Multiple communication, professional conduct and record-keeping failures in baby's death

Key messages from the case

A coroner's inquest into the death of a baby due to birth asphyxia highlights the harms arising from poor communication and record-keeping as well as failure to adhere to professional guidelines.

The case also highlights the paramount importance of honesty and severe sanctions that can result if healthcare professionals are found to have been dishonest or deceptive, such as by altering medical records.

Details of the decision

The coroner was critical of aspects of the clinical care provided by obstetrician (Dr D) and other medical staff. He found multiple failures by those involved had contributed to the death of baby Samara H, who died of birth asphyxia when the umbilical cord was wrapped around her neck. She was also suffering from meconium aspiration.

Professional standards and guidelines

The coroner considered failure by staff to adhere to hospital policies on cardiotocography (CTG) and foetal heartrate (FHR) monitoring significantly contributed to baby Samara's death. These failures meant the baby's distress was not identified early enough and the obstetrician (Dr D) was not called in at a point when intervention may have saved her.

The coroner was critical of the fact that most of the healthcare staff were unaware of applicable hospital policies, and did not follow them. He pointed out that 'it is not worthwhile having policies if even the specialists are unaware of them.'

Record-keeping

The coroner was particularly critical of the 'woefully inadequate' record-keeping. One of the midwives claimed to have kept records of the baby's heart rate on a piece of paper in her pocket – which she later lost.

The coroner found that if records had been kept, and consolidated into the patient's medical record, a non-reassuring trace would have been evident, and this should have caused the obstetrician to be called in immediately.

Further, following the adverse event, the job of working out what had gone wrong was made more difficult by the fact that records were incomplete or completely missing.

If Ms H had actively refused intervention, this was never documented as it should have been – along with a record of the information that had been provided to her.

During the inquest it became clear that one of the midwives had later altered the medical records, changing the time of one of the observations. The coroner noted that altering records in the face of a police or coronial investigation may amount to an attempt to pervert the course of justice.

Patient communication – providing information

The coroner characterised communication with Ms H as 'woeful'. It seemed from evidence that healthcare staff had consistently failed to provide Ms H with enough information to make healthcare decisions. It was suggested that she had refused to continue with the initial CTG (though this was not documented). However, the coroner found the midwives did not explain to her why they were asking her to persist with the discomfort and why it was necessary for the baby's welfare.

When the obstetrician (Dr D) arrived, he delayed intervening to assist in the birth. He appears to have offered Ms H options including continuing to aim for a natural delivery or commencing assisted delivery. However he did not explain the urgency of the need for intervention or risks of non-intervention. He failed to provide any explanation or recommendations. The coroner notes Ms H was left trying to get advice from a relative by phone.

Outcome

Standards and guidelines

The coroner recommended the hospital act urgently to ensure all staff working in the hospital were aware of relevant policies – including scheduling paid time for staff to familiarise themselves with policies; and formal assessment of their understanding.

He also recommended all midwives and obstetricians needed to ensure they are familiar with relevant RANZCOG guidelines and that they implement these in their clinical practice.

Record-keeping

The coroner recommended the hospital implement appropriate records management systems and policies. The coroner recommended that relevant forms and documents be amended so that they are easier to read, kept closer to the patient to make them easier to access, and consolidated to avoid having duplicate information.

He also recommended implementing policies to ensure that any additional records are incorporated in the patient records, and that all staff are aware of appropriate process to amend records as necessary, and to ensure records are maintained securely.

The coroner referred the matter to the Director of Public Prosecutions to consider prosecuting the midwife for attempting to pervert the course of justice.

Communication

The coroner considered Dr D's communication with Ms H was substandard and he should undertake retraining in communication skills.

The coroner considered that Dr D's care overall had been substandard and referred the matter to the Medical Board. The Medical Board referred Dr D to the state Civil and Administrative Tribunal which found Dr D to have engaged in unsatisfactory professional conduct and imposed a 12-month suspension and professional sanctions.

He recommended all medical professionals should be required to undertake ongoing professional development on communicating with patients in stressful situations as a condition of maintaining registration.

Key lessons

- It is not enough just to have policies in place. Healthcare organisations are expected to take steps to ensure staff are aware of and are following protocols and guidelines.
- Adequate and contemporaneous record keeping is essential – to support effective transfer of care, ensure patient safety and to help understand what has gone wrong if an adverse event occurs.
- Health care organisations need to have policies in place to ensure security of records and appropriate ways to correct records.
- Never alter a record to attempt to conceal an error.
- Give patients enough information so they can make an informed decision about their healthcare. It is not enough just to provide options with no context or advice about risks or recommended treatment.

References and further reading

- Avant factsheet – Medical records: The essentials
- Avant eLearning – Consent: informed consent and more
- Avant factsheet – Consent: the essentials

For more information or immediate medico-legal advice, call us on 1800 128 268, 24/7 in emergencies.
avant.org.au/mlas

avant.org.au/avant-learning-centre