



**Office of the
Health Complaints
Commissioner
2007**

700-0406017 – Mersey Community Hospital – obstetric care

Section 23(1) (d) *a health service provider failed to exercise due skill and subparagraph (g)(ii) a health service user was not provided - with a reasonable opportunity to make an informed choice of the treatment or services available – whether there was poor obstetric care during labour and whether problems encountered during resuscitation contributed to a neonatal death. Report issued April 2007.*

A complaint was lodged against the Mersey Community Hospital, which at the relevant time was operated by a private company, Healthscope Ltd. The complaint related to the death of the complainant's first-born child and alleged that the Hospital provided poor obstetric care during labour. The complainant believed that the problems encountered during the attempted resuscitation might have contributed to the baby's death. The complainant believed that the Hospital personnel were insensitive when they attempted to raise their concerns about the birth.

The hospital is now the Mersey Campus of the North West Regional Hospital and is now a public hospital. It was said that antenatal care had changed as a result of the death of this baby. Patients are encouraged to have a greater input into their birthing plans and there is a program available for neonatal resuscitation for all staff and not just the midwives. Alternative pain relief is available and there is a new CTG machine, which allows a patient in labour to move around whilst still being continuously monitored.

The complainant was admitted post term for induction of labour. She felt that the pethidine administered during labour, rendered her "semi-conscious and immobile" and unable to participate more actively in the birth. After slow progress in the second stage of labour, the RMO called to perform an episiotomy and became involved in the resuscitation. The baby was born in an unexpectedly poor condition with the umbilical cord around her body. She was limp and listless, there was no heartbeat observed and no breathing efforts. The RMO cleared the baby's respiratory passages and started cardio-pulmonary resuscitation (CPR) by means of chest compressions and ambu-bag ventilation with oxygen. His attempts to pass an endotracheal tube down her throat were unsuccessful and he was unable to establish intravenous access to administer adrenaline.

The paediatrics specialist called arrived within 15 minutes. By then the baby was not asystolic. She had a good heart rate of 130/min and oxygen saturations between 88 and 90% but she was not breathing and her pupils were fixed and dilated. The infant

intubated at 22 minutes and her oxygen saturations increased to 100% and the heart beat to about 200 b/min. Adequate ventilation and oxygenation was achieved and positive pressure ventilation continued thereafter until the arrival of the Newborn Emergency Transport Team (NETS).

The infant was transferred to the Neonatal Intensive Care Unit (“NICU”) at the Royal Hobart Hospital (“RHH”) but it was apparent that she had sustained a profound hypoxic-ischaemic insult to the brain and intensive care support was withdrawn at 2140 hrs.

The Coroner found that the death of the baby was due to natural causes. The medical evidence presented to the Coroner was that the baby appeared to have sustained an acute discrete asphyxial insult in the minutes before delivery, which continued after delivery for 15 minutes before circulation was established.

Professor Dargaville, in his evidence to the Coroner, thought it unusual for an infant who had lost cardiac output only 5 minutes before delivery to be so difficult to resuscitate after delivery. He was critical of the failure to administer adrenaline though said that it was not possible to say whether this would have changed the outcome. He also reported to the Coroner that the loss of cardiac output might have related to the entwinement of the umbilical cord around the body of the infant.

The matter raised some systemic issues and was therefore investigated under Part 6 of the *Health Complaints Act 1995*. The conclusions reached were that the complainant had some risk factors including post-term gestation, slow progress in the second stage labour, heavy sedation and the use of pethidine as pain relief during labour. The conclusion reached was pethidine may have had an effect on the baby although there is no conclusive evidence that it act as a respiratory depressant and contributed to the adverse outcome.

It was recommended that pethidine only be used as a method of pain relief after weighing the needs of the mother during labour against the risk to the foetus, that medical and nursing staff look at the totality of all risk factors involved in a birth and if a birth is high risk, or expert assistance is required, then this should be available.

The conclusion was that the resuscitation attempts on the baby were not in accordance with the ILCOR Advisory Statement on Resuscitation of the Newly Born Infant in that Adrenaline was not administered when circumstances clearly indicated it should have been. The use of adrenaline was intended but the RMO was unable to intubate the infant or cannulate a vein and there were no medical practitioners with this level of expertise in the birthing unit at the relevant time.

Recommendations were made relating to training according to the ILCOR Advisory Statement on Resuscitation of the Newly Born Infant. This has since occurred. Further that the hospital implement all guidelines recommended by the Council of Obstetric & Paediatric Mortality and Morbidity in the Draft Guidelines for Investigation of “Unexplained” Stillbirths. It was recommended that the hospital send all placentas for pathological examination in all cases of foetal death and, where possible, in all cases of early neonatal death.

It was recommended that a comprehensive Root Cause Analysis (RCA) investigation be undertaken where there is serious morbidity, associated with labour or delivery and debriefing and counselling available to medical and nursing staff following an adverse event.

The CTG recording was of poor quality, the timestamp was incorrect and the recording was not accompanied by an associated tocograph. The pressure dial on the ventilator was malfunctioning. The placenta was not submitted for pathological examination.

The investigation established that there were some deficiencies relating to adequate briefings at shift changeovers, contemporaneous and relevant documentation in health care records, and defective equipment and recommendations were made accordingly.