised Southland DHB that he was no longer willing to supervise Dr B in light of his actions while caring for Ms A and her daughter. A special medical advisors' meeting was convened in response, and it recommended that a sentinel event investigation[23] into Baby A's birth be conducted. The medical advisors also believed that Dr B posed a risk to patient safety, and recommended that he be stood down pending further investigation.

Accordingly, Southland DHB immediately restricted Dr B's practice to non-clinical duties, and his practice was formally restricted from 29 June 2006 to exclude obstetric practice and participation on the on-call roster. Dr B continued to work in an administrative role until 1 September, when he was granted three weeks' annual leave. On 19 September 2006, Dr B tendered his resignation, which was accepted by Southland DHB.

## Subsequent reviews

*Southland DHB*

In accordance with the recommendations made by the special medical advisors meeting, Southland DHB asked an Auckland-based obstetrician to provide an independent and confidential review of the care Dr B provided to Ms A and her daughter. I have not been provided with a copy of the report. The Chief Executive Officer of Southland DHB, advised:

> "Southland DHB has no objection to providing [the] report to you but will not be able to do so without [Dr B's] consent. Southland DHB does not expect such consent to be granted and has accordingly not even approached [Dr B] in relation thereto. This is largely based upon the approach taken by [Dr B] and his legal representative during the review process."

Southland DHB also conducted a sentinel event investigation. In response to recommendations made in the sentinel event report, a maternity services action plan was developed on 2 July 2007 (see Appendix 2). Southland DHB advised that the recommendations have largely been implemented.[24]

*ACC*

On 15 September 2006, ACC received independent advice from an obstetrician and gynaecologist, who advised:

[23] A sentinel event investigation is a confidential process, and only the recommendations made in the final report are publicly available.

[24] Southland DHB advised HDC that the only recommendation that has not been implemented is that LMCs must undertake education relating to the issues raised in the sentinel event investigation report as a requirement of their access agreements with the District Health Board. Southland DHB submitted that it did not have the capacity to implement this recommendation.

> "Subgaleal haemorrhage is a rare complication of vaginal delivery, normal or assisted. ... It is more likely to be associated with difficult or failed vacuum extractions."

On 18 September 2006, ACC accepted Ms A's treatment injury claim for fetal-maternal injury (subgaleal haemorrhage sustained through ventouse extraction) causing the death of Baby A.

*Coroner*

On 22 August 2007, the Coroner held a hearing for his inquest into the death of Baby A. In his decision of 24 October 2007, the Coroner found:[25]

> "[Baby A] ... died at Dunedin Public Hospital from a massive subgaleal haemorrhage with subsequent hypoxic brain injury plus renal failure, following a forceful vacuum assisted delivery, and with blood loss from an accidentally avulsed umbilical cord being also a contributing factor."

The Coroner did not make any recommendations in light of his findings.

**Malpractice proceedings — *Cases 3 and 4***

As noted earlier, *Case 3* was tried by jury in a state court on 26 May 2006 — approximately two weeks before Dr B provided obstetric services to Ms A. The jury unanimously found in favour of the plaintiff and awarded $US275,000 in damages against Dr B and his company (a joint defendant). In a final order on 13 July 2006, the Court accepted the jury's verdict. Dr B and his company paid the amount awarded in damages. On 3 December 2007, *Case 4* was settled between the parties. On the same day, the Court dismissed the case and made its final order.

[25] Finding of Coroner, *In the Matter of an Inquest into the Death of Baby A* (Coroner's Court, Invercargill, 24 October 2007), [36].

## Responses to Provisional Opinion

The majority of the parties' comments have been reflected through amendments to the above text. Their remaining comments are outlined below.

*Ms A and Mr A*
Ms A and Mr A believe that Southland DHB should be held vicariously liable for Dr B's breaches of the Code. They consider that Southland DHB should not have employed Dr B after receiving information about medical malpractice cases pending and previously settled by him in the United States, and that the DHB did not respond appropriately to concerns raised by Dr B's supervisor and other staff.

Ms A and Mr A stated:

> "[Baby A's] death and suffering were avoidable and we hold Southland DHB accountable for not investigating [Dr B's] malpractice background and not putting in a safety plan when it was identified that he had serious practice issues."

*Dr B*
Dr B submitted that he "truly felt" that he had obtained Ms A's informed consent before attempting another ventouse-assisted delivery. Dr B believed Ms A had clearly refused a Caesarean section and his only available delivery option was an instrumental delivery with forceps or a ventouse. Dr B is "greatly saddened by the loss of [Baby A], and that [Ms A] felt that [he] was rude".

*Southland DHB*
Southland DHB explained that "[Dr B] was in the middle of disciplinary action when he resigned. This was centred around his treatment of [Dr G] who had made management aware of her concerns. This in itself is evidence of the change in culture, as previously such matters would often not be brought to our attention."

Southland DHB advised that it had taken "decisive action" to address the issue of bullying, by reviewing and implementing relevant policies, and taken disciplinary action against staff members who engaged in inappropriate behaviour. A strong commitment by management and clinical staff to the issue of bullying had seen a "gradual change in culture" within the District Health Board.

Southland DHB also stated:

> "The relationships between medical and midwifery staff within Southland DHB have improved since 2006. Midwifery staff are now much more prepared to act on instances of bullying behaviour by directly approaching the individual involved and dealing with the issue on a one-to-one basis. Where this does not result in resolution there is a commitment from both the medical

and nursing and midwifery leadership that the issue is dealt with in a disciplinary manner.

The service leaders have agreed that both those that bully and those that are bullied need to be recognised. The recognition of those that are potential victims of bullying has been an important development. These staff members are given additional support by colleagues and service leaders as they are often found to be subservient and reluctant to report their bullying experiences."

Southland DHB advised that there is presently an expectation that open disclosure will be pursued by all clinical staff following an adverse event. It is awaiting the Quality Improvement Committee's review and redevelopment of a national policy and guidelines for management and open disclosure of adverse events. Southland DHB will then provide comprehensive education on open disclosure.

## Code of Health and Disability Services Consumers' Rights

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

*Right 1*

*Right to be Treated with Respect*

*(1) Every consumer has the right to be treated with respect.*

*Right 4*

*Right to Services of an Appropriate Standard*

*(1) Every consumer has the right to have services provided with reasonable care and skill.*

*(2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.*

*Right 6*

*Right to be Fully Informed*

*(1) Every consumer has the right to information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including —*

*(a) An explanation of his or her condition; and*

*(b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; …*

*Right 7*

*Right to Make an Informed Choice and Give Informed Consent*

*(1) Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.*

## Commissioner's Opinion

## Breach — Dr B

### Introduction

Although Dr B had only recently come to New Zealand from abroad, he was required to comply with the Code of Health and Disability Services Consumers' Rights (the Code) and with all the professional standards applicable to his role as an obstetrician and gynaecologist. Ignorance of the Code, or of professional standards for obstetricians and gynaecologists in New Zealand, do not excuse Dr B's breaches of the Code.

Under Rights 4(1) and 4(2) of the Code, Ms A was entitled to be treated with respect and have services provided with reasonable care and skill, and in compliance with professional standards. Under Right 6(1), Ms A was entitled to the information that a reasonable consumer, in her circumstances, would expect to receive. Under Right 7(1), services could only be provided to Ms A if she had made an informed choice and given informed consent.

