London Ambulance Service
NHS Trust

Obstetric Emergencies

Themed Section of the Risk Information Report

Clinical Governance [13.08.07]

OBSTETRIC EMERGENCIES
RISK INFORMATION REPORT

Contents **Page**

1. COMPLAINTS

Obstetric Complaints 2001 to 2007

The number of complaints received by the Service relating to Obstetric issues is recorded as:

2001 - 8
2002 - 8
2003 - 8
2004 - 7
2005 - 8
2006 - 13
2007 - 14 (to current date)

The number of complaints relating to Obstetric cases should be considered against the number of such cases that are handled by the LAS each year as follows:

2001 - 20560
2002 - 20649
2003 - 21506
2004 - 22042
2005 - 20670
2006 - 20145
2007 - 10664 (up to the end of June07)

2001
Of the eight complaints recorded, 3 babies died, 1 baby suffered from brain damage, 1 baby was premature, 1 case involved Placenta Abrupta, 2 babies were born before arrival and there were 2 instances of a delayed response. In 2 cases, the mother was not taken to the hospital of choice, 2 complaints were related to walking the patient and there were 2 cases where the attitude or comments of the crew were the subject of complaint.

2002
Of the eight complaints recorded, 2 babies died, one case related to Placenta Abrupta, 2 complaints were made relating to treatment or the lack or treatment and 3 complaints related to walking the patient. ! mother was not taken to the hospital of choice, 1 patient was not conveyed and 4 complaints related to the attitude or comments of the ambulance crew.

2003
Of the eight complaints recorded, 2 babies died, 2 babies were born before arrival and 3 complaints were made relating to treatment or the lack of treatment. 1 cases related to the walking of the patient, 2 related to a delayed response, 2 complaints related to the attitude or comments of the crew and in 1 case the patient was taken to A&E instead of Maternity.

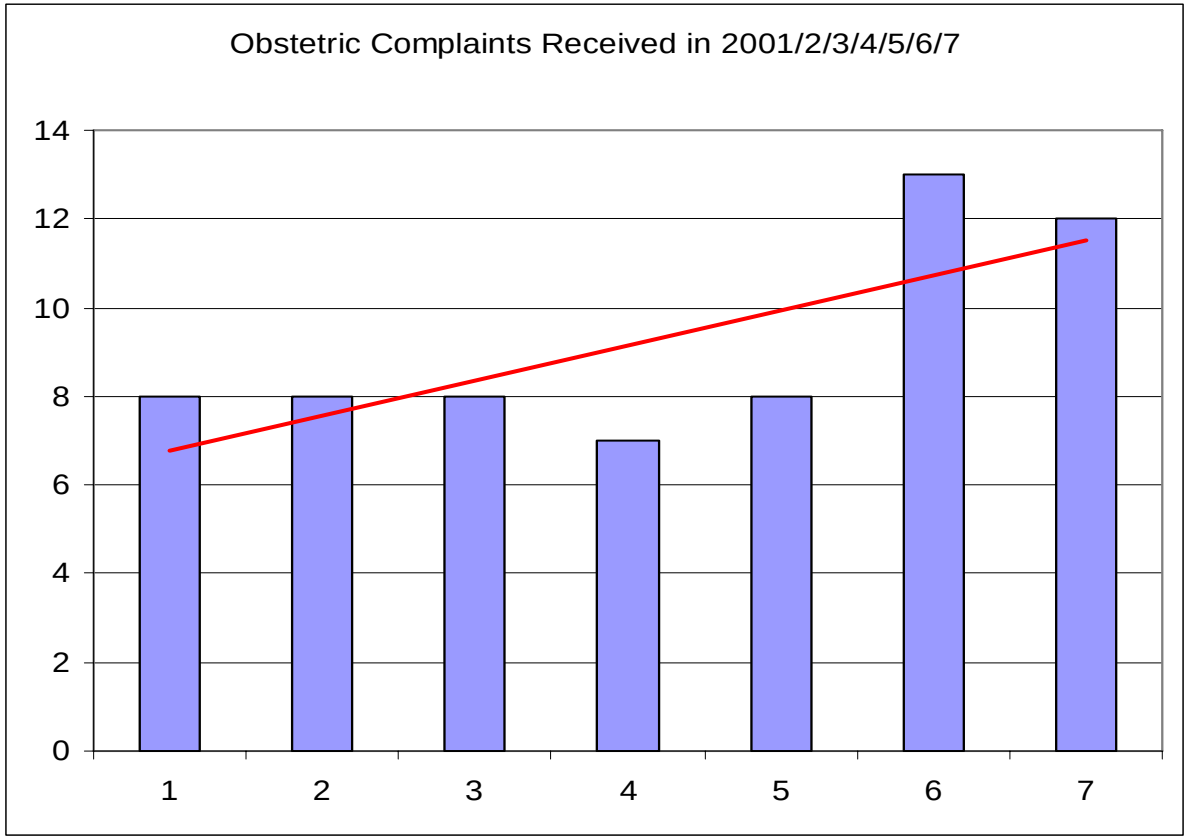
2004
Seven complaints are recorded for this year. 1 baby died and one was premature. 3 complaints were made relating to treatment or the lack of treatment and 4 complaints were made relating to the attitude or comments of the crew.

