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Request for Clinical Advice

Date: 29 April 2024

Case reference number: 20230XXXX

Caseworker Name: [redacted]

Contact details: [redacted]

Name of Health Board and hospital which provided treatment: Betsi Cadwaladr University Health Board

[redacted] Hospital

Nature of the advice required:

Adviser required:

Consultant Obstetrician

Brief details of clinical issues requiring advice:

The complaint considers the management and care of Dr C during mid to late pregnancy, throughout labour and post partum, both at the hospital and upon discharge home.

The Ombudsman is seeking a peer review of the care provided. The complaint is about the actions of professionals in the above specialism, and it is for this reason this adviser has been requested. The adviser is asked to advise on the complaint in this capacity.

Estimation of time required to undertake work

For each element (and for each piece of advice requested), you should tick which criteria applies and then add up the scores to find the indicative time for the case.

Elements to be considered	Points matrix					
		1		2		3
Volume of case records to be considered.	< 250 pages	☐	250 - 500 pages	✓	Over 500 pages	☐
Number of questions (including sub-questions) to be answered.	1-3	☐	4-6	✓	7-9	☐
Length of time the complaint relates to.	Up to 7 days	☐	Several weeks	✓	Several months or longer	☐
Complexity of complaint - number of 'Heads of Complaint'	1	☐	2-3	☐	4 or more	✓
Column Totals*				**6**		**3**
Total score	**9**					

Key	
Total Score of	**Indication of time required to consider case**
4-6	1 - 5 hours
7-9	6 - 10 hours
10-12	11 - 15 hours

Note for Adviser – Please could you confirm, following an initial consideration of this complaint, that you are content to provide your advice within the timescale indicated. If you do not consider the timescale identified sufficient, please contact the Professional Advice Co-ordinator or the caseworker to discuss how long you consider the advice will take to prepare.

Investigation Officer to provide details of documents/sub file/CDs to be sent to Adviser with advice request.

Sub File Name as on Workpro	Activity date on workpro
Subfile for IPA	07/04/24

Clinical Adviser

I set out below my request for clinical advice.

The complainant and their relationship to the patient

The complainant, Dr C, is also the patient.

The complaints subject to investigation

The investigation is considering the following:

- Whether Dr C should have been diagnosed with pre-eclampsia and hypertension earlier in her pregnancy and if this was managed appropriately.

- Whether during labour, Dr C's pain was managed appropriately and whether it was appropriate to carry out her episiotomy and if consent was obtained.

- Whether Dr C was discharged appropriately and if the re-fashioning of her perineum should have been carried out sooner.

- Whether Dr C received appropriate support from health workers following her return home.

Background and the events

Dr C's care was transferred to the [redacted] area at 26 weeks gestation. A booking and antenatal check on 31 March **2022** noted no clinical concerns. Dr C's blood pressure was within normal range and the urine test was normal. Dr C was assessed as suitable for midwifery led care.

On 19 April 2022 Dr C presented at Hospital with a three-day headache which she believed was a migraine. Dr C was assessed throughout the day and self discharged later that evening, reporting that the headache had gone.

Dr C was reviewed again at antenatal appointments at 28 weeks, 31 weeks, 34 weeks and 36 weeks gestation. At these reviews, Dr C's blood pressure was within normal range and the urinalysis was normal.

On 22 June 2022 at 38+3 weeks gestation Dr C reported that she was experiencing swollen ankles. Dr C's blood pressure was recorded as 138/82 with a normal urinalysis. Dr C was referred to the Maternity Day Assessment Unit and attended on 23 June where all investigations were returned as normal.

On 6 July 2022 at 40+2 weeks gestation Dr C attended a routine antenatal appointment. Her blood pressure was recorded at 140/80 and later at 122/80. No

urine sample was provided. Dr C requested a membrane sweep but the head was not in the pelvis so the plan was to reassess the following week.

On 11 July 2022 at 41 weeks gestation Dr C attended a further antenatal appointment and reported losing the mucous plug. Her blood pressure was 140/92 at the beginning of the appointment and 135/80 at the end. A vaginal examination was undertaken but the midwife was unable to perform the sweep due to the cervix being in the posterior. An induction of labour was arranged for 14 July.

On 14 July Dr C attended the Maternity Day Assessment Unit with decreased fetal movements, visual disturbances and swelling of the feet. Her blood pressure was noted to be raised and she was admitted to hospital for induction of labour, which was commenced at 23:05.

Dr C was reviewed at 12:10 on 15 July and a vaginal assessment confirmed her cervix was 2cm dilated. Dr C was struggling with pain and had raised blood pressure. She was transferred to the delivery suite at 12:30 for an early epidural. Dr C discussed pain relief options with the anaesthetist and a decision was made for siting the epidural. The epidural was sited and effective by 13:55. Dr C was reviewed by the Obstetric Registrar at 17:35.

