



**Office of the
Health Complaints
Commissioner
2007**

**700-0404014 – Tasmanian Ambulance Service – Launceston General Hospital -
DHHS – Patient transfer and the standard of care in the management of labour
– infant still-born**

Section. 22(1)(c) the *Health Complaints Act 1995* - “a health service provider acted unreasonably in the manner or providing a health; Section 23 (1)(d) “a health service provider failed to exercise due skill”. Report issued May 2007.

On 23 June 2005, a complaint was lodged under the *Health Complaints Act 1995* against the Launceston General Hospital (“LGH”) and the Tasmanian Ambulance Service (“TAS”). The complaint related to the complainant’s antenatal care, the delay in TAS transporting her from St Helens to the LGH and her care on admission, which she believes contributed to the still birth of her son at the LGH in March 2002.

The complainant was then 25 and this was her third pregnancy following normal deliveries in 1997 and 1999. Antenatal care was provided by a medical practitioner at the St Helens’ Medical Centre and consisted of at least 18 scheduled attendances and some unscheduled ones. Appropriate tests were undertaken including ultrasounds to monitor the size of the fetus. The fundal height was regularly measured at the antenatal visits. A referral was made to the LGH Antenatal Clinic at 36 weeks for the Obstetric Registrar at the LGH to review a fetal hydronephrosis of the left kidney but the complainant did not attend the 36 week antenatal visit. She was advised by her doctor to move residence closer to Launceston from 37 weeks gestation until the birth, but did not do so.

The conclusion was that the antenatal care was of an appropriate standard. However the complainant resided on the east coast of Tasmania and was not aware that the Patient Travel Assist Scheme (PTAS) and accommodation in the Spurr Wing of the LGH could be arranged. She regrets not having attended the clinic and hospital when advised. Recommendations for the better dissemination of information were made accordingly.

The investigation considered whether the delay in the TAS transfer contributed to the adverse outcome. There were delays, some attributed to the TAS and some to the complainant, but although an earlier arrival would have provided more time for an initial assessment, it is doubtful whether the delay contributed to the adverse outcome.

On 19 March 2002 the complainant presented at the St Helens District Hospital, in early labour at 38 ½ weeks gestation. She was referred to her doctor but some four hours elapsed before she was examined as she was unable to arrange childcare. Her doctor arranged the road ambulance transfer and the ambulance was dispatched from St Helens at 1704 hrs. but returned the patient to the St Helens Hospital for reassessment, as the paramedics believed that the birth might occur during the transfer.

The complainant was reassessed at 1730 hrs and the ambulance resumed the transfer at 18:00. There were delays during the transfer involving collecting volunteers, changing vehicles and crews at Fingal, obtaining water and attend the patients needs but there were other delays of a private nature unrelated to the patient's needs. TAS said that the total time for the ambulance transport, including the delay at the St Helen's District Hospital was 3 hours and 49 minutes and the estimated additional delay during transit was 23 minutes. The conclusion was that there were delays, most relating to the service model and the complainant's care, but these delays were not causally related to the adverse outcome. The reassessment requested by the paramedic was reasonable.

The matter primary issue investigated was whether the care provided by the Maternity Unit at LGH was of an acceptable standard. Whether the delivery was managed appropriately extended to the question of whether the use of forceps or other operative vaginal delivery techniques should have been considered. The conclusion was that neither an operative vaginal delivery nor caesarian would have resulted in a quicker delivery. There was no reason to anticipate that a caesarian might need to have been considered and too late once the fetal distress became obvious.

There was insufficient fetal monitoring by the midwife during the second stage of labour and a failure by the midwife to contact the RMO as required by the LGH protocol. During the 39 minute period of stage 2 there was one attempt at auscultation. This is contrary to the recommendations in the Intrapartum Fetal Surveillance Clinical Guidelines in relation to auscultation of the fetal heart during the second stage of labour. The LGH submit that auscultation did occur but was not recorded.

In the initial assessment at 2110, the fetal heart was picked up on CTG. It could have been an advantage had the complainant arriving at LGH earlier than 2105 hrs and similarly if the complainant had moved to Launceston at 37 weeks as this would have allowed more time for assessment. However the presence of the fetal heart upon

arrival at 2105 hrs was reassuring to the LGH staff and prompted no immediate intervention. At 2200 hrs thick meconium staining of the liquor was noted, and no fetal heart could be heard. The midwife rang for assistance anticipating the birth of a 'flat baby'. The Obstetric RMO and Paediatric Registrar attended. At 22:14 a stillborn baby boy was delivered. The baby had no discernable heartbeat and was transferred to a resuscitaire where oxygen was administered, external cardiac massage was commenced, and positive pressure ventilation started. An oral airway was inserted, and naloxone was given. At 5 mins the infant was intubated and further resuscitation was undertaken including 3 doses of adrenaline (dose 2 ml, presumably 1:10000) given down the endotracheal tube. There was no response, and resuscitative efforts were ceased.

The cause of the infant's death cannot be clearly established but the care provided by the Maternity Unit at the LGH was adequate. The first real indication of fetal distress was the meconium fluid passed at 22:00 and it is conceivable that a significant degree of fetal compromise was occurring at the time. It is not clear the exact cause for fetal demise, however given that the heart was not auscultative at 22:00 hours and delivery was at 22:14 it is conceivable that fetal death occurred during this period of time. The gap of 3 minutes separating the delivery of the head to the delivery of the body probably reflects the degree of obstructed labour. The infant's face was noted to be congested and covered with small haemorrhages, consistent with a shoulder dystocia. There was no causal connection between the hydronephrosis and the baby being still-born.

The resuscitation responses were in accordance with the Guidelines on Neonatal Resuscitation. However in all cases where no cause is determined for stillbirth, the draft guidelines of the Tasmanian Council of Obstetric & Paediatric Mortality and Morbidity should be used.

The conclusion reached is that the birth would have been better managed had accommodation arrangements been facilitated close to the LGH and prior to the birth, as recommended by the complainant's doctor in St Helens.. Information about these services need to be disseminated so that pregnant women with a medium to high risk pregnancy living in remote areas can reside close to a hospital with obstetric facilities.

Recommendations were accepted that information about the availability of the PTAS and accommodation in the Spurr Wing of the LGH, if required on a medical needs basis, be more widely disseminated to pregnant women in remoter areas who have been advised by their obstetrician to be close to that labour ward in readiness for the birth.

It was also recommended that the DHHS ensure all public hospitals implement the draft guidelines issued by the Tasmanian Council of Obstetric & Paediatric Mortality and Morbidity for the investigation of unexplained stillbirths in order to help determine the causes and help prevent recurrences.