Having considered all the available information, I have concluded that Dr B breached the Code by failing to provide Ms A with obstetric care of an appropriate standard. I also consider that Dr B breached the Code by failing to provide Ms A with adequate information about the available delivery options; failing to obtain her informed consent to the third attempt at ventouse-assisted delivery; pressuring other providers to make false entries in the clinical notes; making his own misleading entries in the clinical notes; and failing to discuss the adverse event with Ms A. In my view, Dr B's breaches of the Code were a significant departure from an appropriate standard of care

and would be viewed by his peers with severe disapproval. The reasons for my decision are set out below.

## Obstetric care

*Ventouse delivery*

When Dr B attended the delivery, he knew that Dr G had made two previous attempts to deliver the baby by ventouse, and he instructed her to make preparations for a Caesarean section. However, he subsequently decided to attempt another ventouse extraction, stating that Ms A and Ms E refused the option of proceeding to a Caesarean section. Ms E confirmed that she told Dr B "the baby was coming", although Ms A denies that she was ever consulted about, or declined, a Caesarean section. Dr B stated:

> "I offered to make one attempt to deliver with the [ventouse] ... I explained that the baby's head was already [o]edematous[26] ... and there was a significant danger of injuring the child ..."

My independent expert, Dr Sharma, advised:

> "Once [Dr B] was contacted it seems apparent that an 'adequate trial' of the ventouse had already taken place.
>
> …
>
> Despite the allegation by him that the patient (and midwife) refused an emergency Caesarean (refuted by other observers), he should not have offered the option of a repeated instrumental delivery.
>
> ...
>
> Given the normal fetal heart rate pattern, it would have been entirely reasonable to try and convince the patient that she should contemplate Caesarean section as there [was] ample time to do this."

I agree with my expert that it was unwise for Dr B to consider another attempt at ventouse delivery. There was no indication that an urgently expedited delivery was necessary, and the decision to continue the trial of delivery by ventouse placed the fetus at risk.

[26] Oedema is a collection of fluid below the skin. While moderate scalp oedema and bruising is usual with ventouse delivery, further attempts at ventouse delivery are contraindicated where oedema is present.

Dr B's decision to attempt to deliver the fetus by ventouse is especially puzzling given that he had instructed Dr G to prepare for a Caesarean section (which was clearly indicated in the circumstances), and claims to have warned of risks to the fetus if a further ventouse attempt took place. Dr B went against his own advice, and accepted obstetric practice, attempting a ventouse delivery.

*Technique*
I am also concerned by Dr B's technique when performing the ventouse delivery. Although Dr B claims that he "easily delivered the fetal head" following a "gentle vacuum extraction", other witnesses reported that significant force was applied. Mr A stated that Dr B pulled "a number of times, very hard", while Ms F and Dr G reported that Dr B delivered Baby A's head with "a yank". Dr G advised that Dr B climbed onto the bed to gain maximum leverage for his pull, which she considered was very unorthodox. This evidence suggests that Dr B used excessive force to deliver Baby A, resulting in significant vaginal tearing to Ms A. The suturing of the tearing required a general anaesthetic, and a transfusion of two units of blood was required to replace the blood lost during Baby A's birth.

Although I have not received definitive advice on the cause of Baby A's subgaleal haemorrhage, Dr Sharma commented:

> "[C]linically significant subgaleal haemorrhage is associated with difficult ventouse deliveries, multiple detachments, and excessive numbers of traction efforts."

*Pain relief*
Dr Sharma advised that, having decided to attempt a ventouse extraction again, Dr B should have offered Ms A regional anaesthesia (pudendal nerve block or epidural) before the procedure. Given that there was no rush to deliver the baby, and Dr B knew Ms A was "exhausted and in severe pain", Dr B should have offered anaesthesia.

*Difficulties with the umbilicus*
Ms E stated that when Baby A's head was delivered, the umbilicus was around her neck and could not be eased over her head. Ms E called for clamps and scissors to cut the cord but Dr B intervened and, while attempting to lift the cord over Baby A's head, it was avulsed (torn) at her abdomen. Ms E stated that she heard a "snapping" sound and that there was bleeding. In contrast, Dr B claims that he asked Ms A not to push, but she did, and the force of delivery caused the cord to tear.

There were no other witnesses to the tearing of the cord but Ms E and Dr G both confirmed that Dr B later apologised to Ms A and Mr A for "pulling the cord off". On balance, I am satisfied that the cord tore when Dr B attempted to force it over Baby A's head.

Dr Sharma advised that Dr B should have been very cautious when trying to manually lift the cord over the baby's head, following Ms E's unsuccessful attempt. I concur

with my expert's view on this point: "The force applied by [Dr B] was likely to have been excessive."

In summary, Dr B's overall management of the ventouse delivery fell below an appropriate standard. Dr B breached Right 4(1) of the Code because he made a third attempt to deliver Baby A by ventouse when a Caesarean section was indicated; he failed to offer pain relief; he performed the ventouse extraction with excessive force; and he used "excessive" force in an attempt to lift the umbilical cord over Baby A's head.

*Transfer of care*

Appendix 1 of the Section 88 Maternity Notice 2002 (the Guidelines), made pursuant to section 88 of the New Zealand Public Health and Disability Act 2000, sets out clear guidelines for primary practitioners referring patients to obstetric services. The Guidelines define three levels of referral and consequential action for practitioners to follow. The Guidelines list failed instrumental delivery as a condition necessitating "Level 3" referral, requiring the Lead Maternity Carer to recommend to the woman that the responsibility for her care be transferred to a specialist. In situations requiring Level 3 referral, the specialist will usually assume ongoing responsibility for the care of the woman, and the role of the primary practitioner will be agreed between those involved. The Guidelines emphasise that the decision regarding ongoing clinical roles/responsibilities must involve a three-way discussion between the specialist, the Lead Maternity Carer and the woman (or parents) concerned.

As stated above, I do not accept that Dr B has a lesser responsibility, as a doctor trained abroad, to follow professional standards and guidelines for an obstetrician and gynaecologist in New Zealand.

I also do not accept Dr B's statement that on his arrival, "management of the case was not turned over to [him]". Based on the Guidelines, responsibility for Ms A's ongoing care was transferred to Dr B when he arrived at 6.45pm and assumed responsibility for the delivery. There was no discussion at the outset regarding ongoing clinical roles and responsibilities between Dr B, Ms E, and Ms A and Mr A, as required by the Guidelines. It would have been sensible for Dr B and Ms E to discuss the options for delivery so that all parties were aware of where responsibilities lay and what was expected of them.

Based on the Guidelines, ongoing responsibility for Ms A's care had been transferred to Dr B. However, after Dr B had delivered Baby A's head, he attempted to transfer responsibility for Ms A's care back to Ms E. Dr B's actions were very unusual and were contrary to generally accepted obstetric practice. Dr Sharma advised:

> "I have never heard of the handover of completion of delivery after only the head has been born. Handing on an incomplete task negated the nature of the task at hand and the special trust that is placed by the birthing woman."

Dr B also failed to examine the extent of Ms A's vaginal lacerations after attending to Baby A. The Guidelines list cervical laceration as a condition necessitating Level 3 referral (ie, the specialist will usually assume ongoing responsibility). Dr Sharma advised:

> "[Dr B] obviously asked [Ms E] to undertake the repair without examining the degree or extent of the tears as later he would make the decision to take [Ms A] to theatre himself.
>
> [I]n the absence of another emergency to go to and with the additional issues regarding the baby's avulsed cord and very traumatic delivery, I cannot understand why [Dr B] would leave the room and ask [Ms E] to repair the vagina. ... [A] truly professional commitment would have led him to staying and completing the episode."