On 16 July Dr C was reviewed by the Obstetric Registrar at 06:40 and 08:25. She was offered an assisted delivery using forceps due to the prolonger second stage of labour. On crowning of baby's head, an episiotomy was done and baby's head was delivered within 2 minutes of application. Dr C's baby was born at 08:41 and Apgar scores were recorded as 9 at 1 minutes and 5 minutes.

Dr C was transferred to theatre at 09:11 for repair of the episiotomy and third-degree perineal tear.

Dr C had postnatal examinations on 17 and 18 July and was discharged home on 18 July.

Dr C was visited by the Community Midwife on 19 July for the first postnatal visit. Blood pressure was recorded as normal and Dr C advised that she had no concerns with her perineum. A further appointment was arranged for 21 July at the Hospital. At this appointment Dr C was examined and the perineum was noted to be clean and dry with some slight bruising. Dr C advised that it was painful and tender and that she had a GP appointment the following day.

Dr C attended the Midwifery Outpatients Assessment Unit (MOAU) on 25 July and was advised to continue taking antibiotics as an infection was suspected. The plan was to review Dr C in 1 week.

On 27 July the perineum was examined by the Community Midwife who documented that it was improving.

On 1 August Dr C was reviewed on the MOAU. She was offered resuturing of the wound due to a small gap and confirmed she would like to proceed, however, the doctor was called away to an emergency and Dr C was asked to return the following day.

On 2 August Dr C was reviewed and a wound swab was taken. The plan was to continue with antibiotics and for a further review on 16 August.

Dr C returned to the MOAU on 9 August as she reported the wound was oozing. On examination the perineal wound appeared to be healing well.

Dr C attended as scheduled on 16 August and an examination it was noted that the perineal area was healing well. The Consultant Obstetrician advised that the small gap would likely close through the healing process but that if the gap remained, refashioning of the perineal area was suggested. A further review was planned for 30 August and it was agreed that surgery under general anaesthesia would be undertaken.

On 12 September Dr C underwent surgery for refashioning of the perineum. At a review on 23 September it was documented that the wound was healing well.

Dr C raised a complaint with the Health Board in March 2023. They carried out an investigation and provided a copy of the investigation report to Dr C on 1 November 2023.

In response to notification of investigation by PSOW, the Health Board said that Dr C had regular assessments during pregnancy as per policy. They said that there was no evidence to say she developed symptoms and/or signs of pre-eclampsia or pregnancy induced hypertension until she presented for induction of labour at Term+10 weeks of gestation.

The Health Board said that Dr C's pain management at every stage of labour was appropriately managed. Starting from induction of labour, latent phase, active stage of labour, up until delivery, staff ensured she received regular pain relief and was made to be comfortable throughout. The Health Board said that throughout the labour Dr C had hourly epidural top up to keep her comfortable. She was intermittently sleeping throughout the first stage of labour and at no stage did she complain of pain / discomfort once epidural analgesia was sited at 13:33 hrs. The Health Board said that Dr C was comfortable the entire duration of labour, delivery and up until perineal suturing was completed in the operation theatre.

The Health Board said that episiotomy is required in more than or equal to 90% of cases where forceps have been used. The evidence to support use of mediolateral episiotomy at assisted vaginal birth in terms of preventing obstetric anal sphincter injury is stronger for nulliparous women and for birth via forceps (as in the case of Dr C). The Health Board said that following delivery of the baby's head, turtling was noted suggesting evidence of shoulder dystocia and

possible tight perineum. Hence the need for episiotomy was appropriate when using forceps in Dr C's case.

The Health Board said that there is written documentation regarding explanation to Dr C and her partner about assisted vaginal delivery and verbal consent obtained to proceed for delivery of the baby.

The Health Board said that Dr C was appropriately discharged from the hospital. It said that there is no indication for earlier refashioning of the perineal wound.

Questions

I set out below questions relating to the complaints. For each question, please would you set out what happened, what should have happened, the impact of any difference between the two, and any remedy or recommendations to prevent recurrence or improve care for the future.

1. The Health Board's position is that there was no evidence of pre-eclampsia or hypertension until Dr C presented for induction of labour at term plus 10. From the records provided, do you agree with this position or were there signs of both before?

2. Was Dr C's pain managed appropriately during labour?

3. Was it appropriate to carry out an episiotomy and do the records show that appropriate consent was obtained?

4. Was Dr C discharged appropriately?

5. Should the refashioning of Dr C's perineum have been carried out earlier than it was?

6. Please let me know if, in considering my questions, you identify any other relevant clinical matter that gives you cause for concern.

Thank you for your advice. If you need to discuss the case, please do not hesitate to contact me.

