## Case Review Relevant to Medical Records (WITN3416003)

### Pregnancy

Mrs Fyffe was booked under the care of Dr Naren Patel (Consultant) in her second pregnancy in February 1988 at 8-9 weeks gestation giving her estimated date of delivery on the 25th of September 1988.This was Mrs Fyffe's second pregnancy, the first one resulting in a caesarean section due to foetal distress at term with a good outcome.

Mrs Fyffe's pregnancy (1988) was uneventful apart from unstable lie in the third trimester. The foetal lie, however stabilised to a cephalic (head) presentation towards the end of pregnancy. At 41-42 weeks gestation induction of labour was recommended and Mrs Fyffe was admitted to Labour Suite for induction of labour on the GRO-C 1988.

### Induction of Labour

Induction of labour was commenced at 1030 GRO-C 1988. On examination the cervix was 1 cm dilated and 3 cm long and the foetal head was stationed -4 above the ischial spines. Artificial rupture of membranes revealed clear liquor. Syntocinon infusion was commenced to promote uterine contractions. Epidural was administered at 1240 for pain relief. Active labour was confirmed on vaginal examination at 1500. The cervix was 2 cm dilated and the foetal head was stationed -2 above the ischial spines Labour progressed normally and at 0200 on GRO-C the cervix was confirmed to be fully dilated and active pushing in the second stage was commenced.

### Delivery

Due to a previous caesarean section and poor progress in the second stage of labour a forceps delivery was decided upon. The epidural analgesia was ineffective, and a spinal anaesthetic was administered. On vaginal examination the cervix was found to be fully dilated and the foetal head in a transverse position (OT) at the ischial spines. Kjellands rotational forceps were applied and the foetal head delivered and subsequently the foetal body at 0301. The notes state that Syntometrine 1 ml was administered. The exact timing of the Syntometrine administration is not documented. Standard practise is to administer Syntometrine at the delivery of the anterior foetal shoulder.

The placenta was retained and subsequently manually removed. The placenta was documented to be very stuck (adherent) to the uterine wall and removed piecemeal. Following the removal of the placenta and membranes the uterine cavity was checked and found to be empty. The uterus was lax (not well contracted). Syntocinon 10 units were administered intravenously and Syntocinon infusion 20 units/500 mls fluid commenced. Episiotomy was repaired. Blood loss was recorded **500 mls** in the operation notes but **300 mls** in the midwifery documentation. The explanation for this discrepancy may be that the midwife attending the delivery was not present during the episiotomy repair. The midwifery labour/delivery documentation during an operative delivery often takes place prior to medical delivery documentation. In 1988 labour/delivery documentation was not computerised.

### Postnatal progress

**#(star) Day following delivery GRO-C 88)**

**At 0530** Mrs Fyffe was transferred from the delivery room to the recovery area. She was feeling unwell with low blood pressure 74/45 and raised pulse 96. The bed was tilted down (head down tilt)

and the rate of fluid infusion increased. Mrs Fyffe continued to feel faint. At 0830 the blood pressure is recorded 90/54 at 0900 98/58. The blood pressure at the booking in pregnancy appointment (8 + weeks) was 120/65 and 130/76 prior to induction of labour

**At 1500** I attended Mrs Fyffe. Significant vulval swelling (oedema) was present and large protruding haemorrhoids noted. This was treated with icepacks and analgesia.

**At 2030** Mrs Fyffe had a bed bath. She was feeling too faint to get up for a shower.

**At 2200** I attended Mrs Fyffe. Vaginal assessment was performed to exclude a vaginal haematoma and to try to reduce the haemorrhoids. No vaginal haematoma was found, and haemorrhoids reduction was recorded as not very successful. Blood pressure was recorded 120/80, Pulse 96.

**Day 1 Following delivery GRO-C 88)**

Mrs Fyffe is recorded as feeling more comfortable.

I attended Mrs Fyffe on GRO-C 88 on 2 occasions before 1500 hours. It is documented in the midwifery notes that I attended at 1120 that morning. The clinical notes state that Mrs Fyffe is pale, looking anaemic with raised pulse and feeling faint. Significant haemorrhoids and vulval bruising are still present. Haemoglobin is recorded as 6.2g/dl. Due to low haemoglobin and being symptomatic of anaemia I recommended a blood transfusion. I discussed that with Mrs Fyffe, and it is recorded that she is not keen on blood transfusion.

Mrs Fyffe subsequently contacted her husband and at some time later I had a long discussion with both of them regarding blood transfusion and according to the medical notes advice was given. No details of the advice are documented. No definite decision was made regarding a blood transfusion. The notes state that she (Mrs Fyffe) does not want a blood transfusion.

GRO-C 88 According to the midwifery notes at 1500 hours Dr Young from the Scottish National Blood Transfusion Service ("SNBTS") discusses blood transfusion with Mr and Mrs Fyffe. According to the medical notes Mr and Mrs Fyffe are seen by an obstetric medical person at 1530 as documented in the notes. I do not recognise the writing and cannot decipher the signature therefore, I am unsure whether this was the SHO or Registrar. Blood transfusion is discussed again with Mrs Fyffe and Mr Fyffe. SNBTS was contacted and, following that, the screening procedures used for Hepatitis B, HIV and Syphilis were explained to Mrs and Mr Fyffe.They were concerned about the possibility of HIV as the blood is only tested for antibody not antigen. Hepatitis C screening is not documented in the notes and I can't remember if blood product screening for Hepatitis C was routinely undertaken in 1988.

At 1800 Dr Young from SNBTS attends again and sees Mrs Fyffe and discusses the situation with Dr White and Dr Mills. I am not sure whether Dr White was a SHO or Registrar. Dr Mills was most likely the consultant on call for the weekend. The decision was deferred until the next day and Dr Young was to be paged if Mrs Fyffe was going to have a blood transfusion.

At 2000 it is documented in the medical notes that a decision has been made to go ahead with blood transfusion the next morning. This is documented by the same medical person as saw Mrs Fyffe at 1530. No reason is given as to why this was deferred until the following morning. At this time there was no documented recording of active vaginal bleeding and there was no evidence of maternal clinical deterioration. As blood was ready and available and consent obtained, blood could have been administered immediately if clinically required. When Labour Suite is busy at night if can be safer to postpone procedures overnight if possible.

**Day 2 following delivery GRO-C /88)**

Blood transfusion is commenced between 0815 -0845.

I attended Mrs Fyffe twice that morning and noted that she was much improved, but was still feeling faint when sitting/standing up. Blood transfusion was in progress. On the second occasion at 1045 I was called due to Mrs Fyffe passing a large vaginal blood clot (collection of blood). On examination a right vaginal wall haematoma was found and described as a small, non-tense collection of blood. Conservative management was recommended.

Mrs Fyffe received 4 units of plasma reduced blood on the GRO-C 1988. The haemoglobin levels increased from **6.2g/dl** on GRO-C 88 to **11.9 g/dl** on GRO-C /88. Mrs Fyffe haemoglobin level at 39 weeks gestation on 15/9/88 was **11.2g/dl.** The transfusion process was uneventful. Mrs Fyffe progress until discharge was complicated by pyrexia and periods of feeling unwell treated by antibiotics and diarrhoea considered antibiotic related. This resulted in delay in discharge home. Mrs Fyffe was discharged home on the 12/09/88. She was to see myself on Monday 17/10/88, but I cannot find any documentation regarding that having taking place.