In my opinion, Dr B breached professional standards, and thus Right 4(2) of the Code, by attempting to transfer Ms A's care back to Ms E mid-delivery, before he had examined the degree of Ms A's vaginal and cervical lacerations. His actions must have been extremely disconcerting for both Ms E and Ms A, and showed a fundamental lack of understanding of his role.

*Summary — Obstetric care*

Overall, the obstetric care Dr B provided to Ms A fell well below an appropriate standard[27] and amounted to a breach of Rights 4(1) and 4(2) of the Code.

> "[Dr B] did not provide an appropriate and acceptable standard of care, and his failure to do so was major. I believe that given the multiple issues involved, namely repeat attempt at ventouse delivery after a failed previous attempt, leaving the midwife to complete the delivery, avulsion of the cord and initially leaving the midwife to repair the tears, disapproval from other peers of his would be severe."

*Postnatal care*

I agree with my expert that Dr B provided an appropriate standard of care to Baby A when he was attempting to control the bleeding from her avulsed umbilicus.

[27] Although Dr B injured Baby A while performing the ventouse extraction, and avulsed her umbilical cord, any injury the baby sustained before completely proceeding from her mother's body is classified as an injury sustained by Ms A (see *Harrild v Director of Proceedings* [2003] 3 NZLR 289).

## Clinical records

As the Coroner noted in his report following an inquest into the death of Baby A, "A disturbing feature of this case is [Dr B's] attempt to sanitise the record."[28]

Dr G and Ms E both gave independent and consistent evidence that Dr B deliberately asked them to make false entries in the clinical record.

First, Dr B pressured Dr G to write "delivery went well, without difficulty on single contraction" in Ms A's clinical notes. This description of the delivery is contrary to Dr G's subsequent account that Dr B delivered Baby A's head with significant force.

Later, Dr B asked Ms E not to record that he had avulsed Baby A's umbilicus. He explained this on the basis that he wanted to prevent the allocation of blame. Ms E obliged and the cause of the avulsion of the umbilicus was omitted from her record of events.

In light of the subsequent evidence given by Ms E and Dr G during the Coroner's inquest and this investigation, I accept their statements that these entries were false and that they felt pressured to write them by Dr B.

Dr B's entries in Ms A's clinical notes were also misleading. After the birth, Dr B made the following entry:

> "Informed consent, risks described for vac [vacuum] extraction. Instrumental [?] vac. extraction performed — fetal head delivered on single contraction. Nuchal cord, cord snapped, infant delivered [and] compression over stump of cord."

A typewritten summary of the events by Dr B in Ms A's clinical notes contains the statement, "I obtained informed consent and did a vacuum extraction through one contraction."

Those entries do not accurately describe the force required to deliver Baby A and disguise the fact that the avulsion of the cord was caused by Dr B's attempt to lift the cord over Baby A's head. The adverse events should have been clearly and comprehensively described in the clinical record. I note also that although Dr B stated that he conducted a vaginal examination after his arrival in the birthing room, he did not document his findings. In my view, Dr B's clinical notes were incomplete and intentionally misleading.

[28] Finding of Coroner, *In the Matter of an Inquest into the Death of Baby A* (Coroner's Court, Invercargill, 24 October 2007), [35].

Appropriate documentation is essential for coordination between providers, and to ensure consistency and quality of care. Patient care and sentinel event investigations should not be compromised by individual doctors seeking to avoid responsibility for their actions through dishonest falsification of clinical notes. This point is emphasised in Opinion 03HDC11066[29] and the Health Practitioners Disciplinary Tribunal's subsequent decision.[30] On appeal to the High Court, Courtney J stated:[31]

> "The word of a professional person must be reliable. Patients must be able to rely on their doctors. Those undertaking statutory functions for the protection of the community's interests such as the HDC must be able to rely on the information they are given."

The Medical Council's statement on "The Maintenance and Retention of Patient Records" (the Medical Council Statement) is also relevant. According to the Medical Council, "Records form an integral part of any medical practice; they help to ensure good care for patients and also become critical in any future dispute or investigation." The Council further states:

> "Information should be accurate and updated at each consultation. Patient records are essential to guide future management, and invaluable in the uncommon occasions when the outcome is unsatisfactory."

In this case, Dr B's pressure on other providers to make false entries and omit key facts resulted in incomplete and inaccurate records. Although it was unprofessional for Dr G and Ms E to accede to Dr B's requests and record the false entries, I am satisfied that both providers only did so under duress. Should the situation arise again, I encourage Dr G and Ms E to report such incidents and correct the notes at the earliest opportunity.

In my view, Dr B's pressuring of Dr G and Ms E to make inaccurate clinical notes, and his failure to fully record an adverse event, was a serious departure from professional standards, and a breach of Right 4(2) of the Code.

**Communication**

*Informed consent*

Dr B attended the delivery at the request of Dr G, to assist with delivery after a failed attempt at ventouse extraction. Dr B assumed responsibility for the delivery due to his senior position. He was also responsible for assessing the situation, informing Ms A of her current condition, and explaining the treatment options available to her.

[29] http://www.hdc.org.nz/files/hdc/opinions/03hdc11066gp.pdf (6 July 2005).

[30] *Re N* (Health Practitioners Disciplinary Tribunal, 58-Med05-15D, 31 August 2006).

[31] *Martin v Director of Proceedings* (High Court Auckland, 2 July 2008, Courtney J), paragraph 117.

In his response to Ms A's complaint, Dr B stated that "it should be up to her midwife to advise her [of] the safest mode of delivery — a [Caesarean]". I do not accept Dr B's assertion. Responsibility for informing Ms A of the safest mode of delivery lay with Dr B, as he had assumed responsibility for her care and would be performing the procedure.

There are conflicting accounts of the discussion Dr B had with Ms A about her options for delivery and the various risks. Dr B stated:

> "I discussed a Caesarean delivery, stated it was the best choice, and a repeat attempt at vacuum extraction with [Ms A] and her husband, clearly informing them of the risks of each. She understood and stressed again that she did not want a Caesarean."

Dr B said that he warned Ms A that if another attempt at ventouse-assisted delivery did not succeed, "we would have no option for the sake of her baby but to perform a Caesarean delivery". According to Dr B, Ms A understood and agreed. Later, at 7.15pm, Dr B recorded the statement "informed consent, risks described for [vacuum] extraction" in Ms A's clinical notes.

Ms F reported that Dr B "explained that the options were Caesarean or another attempt at ventouse, and said both of these held risks for the baby". However, Ms F did not identify the risks that were discussed. According to Ms F, Ms A indicated that she preferred another attempt with the ventouse and would rather not have a Caesarean section.

Ms E has confirmed that she assessed the birth as being imminent and expressed this view to both Dr G and Dr B. At 10.51pm, Ms E recorded "informed consent obtained and options for Caesarean section and ventouse. Ventouse option decided upon" in a summary of events in Ms A's clinical notes. This summary of events was also signed by Dr B.

Ms A cannot recall any specific conversation about the risks of proceeding with a third attempt at ventouse. She recalls that Dr B warned her that "if [she] didn't push [Baby A] out in two goes he would take [Ms A] upstairs and cut [Baby A] out of [her]". Ms A stated that she cried out for Dr B to stop once the ventouse extraction was under way, but Dr B interpreted this as an expression of pain.

Ms F states that both options and risks were mentioned but does not elaborate on what the risks were.

Dr G cannot recall a specific conversation about the delivery options and associated risks. According to Dr G, Dr B assessed Ms A and told her he would attempt to

deliver the baby using the ventouse, otherwise a Caesarean section would be necessary.

Dr B stated that he wanted to proceed to a Caesarean section but was pressured by Ms A and Ms E to attempt another ventouse extraction.