2005
Eight complaints are recorded for this year. 3 babies died. 2 patients were not conveyed, there was 1 delayed response and 6 complaints relating to the attitude or comments of the crew.

2006
13 complaints were recorded in 2006. Of these, the baby died in 3 cases and there was 1 case of Placenta Abrupta. 6 complaints related to treatment or the lack of treatment, 1 case related to walking the patient. 2 caes related to delayed responses and 1 related to non conveyance. A total of 8 complaints related to the attitude or comments of the crew. 1 complaint related to the baby not being secured in the ambulance.

2007
12 complaints had been recorded up to the time of this report. Of these the baby died in 4 cases and in 2 cases the baby was born before arrival. 4 complaints related to treatment or the lack of treatment, 1 case related to walking the patient, there were 7 delayed responses and 2 cases of non conveyance. 5 complaints related to the attitude or comments of the crew.

Analysis of Obstetric Complaints Received from 2001 to 2007



Ref	First received	Closed	Details
0012/01/smc	05-Jan-2001	19-Feb-2001	Family unhappy with the way her baby was managed by the crew, believe that the baby suffering brain damage and this was related to the way the crew handled her child.
0077/01/jn	12-Feb-2001	14-Mar-2001	Patient was made to walk down 3 flights of stairs, wasn't helped and fell. Crew did not report this to the hospital staff - patient also pregnant
0229/01	25-Apr-2001	25-May-2001	Patient 38 weeks pregnant, called for an ambulance. Was asked if she could make her own way. Ambulance sent - crew assumed pains were normal labour pains but were in fact due to placenta separating. Baby died.
0342/01/jn	12-Jul-01	24-Oct-01	Complainant gave birth to premature baby, an ambulance was delayed in responding to her '999' call and baby later died.
0424/01/jn	24-Aug-01	25-Sep-01	Patient delivered baby whilst waiting for ambulance and then three arrived in one go, could have been complications in the birth.
0511/01/jn	17-Oct-2001	15-Nov-2001	Complainant unhappy with the attitude of the crew that was called to her pregnant friend. They apparently told her that it was a waste of her time.
0562/01/smc	13-Nov-2001	18-Dec-2001	Crew refused to take a pregnant woman to the hospital she requested then discussed the patient with one of her neighbours.
0591/01/jn	28-Nov-2001	21-Mar-2002	Delayed response of an emergency ambulance, then crew took her to the wrong hospital, delivered a stillborn baby by c section

