Scottish Parliament Region: Lothians

Case 200500864: Lothian NHS Board

Introduction

1. On 4 July 2005 the Ombudsman received a complaint from a man (referred to in this report as Mr C) on behalf of his wife (Mrs C) about one of Lothian NHS Board's (the Board) hospitals in caring for and treating her problems following the delivery of their son in January 2005.

2. The complaints from Mr C which I have investigated were put by Mr C as a series of questions at a meeting between him and the Health Board's West Lothian Healthcare Division (the Division):

(a) why was Mrs C cut so deeply?;

(b) was it usual for the registrar to work unsupervised?;

(c) as it was painful, why did the stitching take so long?;

(d) why was the blood from the delivery not cleaned up promptly?;

(e) on her re-admission to hospital, why was Mrs C's wound not checked for three days and why was no aftercare offered?;

(f) can the Division comment on some discrepancies in the clinical records?

3. Following the investigation of all aspects of this complaint, I found that Mrs C's care and treatment at the hospital were appropriate and consequently I did not uphold this complaint. The answers to Mr C's questions (a) to (f) are set out at paragraphs 9 to 26.

Investigation and findings of fact

4. I was assisted in the investigation by one of the Ombudsman's clinical advisers, a consultant obstetrician and gynaecologist. His role was to explain, and give an opinion on, the clinical aspects of the complaint. We examined the papers

provided by Mr C, the Division's complaint file and the clinical records relating to Mrs C at the hospital concerned (which I shall refer to as the Hospital). We also examined correspondence and records from a consultant at another hospital, who had been asked by the Hospital to give a colorectal opinion. During the investigation Mrs C telephoned to ask if I had requested the records written by the district nurses in Mrs C's own area (not part of the Board's area) because they considered that her wound was very bad. As the investigation progressed, I decided not to obtain these records because at the Hospital clinicians acknowledged themselves that the wound was serious. In light of this acknowledgement there was no need to corroborate the fact through obtaining sight of district nursing records and opinions.

5. To identify any gaps and discrepancies in the evidence, the content of relevant papers on file was checked against information elsewhere on file and also considered against my own and the adviser's knowledge of the issues concerned. The evidence on file was so clear that no staff interviews were necessary. I am, therefore, satisfied that the evidence has been tested robustly. Finally, in line with the practice of this office, the standard by which the complaint was judged was whether the events were reasonable, in the circumstances, at the time in question.

6. I should add that part of Mr C's complaint was a question about why another hospital had the wrong impression about the date of his son's birth. This was not included in my investigation because the Division replied to Mr C that they could not understand this because the Hospital's correspondence to that hospital had clearly and accurately stated the birth date. I have seen that correspondence and can confirm this. There would have been no value in my adding such a minor point to the investigation, where there were clearly no shortcomings by the Hospital.

7. Mr and Mrs C and the Division have had the opportunity to comment on a draft of this report.

8. I turn now to the events in question. I would normally cover each aspect of the complaint separately. In this case the issues are so inter-linked that it makes sense to tell Mrs C's story chronologically, covering the issues as they arise. A reminder of the abbreviations used is at Annex 1.

9. Mrs C's records reveal that on the whole her pregnancy progressed normally. She was admitted to the Hospital on 14 January 2005 because of signs that labour had started. Labour progressed satisfactorily during the rest of that evening and through the night. However, although the opiate pain relief appeared to be effective for the labour pains at first, a further dose was not helpful, so an epidural (stronger pain relief) was given. Because the second stage of labour was late and was associated with some contractions of a particular type, it was decided to contact the on-call registrar at around 05:30 on 15 January. Because of the length of time the delivery was taking, the registrar carried out a ventouse delivery, and the baby was born shortly before 07:00 on 15 January. Ventouse means that a suction cup was used to aid the delivery. The little boy was delivered with an Apgar of 9/10, which indicates that he was in good condition.

10. One of Mr C's complaints was that the delivery had been carried out by a registrar. A registrar is a senior doctor. The adviser has said that there is no reason why in this particular case he should have been supervised by a more senior doctor.

11. During the delivery, a second degree perineal tear occurred. This was caused by the stretching of the perineum, which is the skin between the vaginal and anal passages. It was classed as a second (rather than first) degree tear because it did not reach as far as the anal (back) passage. From his own experience and from information published by the Royal College of Obstetricians and Gynaecologist), the adviser has explained that second degree perineal tears are common with vaginal deliveries (in other words, like this one, rather than a caesarean delivery, which is made through the abdomen wall), regardless of whether the delivery is spontaneous or has been aided (as in a ventouse or a forceps delivery). It is estimated that over 85% of women who have a vaginal birth will have some perineal trauma. Of that number, 60% to 70% will need stitches. In other words, it was always very likely that Mrs C's perineum would tear as part of the normal delivery process.