In circumstances where Dr B was aware that two previous attempts at a ventouse extraction had occurred, I consider it reasonable for him to assume that Ms A had already been advised by Dr G about the risks associated with ventouse extraction. Accordingly, it was not necessary for him to give another full explanation of all the expected risks and benefits associated with ventouse. What Ms A needed was Dr B's assessment of her current condition and the options for delivery. If there was some additional risk presented by a third attempt at ventouse because, as Dr B noted, Baby A's head had become swollen, Ms A needed to be informed of that risk. She also needed information about the relative risks and benefits of proceeding to Caesarean section, Dr B's assessment of the urgency of the matter, and his opinion on the safest course of action, so that she could make an informed choice.

On balance, I am not satisfied that Dr B gave Ms A sufficient information about the risks involved with a third ventouse and his preferred option of a Caesarean section. While Dr B was required to take Ms A's preferences into account, it was his responsibility to ensure she had enough information to make an informed choice. Ms A had only been informed about the risks and benefits of a ventouse delivery at that point so could not make an informed choice. Even though this was a highly stressful situation and prompt action was required, there was no rush to expedite the delivery. Dr B had sufficient time to explain the available options, and allow Ms A time to make an informed decision. He failed to do so.

When Dr B attached the ventouse cup, Ms A asked him to stop, but he did not, and delivered Baby A in the next contraction. Although it may not have been clear whether Ms A's request to stop the delivery was genuine or simply a reaction to pain, I agree with Dr Sharma that it would have been appropriate for Dr B to take brief "time out" to clarify the issue with Ms A. Dr Sharma noted:

> "In my experience, this clarification is important and can be undertaken in a few seconds."

The importance of providing consumers with full information has been highlighted in previous HDC Opinions. Notably, in Opinion 05HDC16711, an obstetrician was found in breach of Right 6(1) of the Code for failing to provide a consumer with full information about options when her labour was not progressing. It was held that the obstetrician should have provided the consumer with an explanation of her condition

as well as an explanation of all available delivery options and their relative risks and benefits.[32]

In my view, Dr B breached Right 6(1) by failing to provide Ms A with an adequate explanation of the options for delivery. Without that information, Ms A could not make an informed choice. Accordingly, Dr B also breached Right 7(1).

*Open disclosure*
There is no evidence that Dr B met with Ms A to explain the adverse events that had occurred during Baby A's delivery. Dr B should have checked on Ms A and discussed the difficult ventouse-assisted delivery and avulsed umbilicus at an early stage, so that she was aware of what had happened and why, and the options for further treatment. A reasonable consumer would expect no less. Dr B's failure to share this information with Ms A was also a breach of Right 6(1) of the Code.

*Respect*
Ms A was concerned by Dr B's manner and lack of respect towards her throughout the delivery. She reported that Dr B told her that she "[had] to stop using [her] words and use [her] energy to push [Baby A] out". She felt that Dr B was "rude in the way he was saying it". This was confirmed by Ms E, who stated that "[Dr B] was so rude telling her to shut her mouth", and Mr A, who described Dr B's approach as "shut up and push".

Ms F reported:

> "[Ms A] was making noise with each contraction, and [Dr B] asked her to focus, look at him, be quiet, put her lips together and push, and said she was making too much noise and wasting energy."

Dr G made general statements about Dr B's manner towards the parties involved. She said he was "a little stressed, but was not rude to anyone" and explained that Dr B "just had a loud voice". Dr B has not responded on the issue of his manner towards Ms A.

As a health professional, Dr B was required to communicate with Ms A respectfully during her very stressful delivery. On the basis of the evidence of Ms E, Mr A and Ms A, I consider that Dr B showed a lack of respect for Ms A by asking her to reduce her noise during contractions, in a manner that was perceived as berating. If there was some clinical benefit in Ms A redirecting her energy to pushing, this should have been explained to her calmly and respectfully. On the available evidence, I am not

[32] At page 18.

persuaded that he did so. Reprimanding a labouring woman is inappropriate and, in this case, amounted to a breach of Right 1(1) of the Code.

## No breach — Southland District Health Board

*Postnatal management*
Baby A developed a subgaleal haemorrhage shortly after her admission to the neonatal unit, and it was diagnosed two hours after birth.

Baby A received appropriate care during her admission to the neonatal unit. The paediatrician was immediately consulted when her condition deteriorated suddenly, appropriate contact was made with Dunedin Hospital's paediatric unit to discuss the correct management, and she was promptly transferred to Dunedin Hospital when it became clear that she required more specialist care than was available at Southland Hospital.

*Employment of Dr B*
During the period under investigation, Dr B was employed by Southland DHB. Under section 72 of the Health and Disability Commissioner Act 1994 ("the Act") an employer is liable for acts or omissions by an employee unless the employer proves that it took such steps as were reasonably practicable to prevent the employee from breaching the Code. As an employer, a DHB may also be directly liable for ensuring that its clinical staff are appropriately credentialled and (if necessary) supervised.

Dr B breached Rights 1(1), 4(1), 4(2), 6(1) and 7(1) of the Code, by failing to treat Ms A in a respectful manner, failing to provide her with appropriate obstetric care, failing to provide her with adequate information about the options available, failing to obtain her informed consent to the ventouse-assisted delivery, failing to document events appropriately in the clinical notes, and failing to explain to Ms A the adverse events that had occurred. In my view, Dr B's breaches of the Code were the result of poor professional judgement, which could not have been anticipated, and which Southland DHB could not reasonably have been expected to prevent.

In response to my provisional opinion, Ms A and Mr A challenged the provisional finding that Southland DHB was not liable for Dr B's breaches of the Code. They believe Southland DHB should have foreseen Dr B's breaches of the Code and the untoward events that occurred during Baby A's birth, because the DHB knew about his previous malpractice claims. Since Baby A's death, Dr B and care of Ms A and Baby A, and Southland DHB's role in employing him, have received significant media attention.

I have scrutinised the steps Southland DHB took to ensure that Dr B was appropriately recruited and supervised during his time at Southland Hospital. I am satisfied that, in

contrast to the recruitment and supervision of the overseas-trained medical officer (Dr Hasil) in the Whanganui DHB inquiry,[33] Southland DHB took appropriate care in the recruitment and supervision of Dr B.

Dr B openly disclosed his malpractice claim history in the course of his application for employment and registration, and it was duly considered by both the DHB and the Medical Council. He was then subject to regular supervision and received favourable reports. There was no indication that Dr B had performance issues that required addressing and would be likely to breach the Code. In these circumstances, Southland DHB cannot be held liable for his actions.

The processes surrounding Dr B's recruitment and supervision are discussed below.

*Recruitment*
A DHB must exercise reasonable care and skill when recruiting staff so that only candidates with the appropriate skills, experience and qualifications are employed. A DHB must have robust recruitment processes and support staff to comply with them.[34]

In this case, Dr B's recruitment was overseen by Dr C. Dr C became aware of the previous malpractice claims when Dr B disclosed them during his initial telephone interview. Dr B confirmed that none of the claims had been substantiated and provided details for five referees. Dr C subsequently spoke to two referees, who described Dr B positively. Neither was aware of any malpractice claims.

Dr C said that he considered a number of factors in deciding to make a conditional offer of employment to Dr B. He was reassured by Dr B's candour and the fact that Dr B's malpractice claim history in the United States would be thoroughly considered by the Medical Council before an offer was confirmed. Dr C discussed Dr B's application with two senior colleagues, and they agreed that the previous complaints did not constitute a barrier to Dr B's employment. He was of the view that the complaints were based on reasonably common obstetric adverse events, such as shoulder dystocia, they had not been substantiated and, given the culture surrounding complaints and compensation in the United States, four complaints in the course of a 20-year practice was not unreasonable.