Complaint Subject		Treatment	Brain Damage	Walking	Fell (walking)	Placenta Abrupta	Baby Died	Premature	Delayed Response	BBA	Attitude or Comments	Not taken to hospital of choice	Not conveyed	Taken to A&E	Non securing of baby
2001	**1**	1	1												
	2			1	1										
	3					1	1								
	4						1	1	1	1					
	5								1	1					
	6										1				
	7										1	1			
	8						1		1			1			
Total		**1**	**1**	**1**	**1**	**1**	**3**	**1**	**3**	**2**	**2**	**2**	**0**	**0**	**0**

Ref	First received	Closed	Details
0014/02/jn	09-Jan-2002	12-Jun-2002	Pt states baby's head must have been showing at her home, ambulance crew made her walk - no examination was carried out by the ambulance crew that attended to her.
0022/02/smc	14-Jan-2002	26-Feb-2002	Pt pregnant and was worried that she was going to lose her baby. Female member of the crew was rude and told her if her husband was following in the car he should have driven her to the hospital and not called an ambulance.
0040/02/smc	23-Jan-2002	11-Mar-2002	Pt pregnant and felt male member of crew was very rude and didn't want her to touch him when she went to hold his hand when she was in pain.
0078/02/smc	07-Feb-2002	03-Apr-2002	Patient fell, (pregnant) crew did not convey
0129/02/jn	11-Mar-2002	28-Oct-2002	Patient believes that the crew did not treat her situation as an emergency. Lady was pregnant and was experiencing continuous abdominal pain. Subsequently had a stillbirth.
0126/02/smc	11-Mar-2002	16-Apr-2002	Pregnant patient booked into St Thomas taken to Kings and left in the A&E.
0268/02/smc	02-Jul-2002	02-Oct-2002	Pt 35 wks pregnant with severe stomach pains. Crew failed to recognise obstetric emergency. Walked pt to ambulance and drove with no urgency. Pt suffered a placental abruption. Delivered stillborn baby girl few hours later

Complaint Subject		Treatment	Brain Damage	Walking	Fell (walking)	Placenta Abrupta	Baby Died	Premature	Delayed Response	BBA	Attitude or Comments	Not taken to hospital of choice	Not conveyed	Taken to A&E	Non securing of baby
2002	**1**										1				
	2	1		1											
	3										1				
	4										1				
	5				1								1		
	6	1					1				1				
	7											1			
	8			1		1	1								
Total		**2**	**0**	**2**	**1**	**1**	**2**	**0**	**0**	**0**	**4**	**1**	**1**	**0**	**0**

Ref	First received	Closed	Details
0343/03/jn	05-Aug-2003	17-Oct-2003	Crew took pregnant woman with PV bleed to A&E instead of delivery suite.
0377/03/smc	27-Aug-2003	22-Sep-2003	Crew called to BBA breech birth, cut cord, baby died. Complainant unhappy with treatment provided
0412/03/smc	19-Sep-2003	23-Sep-2003	Patient needed to be transferred from the Birth Centre urgently due to the baby's condition. EMD's did not seem to understand this until the patient started bleeding and the foetal heart was lost.
0456/03/jn	17-Oct-2003	05-Nov-2003	Delayed ambulance response to pregnant woman who had collapsed.
0467/03/jn	23-Oct-2003	19-Feb-2004	Called an ambulance for patient who is 16 weeks pregnant and had fallen, waited an hour and twenty five minutes before an ambulance arrived.
0472/03/smc	24-Oct-2003	30-Oct-2003	concerns raised by the hospital about a BBA,
0537/03/smc	19-Dec-2003	29-Jan-2004	Crew were rude and pushed a 6 month pregnant lady out of the way

Complaint Subject		Treatment	Brain Damage	Walking	Fell (walking)	Placenta Abrupta	Baby Died	Premature	Delayed Response	BBA	Attitude or Comments	Not taken to hospital of choice	Not conveyed	Taken to A&E	Non securing of baby
2003	**1**				1						1				
	2													1	
	3	1					1			1					
	4	1					1								
	5								1						
	6								1						
	7	1								1					
	8										1				
Total		**3**	**0**	**0**	**1**	**0**	**2**	**0**	**2**	**2**	**2**	**0**	**0**	**1**	**0**

Ref	First received	Closed	Details
0087/04/smc	04-Mar-2004	12-Mar-2004	Complainant unhappy with the crews attitude toward them being called out to his pregnant wife who had high blood pressure. Wife had a premature birth.
0120/04/ab/pt	24-Mar-2004	24-Mar-2004	Parents concerns about the treatment offered to new born baby. Baby subsequently passed away.
0241/04/jn	23-Jun-2004	09-Aug-2004	Maternity emergency: crew clamped and cut cord, moved patient with placenta in situ, didn't wait for midwife. Baby cold on arrival but now ok.
0342/04/jn	24-Sep-2004	12-Nov-2004	Patient unhappy with crews attitude following her calling them out to her when she was vomiting, had severe back ache and was pregnant and concerned for her unborn child. Patient kept in hospital for 3 days and given morphine to control the pain she was in
0395/04/jn	02-Nov-2004	29-Nov-2004	RTA involving complainants daughter and son in law, daughter is pregnant - crew were very uncaring in their attitude and caused friction on scene and tried to blame the complainant for the patients high blood pressure.
0435/04/smc	07-Dec-2004	14-Dec-2004	QEH not happy that patient was brought to their hospital, when she was in fact booked into Lewisham and QMS was nearer if the patient had complications. Maternity unit was stretched to cope.

Complaint Subject		Treatment	Brain Damage	Walking	Fell (walking)	Placenta Abrupta	Baby Died	Premature	Delayed Response	BBA	Attitude or Comments	Not taken to hospital of choice	Not conveyed	Taken to A&E	Non securing of baby
2004	**1**										1				
	2							1			1				
	3	1					1								
	4	1													
	5	1									1				
	6										1				
	7											1			
Total		**3**	**0**	**0**	**0**	**0**	**1**	**1**	**0**	**0**	**4**	**1**	**0**	**0**	**0**

Ref	First received	Closed	Details
0048/05/smc	10-Feb-2005	25-Feb-2005	Patient is 38 weeks pregnant, told by hospital to call for an ambulance as she had belly pains. Female crew arrived and were very rude with their comments and made her feel like she was wasting their time and abusing the service.
0078/05/jn	04-Mar-2005	15-Mar-2005	Patient is 10 weeks pregnant and had PV bleed, person at train station called for an ambulance and was told by the crew that she should have called a taxi and were very off with the patient.
0092/05/jn	10-Mar-2005	26-Jul-2005	Patient was in extensive labour pains, crew arrived and took her to one hospital and kept her waiting in the ambulance for 10 minutes, then came out and said the hospital didn't have a bed. Crew then had to convey her to another hospital and she was bleeding severely, at hospital found that the baby had no heartbeat. Family unhappy that crew didn't do more
0319/05/jn	26-Aug-2005	26-Aug-2005	Delivery Suite at Hospital state that the baby was stillborn and crew rushed the baby to hospital leaving the mother at home with the placenta in situ. Hospital unsure if mother was left on her own or if there was another crew present.
0359/05/jn	25-Sep-05	20-Jan-06	Pt in labour, crew arrived and state that partner was assaulting patient. Police took partner away, patient not conveyed ? refused. Mother in law attended and called ambulance, this crew conveyed the baby and then another ambulance came to take the patient.
0465/05/jn	01-Dec-2005	12-Dec-2005	Wife pregnant, crew arrived but were delayed as couldn't find the address. Complainant feels this is because they used there SAT NAV system. En-route to the hospital crew went a long way to the hospital and complainant states that they again used the SAT NAV.
0478/05/smc	08-Dec-2005	12-Dec-2005	Partner unhappy with the behaviour of the ambulance man that attended to his wife. Wife is 16 weeks pregnant and woke up in pain in the abdominal area. Ambulance man launched into a series of questions and gave no assistance to his wife in getting down the stairs.