[redacted]
Swyddog Ymchwilio/Investigation Officer

TO BE COMPLETED BY CLINICAL ADVISER

Clinical Advice

Any comments on Background and Chronology:

Provision of Clinical Advice for Public Services Ombudsman for Wales
Background Information
Case Identifier (Case Reference):XXXXXXXXX
Clinical Adviser's Name and Qualifications: XXXXXXXXX; MD, MRCOG, MFFP, FRCOG
Relevance of qualifications and/or experience to clinical aspects of this case: [Relevant qualifications provided]
Conflict of Interest (clarification of any links with Body or clinicians complained about): None
Confirmation that the Ombudsman's Clinical Standards have been applied in the provision of the advice. Yes
Please confirm the chronology provided by the Caseworker in requesting this advice is correct and correctly identifies the relevant clinical events Yes

Documentation Reviewed:

1. Request for Clinical Advice letter dated 29th April 2024
2. Subfile 1 – Concerns File (395 pages)
3. Chronology as per clinical advice letter

Questions and Responses:

Questions

I was set a series of questions relating to the complaint. For each question, I was asked to set out what happened, what should have happened and the impact of any difference between the two, and any remedy or recommendations to prevent recurrence or improve care for the future.

1. **The Health Board's position is that there was no evidence of pre-eclampsia or hypertension until Dr C presented for induction of labour at term plus 10. From the records provided, do you agree with this position or were there signs of both before?**

Dr C had regular assessments during pregnancy as per Health Board policy. There was no evidence that I could see that she developed symptoms and/or signs of pre-eclampsia or pregnancy induced hypertension until she presented for induction of labour (IOL) at 40 weeks + 10 days. It is my view that Dr C was appropriately managed during her pregnancy.
The timeline as documented in the medical records

14/04/22 at 28+3 weeks
Normal Blood Pressure (BP), urine dipstick negative for protein, asymptomatic of pre-eclampsia

19/04/22 at 29+1 weeks
c/o headache and blurred vision. Obstetric and Medical consultant review diagnosed to have migraine. Her symptoms settled by end of the day and she self-discharged from the hospital

05/05/2022 at 31+3 weeks
Normal BP, urine dipstick negative for protein. No-evidence of pre-eclampsia

11/05/2022 at 32+2 weeks
Normal BP, urine dipstick negative for protein, asymptomatic of pre-eclampsia

26/05/2022 at 34+3 weeks
Normal BP, urine dipstick negative for protein, asymptomatic of pre-eclampsia

09/06/2022 at 36+3 weeks
Normal BP, urine dipstick negative for protein, asymptomatic of pre-eclampsia

23/06/2022 at 38+3 weeks
BP marginally raised 138/82 with ankle swelling. A single blood pressure reading of 138/82 does not qualify as pregnancy induced hypertension or pre-eclampsia and BP profile in Maternity day assessment was also within the normal range with normal bloods and negative urine dipstick. Ankle oedema is seen in over 60% of all pregnancies close to term and is not pathognomonic of pre-eclampsia.

06/07/2022 at 40+2 weeks
BP marginally raised 140/80, but does not qualify as pregnancy induced hypertension or pre-eclampsia. No urine sample given. Asymptomatic of pre-eclampsia

11/07/2022 at 41+0 weeks
Normal BP, urine dipstick negative for protein, asymptomatic of pre-eclampsia (Reference - NICE guideline NG133 2019 "Hypertension in pregnancy: Diagnosis and management")

2. Was Dr C's pain managed appropriately during labour?
Dr C's pain management was appropriately managed at every stage of labour. The records appear to show that starting from induction of labour, latent phase, active stage of labour, up until delivery, staff have ensured she received regular pain relief and was made to be comfortable throughout. Throughout the labour records indicate she had hourly epidural top ups and she was intermittently sleeping throughout the first stage of labour. Once epidural analgesia was sited at 1333 hrs the records do not indicate that she complained of pain/discomfort until perineal suturing was completed in the operation theatre.

3. Was it appropriate to carry out an episiotomy and do the records show that appropriate consent was obtained?
When undertaking a forceps delivery episiotomy is generally recommended/appropriate in over 90% of cases to prevent obstetric anal sphincter injury especially for nulliparous women as in this case. Additionally in this particular case following delivery of the baby's head, turtling was noted suggesting evidence of shoulder dystocia and possible tight perineum. The need for episiotomy was therefore highly appropriate in this case. Verbal consent was documented in two places in her records.
(Reference: RCOG guideline "Assisted Vaginal Birth" 2020. Assisted Vaginal Birth)

4. Was Dr C discharged appropriately?
Dr C was reviewed by registrar the following day after delivery and no concerns expressed regarding perineum by Dr C. I cannot find anything to suggest that she was not discharged appropriately.

5. Should the refashioning of Dr C's perineum have been carried out earlier than it was?
A majority of responsible group of obstetricians would be of the firm view that earlier refashioning of the perineal wound would have been contraindicated with expectant management as the recommended practice especially if there was evidence of infection and necrotic tissue (slough). Suturing of infected tissue would have risked further breakdown with poor healing and scarring. The management timeline in this particular case in terms of the timing of the resuturing would be supported by a majority of responsible obstetricians. .

6. Please let me know if, in considering my questions, you identify any other relevant clinical matter that gives you cause for concern.
I have not identified any other clinical matter that gives me cause for concern

Name & Signature:
[redacted]

Date: