Scottish Parliament Region: Glasgow

Case 200503152: Argyll and Clyde NHS Board[1]

Summary of Investigation

Category

Health: Maternity

Overview

The complainant's representative raised a complaint against Argyll and Clyde NHS Board (the Board), on behalf of the complainant (Mrs C), about the treatment she received at the Royal Alexandra Hospital in respect of a top-up epidural to allow for the surgical removal of the retained placenta after the birth of her son in August 2004.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) clinical errors by the consultant anaesthetist (Dr E) put Mrs C's health at risk during her labour *(not upheld)*; and

(b) Dr E's recollection of the facts differs from those of Mrs C, who believes that Dr E is being untruthful *(not upheld)*.

Redress and recommendations

The Ombudsman recommends that the Board:

(i) consider whether it needs to review when clinical risk reviews of incidents such as these are carried out; and

(ii) ensures that clinical staff are reminded of their responsibility to maintain detailed records, in particular, in respect of anaesthetic procedures.

---

[1] Argyll and Clyde Health Board (the former Board) was constituted under the National Health Service (Constitution of Health Boards) (Scotland) Order 1974. The former Board was dissolved under the National Health Service (Constitution of Health Boards) (Scotland) Amendment Order 2006 which came into force on 1 April 2006. On the same date the National Health Service (Variation of the Areas of Greater Glasgow and Highland Health Boards) (Scotland) Order 2006 added the area of Argyll and Bute Council to the area for which Highland Health Board is constituted and all other areas covered by the former Board to the area for which Greater Glasgow Health Board is constituted. The same Order made provision for the transfer of the liabilities of the former Board. to Greater Glasgow Health Board (now known as Greater Glasgow and Clyde Health Board) and Highland Health Board. In this report, according to context, the term `the Board' is used to refer to the former Board or Greater Glasgow and Clyde Health Board as its successor. However, the recommendations within this report are directed towards Greater Glasgow and Clyde Health Board.

The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify her when the recommendations have been implemented.

Main Investigation Report

Introduction

1. On 2 March 2006 the Scottish Public Services Ombudsman's Office received a complaint from a gentleman (Mr D) who was acting as advocate on behalf of the complainant (Mrs C). Mr D advised that Mrs C wanted to raise a complaint in respect of the clinical treatment provided to her during and after the birth of her son. In particular, she believed that action taken by the consultant anaesthetist (Dr E), when administering a top-up epidural to enable her retained placenta to be removed, almost cost her her life.

2. On 16 September 2005 Mr D, on behalf of Mrs C, raised a formal complaint with Argyll and Clyde NHS Board (the Board) about aspects of the clinical care provided by Dr E. In an attempt to resolve matters a meeting was arranged between Dr E, Mrs C, Mr D and the Complaints Manager at the Board. This meeting and the subsequent letter of explanation did not resolve the complaint and it progressed to the next stage of the NHS Complaints Procedure. On 30 January 2006 the Board issued another letter as a final attempt to address Mrs C's concerns. She remained dissatisfied with the response and indeed, at this stage, questioned the reliability of Dr E's recollection of the events of the day in question.

3. Mrs C was admitted to the maternity unit on 8 August 2004 from her home with a history of contractions. At 23:45 she was transferred to the labour ward with established labour. Mrs C requested an epidural for pain relief in labour at 01:56. She appears to have had an uneventful epidural during her previous labour in 1995. The epidural was inserted at 02:45 by the anaesthetist (Dr F). The written notes describing the epidural procedure are brief and abbreviated but there is no record of any complications associated with the insertion of the epidural. Although there is no record of the effectiveness of the epidural, the height of the sensory block or any leg weakness, the midwifery notes record that at 05:00 Mrs C was comfortable.

4. Mrs C delivered her son at 08:15 on 9 August 2004 in the Labour Suite. Unfortunately she had a retained placenta. As a result of this a decision was made at 08:50 that she required to go into theatre to have it removed. Her epidural infusion pump had run out at 07:35 and Mrs C was apparently distressed and in pain.

5. An entry in the midwifery notes at 09:05 details that Mrs C was complaining of a headache and her blood pressure was elevated at 151/83. During her labour her blood pressure had been recorded between 120/70 and 130/70. At 09:20 Dr E gave Mrs C 20mls of 0.5% bupivacaine into the epidural. Mrs C's blood pressure at 09:20 and 09:25 was recorded as 170/98 and 160/99. At this time Mrs C complained of neck pain. In her statement on the 5 November 2004 Mrs C states that after the epidural top-up she felt dizzy and her neck became very painful followed by paralysis of her face. She also reports that she was unable to move her lips and could not take a breath.

6. After giving the epidural top-up Dr E remained in the room. At about ten minutes after the epidural top-up Dr E reports that Mrs C was slumped against her pillow and complaining in a faint voice that she was unable to move due to a sore neck. Dr E examined Mrs C's neck and did not find any stiffness, her blood pressure at the time was, however, 200/106. Mrs C's colour deteriorated and could not be improved with oxygen and Dr E had to assist her breathing with a bag and mask. Mrs C states that she and her husband were advised later by clinicians that she had stopped breathing for a short period of time.

7. Dr E then gave Mrs C a general anaesthetic and intubated her in the delivery room. An intravenous infusion of an anaesthetic was commenced to keep Mrs C anaesthetised during her transfer to theatre which happened at 09:45. Her placenta was removed and a small perineal tear was repaired. A precautionary CT scan was requested by the consultant obstetrician (Dr G) at 09:30 because of concerns that Mrs C may have experienced an intracranial bleed due to her high blood pressure and her unreactive and dilated pupils. A CT scan took place at 10:19 following the operation. The scan was found to be normal and Mrs C was allowed to recover from her anaesthetic and was extubated. She was transferred to the intensive care unit at 10:55 where she remained for 24 hours before being discharged back to the maternity ward.

8. The complaints from Mrs C which I have investigated are that:

(a) clinical errors by Dr E put Mrs C's health at risk during her labour; and

(b) Dr E's recollection of the facts differs from those of Mrs C, who believes that Dr E is being untruthful.

Investigation

9. I have examined correspondence including responses to Mrs C's complaints from the Board. I have made written enquiries of the Board and

have obtained the clinical records. I have also sought clinical and specialist advice from our Independent Professional Advisers and have received advice from a specialist External Professional Adviser (the Adviser). I have set out, for each of the headings of Mrs C's complaint, my findings of fact and conclusions.

10. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Board were given an opportunity to comment on a draft of this report.

(a) Clinical errors by Dr E put Mrs C's health at risk during her labour

11. Following her epidural top-up Mrs C experienced the symptoms of a high spinal block which caused her to have difficulties breathing and which required her to be given a general anaesthetic to allow her to be intubated and ventilated until she recovered from the high block. She made a full recovery from the high block but has since experienced headaches, anxiety and back pain.

12. At the time of the high block there was concern that Mrs C may have suffered from an intracranial bleed. This was investigated by having an urgent CT scan and the possibility was discounted. The possibility of an anaphylactic reaction was also investigated and excluded.

13. Mrs C has suggested that she may have experienced a 'total spinal'. A total spinal block is where the dose of local anaesthetic injected into the cerebrospinal fluid (CSF) is sufficient to anaesthetise the brain leading to rapid loss of consciousness. The Adviser states that the symptoms shown by Mrs C and the signs noted by clinical staff indicate that she experienced a 'high spinal block'. This term is used when the dose of local anaesthetic injected through an epidural or spinal needle/catheter causes an excessive spread of block which may lead to difficulty with breathing or speaking but which does not lead to loss of consciousness.

14. The Adviser has indicated that the exact cause of the complication can only be speculated on as no radiological investigation of the epidural catheter position was carried out. There are a couple of possibilities as to the cause of the high block. It may be that the epidural catheter was misplaced and that it was not in the epidural space but had either penetrated the dura and was lying in the CSF or was lying within the meninges (subdural). In both cases the most likely time that the catheter was misplaced would be at the time of the original insertion of the epidural.

15. If this had been the case it would have been expected that Mrs C would have suffered from a dense block affecting her legs with significant leg weakness, a high sensory block, hypotension or patchy pain relief. There is nothing in the clinical records to suggest that the epidural analgesia was abnormal, however, the observations relating to the epidural analgesia documented in the case notes are very sparse.

16. The other potential cause of the complications is that during the insertion of the epidural there was an accidental puncture of the dura which was not recognised. The puncture hole would allow local anaesthetic injected into the epidural space to spread quickly into the CSF. The low doses of anaesthesia used during labour may not have caused any reaction other than, possibly, particularly effective pain relief but when a large dose of anaesthetic was given through the epidural to provide Mrs C with anaesthetic for the operation, then it is possible that significant amounts of local anaesthetic entered the CSF from the epidural space to give a very high block and even affect the cranial nerves located within the skull. One complication of a dural puncture is to develop a severe headache afterwards. Post dural puncture headache does not appear to have been considered as a possible cause of Mrs C‘s headaches.