Complaint Subject		Treatment	Brain Damage	Walking	Fell (walking)	Placenta Abrupta	Baby Died	Premature	Delayed Response	BBA	Attitude or Comments	Not taken to hospital of choice	Not conveyed	Taken to A&E	Non securing of baby
2005	**1**						1						1		
	2										1				
	3										1				
	4						1				1				
	5						1								
	6										1		1		
	7								1		1				
	8			1							1				
Total		**0**	**0**	**1**	**0**	**0**	**3**	**0**	**1**	**0**	**6**	**0**	**2**	**0**	**0**

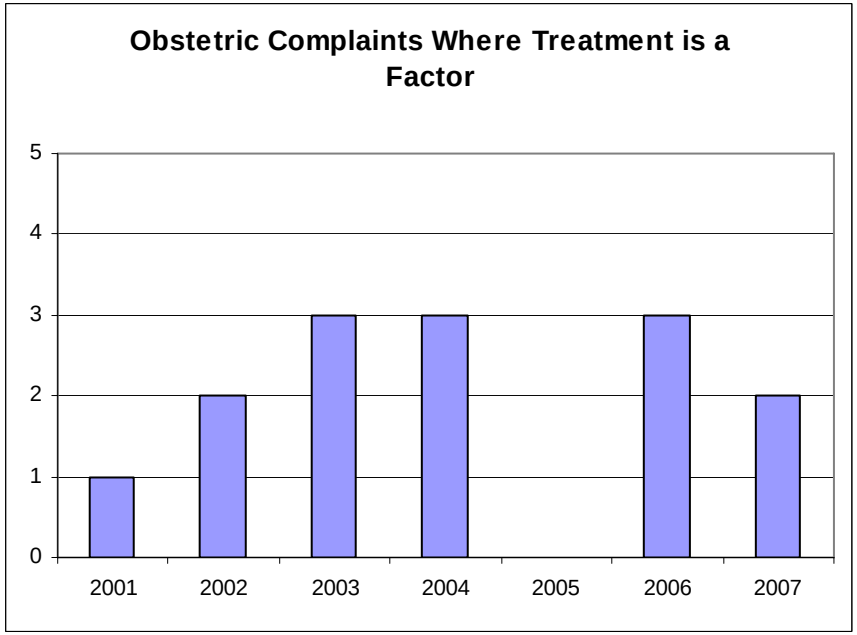
Ref	First received	Closed	Details
0010/06/jn	09-Jan-2006	30-Jan-2006	Patient pregnant, had pains and an ambulance was called on the advice of the GP. Crew arrived and stated that they should not have called for an ambulance and said that there were people more serious. When told called on advice of GP crew replied that the GP was wrong in his advice.
0037/06/SMC	23-Jan-2006	17-Feb-2006	Complaint against treatment and attitude of crew, patient was 3 months pregnant, and following events lost her baby.
0076/06/jn	13-Feb-2006	12-Jul-2006	Patient delivered baby at birth centre but on monitoring her blood pressure dropped significantly and her pulse became raised. Ambulance crew were called but staff are concerned regarding the treatment the crew offered, Paramedic would not cannulate and crew complained about having to carry patient down the stairs. Patient fitted several times and staff state she was not strapped in.
0102/06/smc	03-Mar-2006	23-Mar-2006	Newborn baby needed to be conveyed from Harold Wood Hospital to The Royal London Hospital, baby conveyed in arms throughout journey - no appropriate means of securing baby in vehicle.
0181/06/smc	27-Apr-2006	23-May-2006	Patient had a miscarriage. Crew who arrived said they could not touch or deal properly with the umbilical cord and that she would have to wait for one of their female colleagues to be present. Also stated is that the baby was put into a rubbish bag and placed near a heater inside the ambulance. In the journey to hospital the patient and partner smelt burning.
0185/06/smc	03-May-2006	06-Jun-2006	Patient is pregnant, was experiencing abdominal pain. Ambulance was called and chased up by patient who was at home on her own. Husband was working in Bristol and travelled home to her. He got home before an ambulance and conveyed his wife to the hospital.
0249/06/ch	21-Jun-2006	27-Jun-2006	Pt pregnant and felt male member of crew was very rude and didn't want her to touch him when she went to hold his hand when she was in pain.
0357/06/JN	24-Aug-2006	09-May-2007	Complainant's wife 8 months pregnant and started bleeding very heavily. Ambulance arrived but first thing crew asked was 'Is it domestic violence?' then called the police and refused to treat patient. Husband had to take wife the stairs himself - crew did not examine or treat patient until police arrived. Complainant arrested by police due to allegations of domestic violence made by the crew - allegations false! Complainant released by police. Complainant very distressed due to the whole situation.
0428/06/SMC	16-Oct-2006	16-Nov-2006	Ambulance crew who dropped off pt at a Brent Birth Centre did not give a hand over of her condition. They also seemed in a hurry to leave. The crew left before the pt was checked over to see if it was safe for her to have her baby delivered there. Due to complications another ambulance had to be called to take the pt to Northwick Park Hospital.
0476/06/jn	20-Nov-06	Open	Patient went into hospital, was given medication and sent home, hospital then contacted and said she needed to return urgently. LAS crew arrived and were stand offish with patient and questioned her about her having no money for a cab but that she is having a baby. Crew also would not convey to the hospital where she was being treated and in the ambulance patient only had a seat belt put on her when the ambulance went over a bump and the patient lifted out of her chair. Patient not sure if this was all because she is a young, black lady.
0492/06/ch	28-Nov-2006	09-Mar-2007	Woman pregnant with twins, in labour. Delay (30-45 mins) for ambulance, crew members offered no first aid assistance, crew members did not examine patient. On arrival at the hospital discovered that babies were dead.
0538/06/jn	21-Dec-2006	04-Apr-2007	Patient in early stages of pregnancy crew offered no assistance to the patient just put the steps down and told her to sit down. At hospital they just opened the door and directed patient to get out at A&E. There were Police at the hospital who ended up helping the patient.