12. Mr C asked why his wife had been cut so deeply. Deliberately cutting the perineum is called an episiotomy and in line with current medical practice is only done in about 20% of vaginal deliveries. Mrs C did not have an episiotomy. In other words, Mrs C was not cut: what happened was a naturally-occurring tear.

13. The registrar repaired the tear using vicryl rapide. The adviser considers this to be a good stitching material for perineal repairs and that the registrar's clinical notes indicate that it was used correctly.

14. At a meeting between Mr and Mrs C and the Division to discuss the complaint, Mrs C is recorded as saying that the stitching took around 30 minutes and that she told the registrar that she was in pain because she could feel the stitching being done. The adviser considers this to be a normal time for a careful and proper repair of a second degree tear. The question of what Mrs C told the registrar is one that cannot be proven by evidence because the meeting notes state that the registrar had no memory of being told that Mrs C could feel the stitching. Those notes also say that the registrar said that if he had been told this, he would have topped up the epidural with local anaesthetic, which was already at hand. The adviser has confirmed, as the Division told Mr and Mrs C in their reply to the complaint, that such a top-up for the repair would have been normal practice.

15. At Mr and Mrs C's meeting with the Division, the couple are recorded as being concerned that a large amount of Mrs C's blood was left on the floor after the delivery. The records show Mrs C's blood loss at delivery as 500 mls. The adviser does not consider this to be excessive. The Division explained to Mr and Mrs C that the normal practice would be for the midwife and supporting staff to clean the room as quickly as possible after delivery. They apologised for this not having happened and said they had reminded staff about it for future cases.

16. Shortly after the stitching on 15 January, the records show Mrs C as requesting and receiving pain relief and as finding it helpful. At lunchtime that day she and her son were transferred to the antenatal ward, and on 17 January they were discharged to the care of the GP and community midwifery team where Mrs C lived (outside the Board's area). The post-natal discharge form which the Hospital completed on 17 January records the perineum as 'stitched, comfortable' and Mrs C's condition as 'well'. In other words, there is no evidence that the perineum was not healing appropriately at that time.

17. On 19 January, after apparently being seen by her local midwife, Mrs C returned to the Hospital. She was assessed by a senior house officer (hospital

doctor), whose notes show that Mrs C said she had had severe perineal pain since discharge on 17 January. Examination revealed a deep, open wound extending to the edge of the anal entrance. Although the pain made a rectal (inside the anus) examination impossible, the rectum did not seem to be affected. In-patient admission, swab, antibiotics and pain relief were arranged. The ward records describe Mrs C as feeling much better on 20 January, and she was discharged that day after being seen by an obstetrics registrar (not the one who delivered her son). The records show the registrar to have given hygiene advice, authorised continued pain relief and antibiotics and advised a one-week review for 27 January. At that review the wound edges were recorded as raw but clean. In his routine follow-up letter to Mrs C's GP in February, the consultant obstetrician and gynaecologist (Consultant 1) said that when he saw Mrs C on 27 January, wound healing was taking place. Internal examination indicated that the wound had not penetrated the rectal area, and a four-week review was arranged.

18. On 10 March 2005, before the review date, Mrs C was re-admitted to the Hospital with a breakdown of the wound and some urine leakage and bowel difficulty. She was seen by Consultant 1, who decided to seek an opinion from a colorectal specialist in case there had been damage to the anal sphincter. He arranged to review Mrs C on 17 March, at which time she was still in pain. On 14, 17 and 21 March, Consultant 1 made telephone calls and wrote three detailed referral letters (all expressing urgency) to two colorectal consultants at another hospital in the Board's area. One of them (Consultant 2) saw Mrs C. However, Consultant 1 was unable to obtain anything more than Consultant 2's general views about her examination and treatment because of Consultant 2's extended absence from work. Following her return, I wrote to Consultant 2, requesting information and clinical records. In her reply she explained that there was a significant perineal defect which did involve the external anal sphincter. However, there was no fistula or infection, which was good news. As the tissues were in a suitable state for repair to be attempted, Consultant 2 carried out (amongst other things) a repair of the sphincter and perineum. Consultant 2 added that after a good initial recovery, Mrs C did develop some problems with the skin stitches but the wound healed because the deeper, muscle, stitches remained secure. In September 2005 (while Consultant 2 was away) Mrs C was seen by another colorectal consultant surgeon at Consultant 2's hospital. He confirmed that the wound had now healed but that Mrs C's continuing pain was caused by the

perineal scarring.