I agree that a malpractice claim history (including two settled cases and two open cases) in the context of an obstetrician and gynaecologist practising in the United States over more than 20 years does not preclude a DHB from employing a doctor, provided that reasonable enquiries are made and the results are reassuring. A doctor's

[33] *Dr Roman Hasil and Whanganui District Health Board 2005–2006: A Report by the Health and Disability Commissioner* (07HDC03504).

[34] 07HDC03504, at page 80.

complaint history is one of many considerations to be taken into account in the decision-making process.

Ideally, Southland DHB would have contacted more than two of Dr B's nominated referees (in particular, the two who had not provided a written reference) and contacted Dr B's most recent United States employer. While Southland DHB may have been reassured by Dr B's candour and the fact that further checks would be carried out by the Medical Council, it is also incumbent on an employer to complete its own checks with due diligence. Nonetheless, the references the DHB obtained described Dr B's personal character and professional skills in very positive terms.

On balance, I conclude that Southland DHB exercised reasonable care in recruiting Dr B. Furthermore, I note that after additional checks, the Medical Council went on to register Dr B within a provisional vocational scope of practice in obstetrics and gynaecology. As part of Dr B's application for registration within a vocational scope of practice, the Medical Council obtained advice from the relevant branch advisory body of RANZCOG, which recommended Dr B as suitable for vocational registration subject to 12 months' satisfactory supervised practice.

*Supervision*

The Medical Council's registration process provides a further important safeguard to ensure that only appropriately qualified persons are permitted to practise as doctors in New Zealand. Dr B was also open in his disclosure to the Council of the previous claims against him, in his application for registration. As a result, the Council sought more information about the claims and Dr B's defence, certificates of good standing from his former registration boards to cover the previous three years, and a full curriculum vitae to explain any absences from practice. It obtained a reasonable explanation regarding Dr B's decision not to renew his insurance, and undertook robust reference checks, including a reference from his most recent employer.

Once all of this information had been gathered, Dr B's special purpose application was placed before the Registrar of the Medical Council for consideration. The Council accepted that the history of malpractice claims and the circumstances surrounding Dr B's decision not to renew his insurance did not affect his fitness to practise. Dr B's application was approved on 2 August 2005, subject to Dr C being fully informed of the nature of the previous malpractice claims.

The previous malpractice claims were also taken into account when the Medical Council approved Dr B's application for vocational registration in September 2005. Three referees were contacted, with the only negative comment being that Dr B "can be impatient under stress".[35]

[35] It is easy to appreciate the significance of this comment now, with the benefit of hindsight, but at the time it was received by the DHB it is unlikely to have rung any alarm bells.

The Medical Council's "Policy on registration within a vocational scope of practice for overseas trained doctors" (May 2004) sets out the requirements for a doctor in Dr B's position to be registered within the vocational scope of obstetrics and gynaecology. In order to qualify for such registration, Dr B was required to satisfactorily complete a minimum of 12 months' supervised practice.

According to the Council's policy, the first requirement for supervision was one or more supervisor(s) who are registered within the vocational scope of obstetrics and gynaecology. Dr B was initially supervised by Dr C, and later by Dr D — both vocationally registered obstetricians and gynaecologists approved as Dr B's supervisors by the Council. The standard supervisory regime was implemented and no additional supervision was considered necessary. I note that this arrangement was approved by the Council, and agree that it was appropriate.

The Medical Council requires supervisor(s) to provide comprehensive supervision reports to Council and the relevant branch advisory body at three-monthly intervals. Dr C completed two supervisor's reports and Dr D completed one supervisor's report on Dr B's practice in the ten-month period between the commencement of his employment and a day after Baby A's death — the date when Dr D withdrew his supervision and Southland DHB restricted Dr B's practice to non-clinical duties.

Dr C had almost daily contact with Dr B and filed three-monthly supervisor's reports dated 11 November 2005 and 2 March 2006. Dr B's performance was described as being exceptional and no areas of concern were identified.

Dr D took over as Dr B's supervisor on 9 March 2006. On the day of Baby A's death, Dr D completed one supervisor's report for the period between 10 February and 10 May 2006. Dr D reported that Dr B's performance was "above expectation" with regard to clinical knowledge and skills, and that he was meeting or exceeding expected standards in all other competencies, except in emergency situations, and when dealing with midwives. Dr D noted "overreaction even in not high risk situations" and Dr B commented, "I have been trying to improve my relations with midwives."

Although Dr D made no adverse comments in his report, I note that his report was filed the day after Baby A's death. Accordingly, there is no evidence that Southland DHB was on notice of any concerns with Dr B's performance when Ms A presented in labour.

Ms A and Mr A advised HDC of another birth at Southland Hospital where a baby had died and Dr B had been the attending obstetrician. This was alleged to have occurred a matter of months before Baby A's birth. However, I note that the consumer in that case did not make a complaint to Southland DHB until after Baby A's birth. The

earlier birth was the subject of an internal investigation by the DHB and a subsequent complaint to HDC. The outcome of both reviews[36] was that the premature baby was severely compromised at birth, and the adverse outcome was in no way attributable to Dr B. There is no evidence that this birth should have prompted Southland DHB to consider any additional supervision or restriction on Dr B's practice.

*Summary*
In summary, I am satisfied that Southland DHB took reasonable steps to recruit and supervise Dr B in order to protect patients.

*Bullying*
As noted above, I am concerned at the pressure that Dr B placed on Dr G and Ms E to make incomplete or inaccurate clinical records. In my view, a district health board should have effective processes in place to address staff bullying.

Southland DHB has confirmed that it is addressing the issue of bullying. It has reviewed and implemented relevant policies, and taken disciplinary action against staff members who have engaged in inappropriate behaviour. I agree with the DHB's comment that "policies are meaningless without commitment from management to act upon them".

In relation to Dr B's intimidation of Dr G and Ms E, I acknowledge that Dr G correctly raised her concerns with Southland DHB management and that disciplinary action resulted.

On the broader issue of medical and midwifery relationships, I am encouraged that leaders from both professions at Southland DHB have taken steps to improve relationships between medical and midwifery staff within the DHB, with a particular focus on bullying. I encourage Southland DHB to include independent midwives in relationship-building initiatives.

*Open disclosure*
Like many DHBs, Southland DHB did not have a specific open disclosure policy in 2006.

It advised that staff are expected to openly disclose any adverse event. However, the DHB is awaiting the Quality Improvement Committee's review and redevelopment of a national policy and guidelines for management and open disclosure of adverse events before undertaking policy development and further education in this area.

[36] The HDC assessment relied on independent advice from an expert obstetrician.

## Follow-up actions

- Dr B will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.
- A copy of this report will be sent to:
    - the Medical Council with the recommendation that the Medical Council review Dr B's competence, should he return to practise in New Zealand
    - two United States medical boards
    - the Invercargill Coroner.
- A copy of this report, with details identifying the parties removed (other than Southland DHB, Southland Hospital and Dunedin Hospital) will be sent to the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, the New Zealand College of Midwives, the Maternity Services Consumer Council, and the Federation of Women's Health Councils Aotearoa, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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## Addendum

The Director of Proceedings decided to lay a charge before the Health Practitioners Disciplinary Tribunal. The Tribunal concluded that none of the particulars were established, and the charge was dismissed.