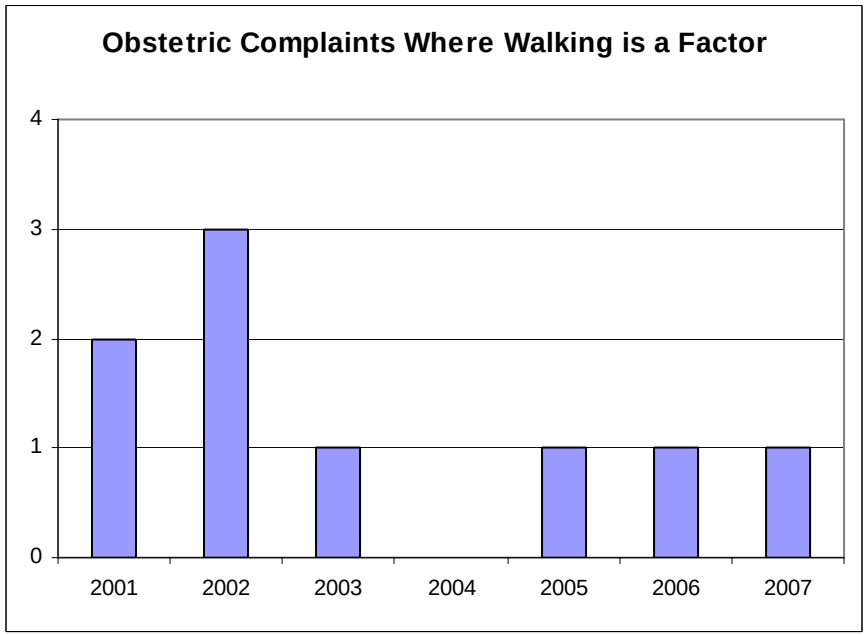
Complaint Subject		Treatment	Brain Damage	Walking	Fell (walking)	Placenta Abrupta	Baby Died	Premature	Delayed Response	BBA	Attitude or Comments	Not taken to hospital of choice	Not conveyed	Taken to A&E	Non securing of baby
2006	**1**	1		1		1	1								
	2										1				
	3	1					1				1				
	4	1									1				
	5														1
	6						1				1				
	7								1				1		
	8										1				
	9	1									1				
	10										1				
	11										1	1			
	12	1					1		1						
	13	1		1										1	
Total		**3**	**0**	**1**	**0**	**1**	**3**	**0**	**1**	**0**	**8**	**0**	**1**	**0**	**1**

