A REVIEW OF 28 MATERNITY CASE NOTES

BY A

CLINICAL REVIEW TEAM

UNDERTAKEN AT THE REQUEST OF

THE HEALTH SERVICE EXECUTIVE

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Executive Summary

This is a clinical review of twenty-eight (28) case notes from three maternity units, Portlaoise (twenty-three cases), University Maternity Hospital Limerick (three cases), and Midland Regional Hospital Mullingar (two cases) by a team of obstetricians referred to as the Clinical Review Team (CRT).

The review is not an audit of maternity services at the Midland Regional Hospital, Portlaoise (MRHP).

The review was requested by the Health Service Executive (HSE) as a consequence of patients contacting either a helpline, or the hospitals directly, following an RTE Prime Time programme broadcast in January 2014 related to maternity services at MRHP. No time limit was set by the HSE regarding patients' care.

The case notes reviewed by the CRT were from 1985 to 2013. Three case notes were from the 1980s, three from the 1990s, twelve between 2000 and 2009, and ten between 2010 and 2013.

It is important to note that the CRT only reviewed the case notes provided to them by the HSE. The CRT relied on the HSE for the provision of all relevant records.

The CRT was asked to do a paper review only and where the CRT thought it appropriate to make a general or specific recommendation as to future action. The CRT did not meet with any patient, family or staff during the course of this review.

The opinions expressed by the CRT may be subject to revision if additional and/or new information becomes available.

The Terms of Reference for the review are set out on pages 4 and 5.

Fourteen of the case-notes involved pregnancies where the baby was either stillborn or died in the neonatal period. The remainder covered a variety of outcomes which are dealt with in more detail in the body of the review.

Seventeen of the mothers were expecting their first baby. Fifteen of the pregnancies were in Groups one and two of the Ten Groups Classification (see appendix).

In six cases it was evident from the case notes that the parents had been met with and their concerns discussed. In three cases an inquest had been conducted. In the remaining nineteen cases there is no evidence of a meeting with the patient/family in the case notes provided to the CRT.

The CRT identified issues to be addressed in ten cases, in six of which the baby was either stillborn or died in the neonatal period.

Please note that no conclusions regarding the safety of the maternity services in the maternity units where the care was provided should be drawn from this review.

Furthermore, no definitive conclusions have been reached on the care provided in any individual case, as the CRT has only carried out a paper review and, as stated, has not met with patients, family members and/or staff.

This review does however emphasise the urgent need to implement a programme of annual audit of Irish maternity services similar to that conducted by the three Dublin maternity hospitals.

The CRT wishes to acknowledge the grief of, and sympathise with, parents who suffered and appreciates their consent to having their case notes reviewed.

The CRT has made a number of recommendations arising from the review as follows:

Recommendations:

1. The commissioner of this review, or a person nominated by the commissioner, should meet with each of the patients to relay the conclusions/recommendations in their individual case.

2. Each hospital in the State should implement a formal system of audit of pregnancy outcome classified according to the Ten Groups Classification as recently endorsed by the WHO (please see the Appendix attached). This audit should take place on a monthly basis and involve all relevant clinicians. Each hospital needs to supply relevant administrative support.

   Using data from individual maternity units an annual audit of Irish maternity services should be implemented without delay.

   Ongoing audit in this manner will allow a pattern of adverse outcomes to be identified in a timely fashion so that appropriate action can be taken.

3. Each hospital should have in place a formal system of review of adverse outcomes. The results of these reviews should be shared with the patients in a timely fashion. We recommend within two months of the incident. This timeline is subject to any relevant legal issues, external investigations or inquiries external to the hospital which might arise.

4. In the event of a perinatal death every effort should be made to gain consent for a post-mortem examination and examination of the placenta by a perinatal pathologist experienced in these examinations.

5. Each hospital should ensure the appointment of a number of midwives trained in ultrasonography such that high quality obstetrical ultrasound is available on a routine basis during the working week and on an on-call basis at other times.

6. Each hospital should appoint bereavement counsellors trained to deal with perinatal deaths.

7. Each hospital should ensure that Midwifery staffing levels are at an adequate and internationally accepted level.

8. Each hospital should ensure that every Non-Consultant Hospital Doctor position is part of a recognised training scheme.