19. The adviser has said that wound breakdown is a recognised, accepted, result of perineal repair. In other words, he concluded that the breakdown was not caused (directly or indirectly) by any fault in the repair work or in Mrs C's aftercare. The adviser is very clear in his view that there has been no fault or mismanagement in this case.

20. Finally, at Mr and Mrs C's meeting with the Division, Mr C expressed concern about discrepancies in the clinical records and conflicting information about the wound. He also asked why Mrs C's midwives in her home area had said that the perineum had broken down and commented that a midwife at the Hospital had described one of those local midwives as over-reacting. My examination of the Hospital's clinical records and correspondence did not reveal any conflicting information.

Conclusions

21. As explained above, Mrs C was not cut at all and there was always a high risk that the perineum would tear. It was entirely appropriate for the registrar to work unsupervised, and his detailed records show him to have repaired the tear well (see paragraph 13).

22. I was most concerned about Mr C's statement that his wife could feel the stitching being done. The registrar said he could not remember Mrs C saying this at the time. This is not surprising, given that this was a routine tear, not (for him) a memorable event, and given the number of patients which doctors see each week (sometimes 50 in one ward round). He would have had local anaesthetic at hand, and the adviser has confirmed that it would be normal practice to top up the pain relief with local anaesthetic if an epidural's effects were fading. In such circumstances it seems unlikely that a senior doctor would not give pain relief if a patient said she could feel stitches being put in. I have no reason to doubt Mrs C, but in the absence of evidence that could prove what happened, I can draw no conclusion about this. But I accept the adviser's advice that the stitching took an appropriate length of time.

23. Regarding the blood left in the delivery room, I am conscious that staff had

been working on Mrs C's delivery for several hours of the previous evening, through the whole night and in the early morning. In such circumstances, I feel that, although not ideal, it is understandable for routine tasks such as room cleaning sometimes to be left for the next shift to deal with. I note too that the Division apologised and took action to try to prevent a recurrence.

24. I turn now to Mr C's complaint that on her re-admission to the Hospital (19 January 2005), his wife's wound was not checked for three days and that no aftercare was given. I am satisfied that Mrs C's wound was checked by a doctor on 19 January and that she was seen by a doctor on 20 January. In other words, Mrs C's wound was checked. Aftercare was given by the Hospital by a one-week review, a planned four-week review and by Consultant 1, who clearly made efforts to arrange a colorectal review because of his concerns. The notes of Mr and Mrs C's meeting with the Division say that the couple had to arrange themselves for nurses to come to their home and look after the wound. Such care was not for the Division to arrange as this was a matter for the local GP (outside the Board's area) and his or her community midwifery team to consider.

25. Regarding Mr C's complaint about discrepancies in the records, neither the adviser nor I consider that the Hospital's notes conflict with, or contradict, each other. Different views developed as Mrs C's clinical situation developed and so the results of the later assessments differed from those of the earlier ones. This is what one would expect in a changing clinical situation and does not indicate a conflict or discrepancy. I think all I can do here is reassure Mr C that the Hospital's standard of record keeping was high (detailed, clear, readable, with each entry accompanied by the writer's signature, in line with good practice) and that the content of the records matched all other evidence seen by me. What the clinical records of nursing/midwifery staff in Mrs C's home area may have said was not the subject of this investigation. But if, as Mr C said, a local midwife said that the perineum had broken down, I can only say that that was an accurate remark. And whether or not a midwife at the Division's Hospital expressed an opinion that a local midwife had over-reacted, the fact remains that the Hospital staff did not act as though they considered there had been any over-reaction: it is clear that they regarded the wound seriously and treated it accordingly.

26. I feel it must have been deeply distressing to Mr and Mrs C that because of her

ongoing clinical problems, Mrs C could not care for and enjoy her new son in the way that she would have hoped. The perineal area is also a particularly uncomfortable area in which to have a painful wound. I hope that the detailed information in this report has helped to reassure Mr and Mrs C that the tear and breakdown were not in any way caused by fault and that the Hospital's care and treatment were good.

27 June 2006

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mrs C	His wife
The Division	Lothian NHS Board's West Lothian Healthcare Division
The Hospital	The Division's hospital, where Mrs C was admitted for birth and follow-up
Consultant 1	The consultant who saw Mrs C at the Hospital in January 2005 and who arranged a colorectal opinion
Consultant 2	The colorectal consultant at another hospital who was asked to check for anal sphincter damage
Ventouse	Vaginal delivery using a suction cup