17. Incidents of misplaced catheters or accidental punctures of the dura can be very distressing. They are not common but do occur, even at the hands of the most experienced anaesthetists. The Adviser has made clear that such incidents are not as a result of any clinical failure.

18. It is clear from the case notes that Dr E gave an appropriate dose of local anaesthetic through the epidural catheter for the proposed operation to ensure that Mrs C would have adequate anaesthesia. This dose of anaesthesia would not have been expected to produce the abnormal high block experienced by Mrs C. It is expected that Dr E would have satisfied himself by examining the patient and inspecting the epidural catheter where it entered the skin and by taking a history from the midwife and Mrs C. Again, it is unfortunate that Dr E did not record this detail in his case notes. Without any reason to suspect the epidural analgesia was abnormal Dr E could not have been expected to foresee that the epidural top-up which he gave would have caused high spinal block.

19. Dr E and his colleagues managed the unexpected complications rapidly and expertly. It was entirely appropriate that a CT san was arranged and this

was done promptly. Mrs C was then admitted directly to intensive care for observation. The Adviser has explained that the immediate management of the complication was commendable.

(a) Conclusion

20. A number of issues have arisen in the examination of this case. From the review of the clinical records it appears that there are shortcomings with regard to the documentation of the epidural analgesia in this case. Documenting specific observations may in some cases provide evidence and a warning that an epidural catheter is misplaced. This documentation was absent in this case. In addition, there is an absence of a written record of discussions between medical staff and Mrs C about what happened during her time as an in-patient. The level of the detail in the case notes could have been identified as an issue had the Board carried out an appropriate clinical risk review of the incident, which it appears did not happen in this case.

21. There is no evidence to suggest that Mrs C's complication was due to a clinical error made by Dr E. The complication of such an unusually high spinal block is rare (less than 1 in 1400) and it could not be expected that Dr E would have foreseen that this complication would occur. When the complication did occur, it was managed well and correctly. For this reason I do not uphold this aspect of the complaint.

22. I acknowledge that Mrs C's experience following the top-up epidural was very upsetting and I fully understand her concerns. It is with this in mind that I hope that the above information has provided some explanation and reassurance in regard to the circumstances surrounding these unusual events.

(a) Recommendation

23. The Ombudsman recommends that the Board

(i) consider whether it needs to review when clinical risk reviews of incidents such as these are carried out; and

(ii) ensures that clinical staff are reminded of their responsibility to maintain detailed records, in particular, in respect of anaesthetic procedures.

(b) Dr E's recollection of the facts differs from those of Mrs C, who believes that Dr E is being untruthful

24. I have fully reviewed all correspondence in respect of this complaint. Mrs C believes that Dr E's recollection of events differs significantly from hers. I

have reviewed her original letters requesting an explanation of her experience and also the responses provided by the Board.

25. Mrs C first wrote to Dr G on 1 September 2004 to request that an explanation for her complications be provided. Dr G reviewed her at a routine postnatal appointment and referred her to a consultant neurologist because of her history of headache and backache since the birth of her son.

26. On 5 November 2004 Mrs C wrote to the Complaints Department stating that she did not feel that she had received an adequate explanation for what happened. The Complaints Team notified Dr E of this letter and requested a written response from Dr E which he provided. On 14 December 2004 the Complaints Team wrote to Mrs C offering a meeting with Dr E or another anaesthetist to discus her concerns. No reply was received from Mrs C despite a further letter on 27 January 2005 and so no further action was taken on the complaint until Mr D contacted the Board on Mrs C's behalf on 16 September 2005.

(b) Conclusion

27. Although it is possible that Mrs C and Dr E's memories of the incident differ in detail, I have no evidence whatsoever, nor do I believe I could obtain evidence to support a claim that Dr E was untruthful in his recollection of the background events to the incident. As such I do not uphold this aspect of the complaint.

(b) Recommendation

28. The Ombudsman makes no recommendation on this point.

29. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify her when the recommendations have been implemented.

19 September 2007

Annex 1

Explanation of abbreviations used

Mr D	The Complainants Representative
Mrs C	The complainant
Dr E	Consultant Anaesthetist
The Board	Greater Glasgow and Clyde NHS Board
Dr F	Anaesthetist
Dr G	Consultant Obstetrician
The Adviser	The External Professional Adviser to the Ombudsman's Office
CSF	Cerebrospinal Fluid

Annex 2

Glossary of terms

Dura	Membrane covering the spinal cord
Extubated	Removal of a tube (for assisting breathing)
Intubated	Insertion of a tube (for assisting breathing)