9. Each hospital should ensure that Consultant Obstetrician staffing levels are at an adequate, internationally accepted level.

10. Each hospital should implement on-going mandatory training programmes for all clinical staff in respect of day-to-day care of pregnant women where such programmes do not already exist.

INTRODUCTION

In January 2014, RTE's Prime Time programme broadcast a report on the Midland Regional Hospital Portlaoise (MRHP) maternity unit. Following this programme a helpline was set up by the HSE which invited patients and/or their families of the MRHP to make contact in relation to experiences they had in Portlaoise. Patients were also invited to contact the hospital directly. No time limit was set as to the date when the care was provided.

In April 2014, the HSE National Incident Management Team (NIMT) approached the Forum of Irish Post-Graduate Medical Bodies who in turn requested the Institute of Obstetricians and Gynaecologists of the Royal College of Physicians of Ireland to commission a Clinical Review Team to review the hospital case notes of patients who had contacted the HSE helpline or the hospital.

The Clinical Review Team (CRT) was appointed in mid-May 2014.

The Clinical Review Team members are:-

Chair	Dr. Peter Boylan, MAO, FRCPI, FRCOG, National Maternity Hospital, Dublin.
Members	Dr. Elizabeth Dunn, MRCOG, MRCPI, Wexford General Hospital, Wexford. Dr. Paul Hughes, MB, FRCOG, Kerry General Hospital, Tralee. Prof. Louise Kenny, MB, ChB, PhD, MRCOG. Cork University Maternity Hospital, Cork. Prof. Peter McKenna, FRCPI, FRCOG. Rotunda Hospital, Dublin. Prof. John Morrison, MD, FRCOG, FRCPI. Galway University Hospital, Galway. Dr. Michael Robson, FRCS, FRCOG, National Maternity Hospital, Dublin.

The Terms of Reference in relation to the review were drafted after the CRT was appointed in mid-May and were finalised in October 2014. **Terms of Reference** are as follows:-

1) "The Clinical Review Team will review a maximum of forty cases arising out of patient contacts to the HSE following the Primetime Investigates documentary broadcast on 30th of January 2014 – referred to them by the HSE".

2. "For cases that are referred to the Clinical Review Team the review team will conduct a preliminary review leading to the following decisions/actions;

a) Where local investigations have been conducted, the Clinical Review Team will review the local investigation and either confirm that it is satisfactory or not. If the team feel the investigation has not been satisfactory they may recommend a more extensive investigation guided by HSE protocols.

b) Where no local investigation has been conducted, the Clinical Review Team may request that a systems analysis investigation to be conducted by HSE investigators

c) The review team may decide that no further action is required. This finding, and the reasons behind it, will be conveyed to the family".

3. "The Clinical Review Team will receive and check the draft system analysis investigation reports against the audit tool in the HSE Guidelines for Systems Analysis Investigation of Incidents and Complaints (HSE 2012). Where the investigation is deemed to be compliant with HSE guidelines and otherwise satisfactory to the Clinical Review Team – it will be released by the investigation commissioner to the family concerned. Where investigations are not deemed to be satisfactory, they will be returned to the investigators with feedback about the issues that need to be addressed in the report for re-submission to the Clinical Review Team. Once the clinical review team is satisfied that the outstanding issues are addressed – the report may be released by the commissioner to the family".

4. "The Clinical Review Team will provide a report of the methods and the findings of their review to the commissioners (i.e. the National Director for Acute Hospital Services) via the Acute Hospitals Office Nominee on the Clinical Review Team".

5. "Indemnity arrangements and payments for the external independent nominations from the Forum of Post-Graduate Training Bodies will be as per the forms of request for nominations from the HSE. and as per agreements between the HSE. and the Forum".

6. "The work of the Clinical Review team will not conflict with the work of the HIQA investigation into the safety, quality and standards of services provided by the HSE to patients in the Midland Regional Hospital, Portlaoise".

In relation to No. 3 above, the CRT has been advised that it would not be appropriate for it to check the draft system analysis investigation reports against the audit tool in the HSE Guidelines for Systems Analysis Investigation of Incidents and Complaints (HSE 2012) and/or give an opinion on the release of the report/review to the investigation commissioner and/or to the patient/family concerned. These are issues for the HSE or the individual Review Teams appointed in each case. The HSE has accepted that this is the correct position.