Link to HPDT decision: http://www.hpdt.org.nz/portals/0/med08107ddecdp070web.pdf



*Names have been removed (except Southland Hospital/DHB, Dunedin Hospital) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.*

# Appendix 1

## Independent advice to Commissioner

The following expert advice was obtained from Dr Anil Sharma:

> "I, Dr Anil Sharma have been asked to provide an opinion to the Commissioner on Case 06/12769 and have read and agree to follow the Commissioner's guidelines to independent advisors.
>
> I am a Consultant Obstetrician who is a member of the Royal College of Obstetricians and Gynaecologists (MRCOG London) and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (FRANZCOG Melbourne).
>
> **Qualifications:**
>
> MB ChB (Bachelor of Medicine and Surgery, University of Leicester, UK, 1987
> DGM Diploma of Geriatric Medicine, Royal College of Physicians, London, UK, 1990
> MRCOG as above, 1996
> FRANZCOG as above, 1999
> CCST, Certificate of Completion of Specialist Training. Specialist Training Authority, UK, 2000
> Disploma in Legal Aspects of Medical Practice, Cardiff University, UK, 2001
>
> **Purpose**
>
> To provide independent obstetric advice to assist the Commissioner to form an opinion on whether [Dr B] provided an appropriate standard of care to [Ms A] and her daughter, [Baby A].
>
> **Complaint**
>
> The following issues are subject to investigation:
>
> - *The appropriateness of care provided by [Dr B] to [Ms A] on [the day of Baby A's birth]*.
> - *The appropriateness of care provided by [Dr B] to [Baby A] on [the day of her birth]*.
> - *The appropriateness of care provided by Southland DHB to [Baby A] [the day of her birth and the following day]*.

**Supporting Information**

- Letter of complaint from [Ms A], dated 25 August 2006. Appendix A (page l–2)

- Copies of statements and reports obtained by [the] Invercargill coroner. Appendix B (pages 3–68)
- Information from Midwife [Ms E]. Appendix C (pages 69–77)
- Information from [Dr B]. Appendix D (page 78)
- Information from Southland DHB. Appendix E (pages 79–80)
- Information from RN [Ms F]. Appendix F (pages 81–86)
- Information from [Dr G]. Appendix G (pages 87–90)
- Copy of [Ms A's] medical notes from Southland DHB. Appendix H (pages 91–136)
- Copy of [Baby A's] medical notes from Southland DHB. Appendix I (pages 137–138)
- Copy of a letter from [Dr B] dated 10th March 2007
- Copy of a letter from [Dr B] dated 6th June 2007

**Expert Advice Required**

I have been asked to advise the Commissioner whether, in my professional opinion, the care provided to [Ms A] and her daughter, [Baby A], on [the day of Baby A's birth] by [Dr B] was of an appropriate standard. In particular:

1. Please comment generally on the care provided to [Ms A] and [Baby A] by [Dr B] on [the day of Baby A's birth].

If not covered above, please comment on the following:

2. Please comment on [Dr B's] decision to use the ventouse.
3. When re-applying the ventouse cup, [Ms A] asked [Dr B] to stop. [Dr B] did not stop and delivered the baby with the next contraction. Please comment on [Dr B's] decision.
4. Please comment on [Dr B's] decision to defer the delivery to Midwife [Ms E] after delivering the baby's head.
5. Did application of the ventouse cause [Baby A's] subgaleal haemorrhage? If yes, which application?
6. Please comment on [Dr B's] management of the baby's nuchal umbilical cord.

7. Please comment on [Dr B's] management of the avulsed umbilical cord.
8. Please comment on [Dr B's] assessment and management of [Ms A's] vaginal tearing.
9. Please comment on [Dr B's] manner and management style.
10. Are there any aspects of the care provided by [Dr B] that you consider warrant additional comment?

If, in answering any of the above questions, you believe that [Dr B] did not provide an appropriate standard of care, **please indicate the severity of his departure from that standard.**

To assist you on this last point, I note that some experts approach the question by considering whether the providers' peers would view the conduct with mild, moderate, or severe disapproval.

**Opinion**

I understand that [Ms A] had a normal and uneventful first pregnancy when she was induced by her midwife, [Ms E] on [the day of Baby A's birth], at 41 weeks and one day gestation (for post-dates pregnancy).

The first stage of [Ms A's] labour progressed well and labour was established at 4:30pm. She was given 1mg and then 2mg of intravaginal Prostaglandin to induce her labour, being managed at home in between.

By 1740 hours her membranes had spontaneously ruptured and she was pushing, albeit involuntarily. At 1800 hours full dilatation was documented to have been diagnosed by vaginal examination on the 'assessment record' (document 00100). I can also say that the intermittent cardiotocograph monitoring and documented intermittent fetal heart rate monitoring does not suggest that the baby was showing any heart rate evidence of fetal distress during the labour.

At 1815 hours, [Dr G] was called, who I note has been called house officer, senior house officer, registrar and also senior registrar at various points in the documents supplied to me to study.

[Dr G] undertook an attempted ventouse delivery on the premise that the second stage (the amount of time that the patient had been fully dilated) had been 'about an hour'. Having failed to deliver the baby, [Dr G] called the on-call consultant obstetrician, [Dr B].

Having assessed [Ms A], [Dr B] attempted further ventouse extraction and if this was unsuccessful, a Caesarean section was to be performed. The ventouse

was applied and the head was delivered in one contraction. [Dr B] passed responsibility for the rest of the birth to Midwife [Ms E]. She found that the cord was around the baby's neck but before she acted further, [Dr B] attempted to manually lift it over the baby's head. In the process, the cord was avulsed at the baby.

The baby was transferred to the resuscitaire table and haemostasis was eventually achieved.

[Dr B] left the room with the baby, but was recalled by Midwife [Ms E] to assess [Ms A's] vaginal tearing, as she found it to be excessive. [Dr B] decided to repair [Ms A's] vaginal lacerations in theatre under anaesthetic.

The baby subsequently died in the neonatal unit at Dunedin Hospital.

I have given opinion to fit with the specific points raised by the Commissioner's office and wish to add my deep condolences to the family of the baby.

*General comments on the care provided by [Dr B] to [Ms A] and [Baby A] by [Dr B] on [the day of Baby A's birth]*.
Overall and without alluding to the specific issues discussed below, it would seem from the statements made by [Ms A] and [Mr A], that courtesy and effective communication were particularly lacking. Although one must make allowances for the stress of the situation for [Dr B], it would be reasonable to say that the couple have very negative memories of the interaction and this in itself alludes to substandard care, at least in communication and establishment of rapport. Other issues that may have played a part in this case are the general impression of dysfunctional relationships between the various practitioners.

*[Dr B's] decision to use the ventouse*
Once [Dr B] was contacted it seems apparent that an 'adequate trial' of the ventouse had already taken place. Despite the allegation from him that the patient (and the midwife) refused an emergency Caesarean (refuted by other observers), he should not have offered the option of a repeated attempt of instrumental delivery. If he was of the opinion that an urgently expedited delivery was necessary and/or that the previous attempt to deliver was made by an incompetent practitioner, then it may have been reasonable to undertake a repeat 'expert' controlled attempt at ventouse. If one accepts that [Dr G] was thought to be a competent exponent of ventouse delivery (no evidence to the contrary supplied), then one must accept that a reasonable attempt at effecting ventouse delivery had already failed and that preparations for Caesarean section were needed (if the delivery occurred naturally whilst these

preparations were being made, then so be it). What is perplexing is that [Dr B] actually advised [Dr G] to prepare for a Caesarean and then changed his mind on arrival.