The HSE wrote to patients who had made contact with the helpline or the hospital requesting their consent for the case notes relating to their delivery to be reviewed by the CRT.

The scope of the review was initially restricted to patients who had delivered in Portlaoise Hospital. However at the end of May 2014 the HSE requested that additional cases be considered and the CRT agreed to this expansion.

By 9 July 2014, consent for case notes review had been received from twenty-five patients. Consent from an additional three patients was received later.

The majority of the patients' case notes began to arrive for distribution to the CRT at the end of July 2014 and were distributed by the end of August 2014.

In September 2014 more case notes were received and were distributed. However some case notes were still outstanding. The remaining case notes were received in October and November 2014.

The internal HSE audits of five of the cases, which had already been reviewed by the HSE, were sent to the CRT for consideration (four internal investigations and one external).

Following distribution of the case notes the CRT undertook a review of the patient case notes. On 31st October 2014 the CRT met in the Royal College of Physicians to review all the case notes and reach consensus decisions in accordance with the Terms of Reference determined by the HSE.

As noted on page 1, a total of twenty-eight case notes were referred to the CRT for review. Twenty-three of the case notes were from Portlaoise Hospital, three were from Limerick, and two from Mullingar. Chronologically the cases ranged from 1985 through to 2013.

The clinical outcomes of the cases referred were associated with:-

- Fourteen stillbirths/neonatal deaths.
- One was a case of infant death at ten months of age.
- Two related to babies who were micro-cephalic.
- One case of cerebral palsy in a child who is quadriplegic.
- One related to massive obstetric haemorrhage.
- One related to a retained swab.
- One related to a wound abscess.
- In three cases multiple questions were raised.
- One case was of an undetermined neurological problem.
- In one case it was difficult to ascertain why a review of the case notes had been requested.
- In two cases the outcome for the baby was unknown.

In relation to the twenty-eight cases the CRT would also note:-

- In two cases HSE NIMT reviews were either requested or underway.
- In four cases internal investigations had been performed but all were deemed to be incomplete by the HSE when checked by the HSE against the audit tool in the HSE Guidelines for Systems Analysis Investigation of Incidents and Complaints HSE 2012. In these cases the CRT thought it was not appropriate to consider the content of those internal investigations as part of the documentation considered by the CRT.
- One case had been subjected to an external review, which concluded that the care was reasonable.
- Three cases had been the subject of a Coroner's inquest.

In eleven cases the CRT concluded that there were possible issues relating to the care and recommended that nine cases be subjected to a full systems analysis review.

This review is not a medical-legal report and is not to be used for that purpose.

APPENDIX

All cases have been classified according to the Ten Group Classification System (Robson Ten Groups) endorsed by the World Health Organisation (WHO) (see attached reference).

The Ten Group Classification System allows for the analysis of all births and is used primarily in the analysis of caesarean section deliveries. The classification system is based on characteristics of pregnancy according to whether the pregnancy is a singleton or multiple (twins etc.), nulliparous (first pregnancy), multiparous (second and subsequent pregnancy), or multiparous with a previous caesarean section. The classification details whether the baby is presenting head first (cephalic), by the breech or other mal-presentation. The system classifies labour as either spontaneous or induced and birth as either term or pre-term.

The following are the ten groups:-

1. Nulliparous, single cephalic, greater than 37 weeks in spontaneous labour.
2. Nulliparous, single cephalic, greater than 37 weeks, induced or caesarean section (CS) before labour.
3. Multiparous (excluding previous CS), single cephalic, greater than 37 weeks and spontaneous labour.
4. Multiparous (excluding previous CS), single cephalic, greater than 37 weeks, induced or caesarean section before labour.
5. Previous CS single cephalic, greater than 37 weeks.
6. All nulliparous breeches.
7. All multiparous breeches (including previous CS).
8. All multiple pregnancies (including previous CS).
9. All abnormal lies (including previous CS).
10. All single cephalic, less than 36 weeks (including previous CS).

This system of classification has gained worldwide approval and facilitates comparison and benchmarking between countries and between institutions within an individual country.

Use of the Ten Group Classification facilitates the identification of peaks in adverse outcomes so that attention can be focused to reducing such adverse outcomes.

ENDS.