Given the normal fetal heart rate pattern, it would have been entirely reasonable to try and convince the patient that she should contemplate Caesarean section as there is ample time to do this. I note that an attempt by [Dr G] to place intravenous access after the failed ventouse delivery and after discussing the case with [Dr B] (who was then en route), was discouraged by the lead maternity carer. A failed instrumental delivery is widely accepted as an indication for readying for urgent delivery by Caesarean and given the time this can take it is good practice to start making preparations even if they are not subsequently needed.

If [Ms A] did indeed refuse a Caesarean (conflicting accounts), then it may have been reasonable to wait longer especially if [Dr B] was aware of the exact circumstances of the previous failed ventouse (3 applications), rather than undertake another ventouse. [Dr B] also talks of a 'repeat, gentle vacuum extraction', although the accounts of the actual repeat ventouse describe anything but 'gentle'.

*[Ms A] asking [Dr B] to stop when he was re-applying the ventouse*
[Dr B] did not stop and delivered the baby with the next contraction. I am satisfied that there is enough doubt as to the nature of the request to stop to not overly criticise [Dr B] on this issue. Whilst I reiterate that I do not condone the second attempt at ventouse, once one is underway, women in the second stage frequently request 'stopping'. A number of other witnesses including [Ms E] felt that the request to stop was a 'pain reaction rather than a demand to stop'. Nevertheless, I would suggest that some 'time out' should occur when a birthing woman requests that we 'stop' to clarify the issue. In my experience this clarification is important and can be undertaken in a few seconds.

*[Dr B's] decision to defer the delivery to Midwife [Ms E] after delivering the baby's head*
Although I know of cases where an obstetric acchoucheur hands over repair of vaginal tears (that are appropriate for midwives to repair) when he or she is needed urgently elsewhere for a medical emergency, I have never heard of the handover of completion of delivery after only the head has been born. Handing an incomplete 'task' over negates the nature of the task in hand and the special trust that is placed by the birthing woman. Because of the multiple descriptions of the dysfunctional relationship between [Dr B] and Midwife [Ms E], I am not convinced that the handover of delivery-completion was based on 'camaraderie' as [Dr B] has stated. I believe this to be a practice that is to be strongly discouraged; at best it was misinformed and at worst, an unethical act of one-upmanship.

*Did application of the ventouse cause [Baby A's] subgaleal haemorrhage? If yes, which application?*
Although subgaleal haemorrhage can occur after spontaneous vaginal birth, an association exists between it and ventouse delivery with a rate that is quoted from 1/100 to l/l0,000. Many instances of subgaleal haemorrhage do not cause any clinical effects. It is not possible to definitively decide which application caused the damage as there were 3 separate applications by [Dr G] and one from [Dr B]. Although it has been stated that [Dr B's] delivery with one pull included him sitting on the bed (a scenario that is difficult to imagine given the lack of space in the lithotomy position with the lower half of the bed having been removed) and was associated with quite major tears and blood loss which lends support to it being a difficult ventouse, I cannot say with any objectivity whether it was he or the previous acchoucheur that caused the subgaleal haemorrhage. I am concerned however that [Dr B] did not document his findings on the vaginal examination he undertook just before his attempt at ventouse. It is appropriate to point out that clinically significant subgaleal haemorrhage is associated with difficult ventouse deliveries, multiple detachments, and excessive numbers of traction efforts.

*[Dr B's] management of the baby's nuchal umbilical cord*
In cases where the cord is around the baby's neck it is accepted practice to try to lift the cord over the head and if this is not possible, then it is divided between clamps and untwisted from around the baby's neck to effect delivery. I have not heard of a case of avulsion of the cord at the baby's end until now. I am surprised that the records state that clamps and scissors were not immediately available. This point needs further clarification. Was an instrument trolley with clamps and scissors and other important items on it available or not at the delivery? Any acchoucheur should be prepared with a stocked trolley. Given that there were three potential acchoucheurs ([Ms E], [Dr G] and [Dr B]) why weren't these instruments ready and waiting?

Since [Ms E] had already attempted to manually ease the cord over the baby's head, [Dr B] should have been very cautious in his attempt to do the same. The force applied by [Dr B] was likely to have been excessive.

*[Dr B's] management of the avulsed umbilical cord*
I find it difficult to comment on this issue as it is a genuine emergency with even small amounts of fetal bleeding being serious. I am satisfied that [Dr B] tried to arrest the bleeding and although note the comments about him asking [Dr G] to move her fingers and thus lead to further bleeding, cannot comment further on his skill at arresting the bleeding. If his account of pressure on the baby's abdomen and subsequent attempt to clamp and suture the vessels is accurate, then it seems reasonable. I am however perplexed by the conflicting

accounts with both [Drs B and G] claiming it was him/her that stopped the bleeding (with stitching).

*[Dr B's] assessment and management of [Ms A's] vaginal tearing*
Again, in the absence of another emergency to go to and with the additional issues regarding the baby's avulsed cord and very traumatic delivery, I cannot understand why [Dr B] would leave the room and ask [Ms E] to repair the vagina. I can understand if he momentarily left out of concern for the baby, but he should have returned quickly. He obviously asked [Ms E] to undertake the repair without examining the degree or extent of the tears as later he would make the decision to take [Ms A] to theatre himself. Whilst I have some sympathy for him in his self professed 'embarrassment' at the events thus far including the cord avulsion, a truly professional commitment would have led to him staying and completing the episode. [Dr B] should have made certain that he assessed [Ms A's] vaginal tears before delegating the repair to [Ms E], and it was inappropriate for him to leave without doing so.

*[Dr B's] manner and management style*
It is difficult to be highly objective as the accounts of [Dr B's] manner and management style are conflicting. In general from witnesses' accounts however, it would seem that he was poorly communicative with his discussion, consent process and explanations. He professes to have repeatedly advised for a Caesarean and that the second ventouse could be 'dangerous'. However, no account other than his own mentions these issues. Whether he was under a great deal of stress and whether this was responsible for his manner is conjecture (at least one witness has described his differing personalities at work and in a social environment).

*Are there any aspects of the care provided by [Dr B] that you consider warrant additional comment?*
Whilst the immediate post natal period was highly stressful for the parents and the workers involved in the care of both mother and baby, and although the couple were grieving and spending time with their loved ones, I could not find any evidence in the notes or documents supplied of an attempt by [Dr B] or anyone else to provide 'de-briefing' some weeks or months later. This may well be because other events overtook the scenario, or indeed may have been refused by the parents but needs comment from both the hospital and [Dr B].

**Other general comments on the care provided**

*Post-dates pregnancy induction of labour*
Many hospital protocols are based on research studies that suggest induction after 41 weeks and 3 days gestation, in practice 41 weeks plus is often the norm and in this case (41 weeks and 1 day) and with retrospect, this slightly earlier induction is unlikely to have affected the subsequent events.

*The indications and circumstances for the first attempted ventouse delivery*
I remain unconvinced that this was necessary at the time it was undertaken (1825 onwards). The notes document full dilatation at 1800 hours. Although it may well be likely that [Ms A] was fully dilated slightly earlier than 1800, this is conjecture only. In other words, the indication for the attempted ventouse delivery was not 'delay in the second stage' as officially this would be at 1900 hours onwards. Although no actual indication for undertaking the first attempted ventouse is recorded, it would seem that it was for maternal distress. In the presence of involuntary pushing and a documented request from [Ms A] for an epidural at 1740 hours, why was the provision of an epidural not given due consideration?

There is clear guidance on the indications for instrumental delivery in every textbook of obstetrics and in general in the absence of fetal distress (as in this case), one is supposed to allow one hour of active pushing. Also I would be interested to hear if any consideration was given to attempting the trial in theatre so that if it failed, a timely Caesarean could be carried out. It may be that [Dr G] thought that it would be a straightforward ventouse delivery in which case attempting it in the room was appropriate.

Is it the norm in this hospital for ventouse deliveries to be undertaken without discussion with the duty consultant? Again it may well be, but in general, it is best practice for junior trainees to discuss the proposed delivery with the duty specialist.

Three applications of the ventouse were necessary and I am unsure why. Did [Dr G] doubt the position of the baby's head? In general terms the ventouse is thought to be a 'safer' instrument compared with obstetric forceps. However both cephalhaematoma and subgaleal haemorrhage are well recognised fetal complications and it is likely though not proven that both number of traction efforts and number of applications increase the risks of these complications. In [Dr G's] favour, she only undertook two traction efforts before abandoning the procedure.

*What analgesia or anaesthesia was used for both the ventouse efforts?*
Although the modern use of forceps has now generally led to regional anaesthesia being used i.e. an epidural or spinal, ventouse assisted delivery can in many circumstances be undertaken with local anaesthetic infiltration and pudendal nerve block. I could not find any documentation that anything was used for these two separate ventouse attempts. If indeed no local anaesthetic was used, why not as there was no rush to effect the delivery as the baby was not in distress?

For the same reasons, effective anaesthesia e.g. a pudendal nerve block or even a spinal anaesthetic ought to have been offered to [Ms A] prior to the second attempt at ventouse delivery.

*Conclusion*

It is my opinion that [Dr B] did not provide an appropriate and acceptable standard of care and that his failure to do so was major. I believe that given the multiple issues involved, namely repeat attempt at ventouse delivery after a failed previous attempt, leaving the midwife to complete the delivery, avulsion of the cord and initially leaving the midwife to repair the tears, that the disapproval from other peers of his would be severe. I wish to reiterate my opinion that after a failed initial ventouse delivery, that all personnel should have made preparations for an expedited Caesarean and the reluctance to do this may have contributed further to this tragic outcome."

# Appendix 2 — Southland DHB Maternity Services Action Plan

Sentinel Event Report – Baby NHI
Maternity Services Action Plan

Developed: 2 July 2007
Updated: 6 August 2007
Further Updated: 3 September 2007

| Recommendation: | Discussion: | Action/Progress: | Responsible: | By when /Complete: |
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| 1. It is evident that there were dysfunctional relationships/communication between and that a disciplines, communication/relationship team building project sponsored by SDHB should be instigated and require comprehensive engagement from all obstetric practitioners. | 07/07 The Maternity Service would welcome such activities, but suggest that this is delayed until two new specialists commence their employment in July. | Wait until Aug 07 to develop.<br><br>Aug 07 – One of the two new specialists has commenced, but the second has been delayed. | | Mid August to commence planning |
| 2. SDHB reviews its policies and procedures regarding: | 07/07 The Maternity service regularly reviews its guidelines for practice along with policies and | Aug 07 – Independent Service review to be undertaken in Sept 07 by Past President of RANZCOG and a NZCOM appointed midwifery leader | | |



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| | procedures. As per the 2007 access agreement holders must declare that they have the appropriate clinical competencies to provide care for women with an epidural, requiring induction or augmentation, instrumental vaginal deliveries and the interpretation of CTG's. SDHB has the responsibility of opening its educational opportunities for staff to access agreement holders and this has always been the case. The 2007 access agreement also sets out the process by which facilities consult with agreement holders regarding policy and procedure development. The existing SDHB process meets these expectations. Whilst SDHB does have a obligation to consult and inform access agreement holders of proposed changes to policies, procedures and guidelines, and to provide access to education on the clinical presentations outlined above, SDHB cannot require access agreement holders "as a requirement of their access agreement undertake education" as set out by SDHB. This is however determined in a quite specific manner for midwives by the Midwifery Council of NZ. | | | |
| Ensure that LMCs as a requirement of their access agreement undertake education relating to these issues. | | | | |



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| - Induction of Labour (IOL) and the use of prostaglandins<br>- Augmentation of labour and use of oxytocics<br>- Operative vaginal delivery.<br>- Management of nuchal cord. | • Guideline updated May 2007<br>• Current guideline due for review in Sept 07. Reviewed and no significant changes will be made.<br>• This guideline is current.<br>• This is regarded as a core competency for a birth attendant. The decision of ligating a cord or slipping it over the head is made based on clinical presentation at the time. | | | | |
| 3. Audit medical records against documentation standards and promote education as part of an ongoing education program for all LMC's, medical and Midwifery staff. | 07/07 Medical records are audited as per the SDHB Quality Plans ie 6 random charts per month. These are audited for Nursing and midwifery, medical staff and LMC's with feedback being given to all those involved of both positive and negative documentation.<br>A new postnatal and antenatal care plan with provision for provider instructions and routine postnatal checks of mother and baby have been introduced. These will be audited one month after introduction. | 07/07 Documentation audit to be collated<br>08/07 No update as on leave<br>09/07 Collation of six months of documentation audits underway | | | |
| 4. Undertake "Running drills" or medical/obstetric/neonatal emergency practices in maternity and neonatal services on a regular auditable basis. | 07/07 A number of emergency education sessions are undertaken annually on a rotating basis. These are undertaken in actual clinical rooms within the maternity unit as | 07/07 At this stage given the units staffing challenges and the bed pressure full running | | | |



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| | opposed to previous sessions which were undertaken in an education room. This has met with positive feedback from staff, but it is still subject to bed availability. They are however "cold". To undertake running drills sufficient overseeing staff to run the scenario would be required and staff on the floor would have to accept a level of disruption to their regular clinical activities. This would be difficult within the current staffing challenges. Existing emergency education attendance records are available. These are open to all practitioners. | drills are not possible. SDHB could examine the possibility of sending staff to an ALSO (Advanced life support in obstetrics) course as is the case in IDHB. | | |
| 5. Review diagnosis and management of hypovolaemic neonates and procedures for tertiary and medivac retrievals. | This recommendation relates to paediatrics. | 08/07 Forwarded to paediatric dept by Quality Team 09/07 Letter outlining review as suggested received from ..... Clinical Director Child Health | | |
| 6. The on call consultant is to be advised of any labouring women booked under other Consultants, and all inductions in the unit. Given the "locumisation" of the O and G workforce currently, there is also a requirement for the O and G and paediatric consultants to ascertain at the beginning of their on call shift, with the on call RMO, their agreed parameters for | 07/07 This already occurs. Consultants are also updated at 10pm regarding all women labouring in the unit at that time. | | | |



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| consultation and timely involvement of the specialist | | | | | |
| 7. Clear communication with the mother and other healthcare professionals regarding the risks of operative vaginal delivery is imperative. With regard to Ventouse this should include the potential known risks of subgaleal, retinal haemorrhage etc. | 07/07 Clear communication with the mother and other healthcare professionals regarding the risks of any intervention is an expectation. There needs to be agreement regarding the relativity of risk and providing explanation without undue fear being implanted for any particular intervention over another. | 07/07 Relative risk of the mentioned adverse outcomes to be investigated and discussion to ensue regarding what information should be given to women. The RANZCOG operative delivery patient information sheets sets out the risks. | All maternity practitioners | | |
| 8. The above recommendations are to be discussed at Clinical departmental meetings with feedback to all stakeholders | 07/07 The initial discussion was undertaken at our July Adverse Meeting. Subsequent to the action responses to these recommendations being established further discussion and education will be undertaken with staff and access agreement holders. | | | | |



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