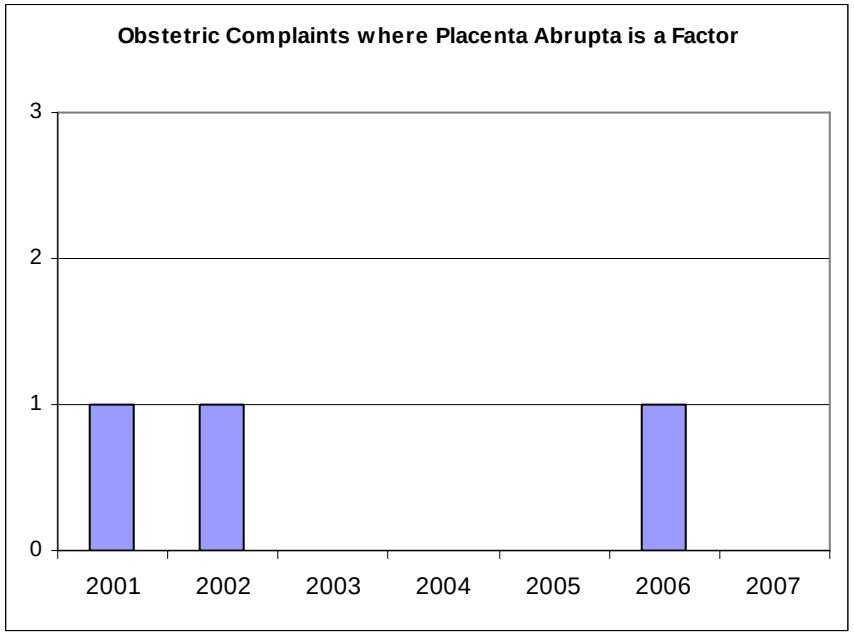
Ref	First received	Closed	Details
0053/07/CH	05-Feb-2007	15-Mar-2007	Pt fell off stool, 3 1/2 months pregnant. Was told ambulance was on the way. 12:30 ambulance service called back informing of delay with ambulance. 12:45 complainant rang ambulance service for update, still no ambulances available. 13:00 Pt's sister arrived and decided to convey Pt personally, so rang ambulance and cancelled. Pt has since lost baby.
0066/07/ch	12-Feb-2007	15-Mar-2007	Patient involved in an RTC, is 7 months pregnant and had to wait 55 minutes for an ambulance to arrive. Ambulances kept passing them, so they flagged one down in the end, told that the ambulance was told to take it's rest break when it could have been dispatched to attend them.
0106/07/dm	05-Mar-2007	02-Apr-2007	Patient complained to hospital, also mentions in letter that the crew when they arrived were very distant and cold in their behaviour toward her. She asked them for a chair but they told her she could walk. Patient pregnant and waters had broken.
0112/07/ch	06-Mar-2007	03-Apr-2007	Husband complaining that an ambulance was not available to send to him when his wife had back pain when she was 4 months pregnant.
0125/07/jn	15-Mar-2007		Patient 24 weeks pregnant, waters broke and she was bleeding. Crew told her they were not a taxi service and that she should have paid for a cab. Patient lost her baby.
0163/07/JH	30-Mar-2007	03-May-2007	Delay in ambulance arriving. Patient in labour and delivered baby at home whilst waiting for ambulance. Crew did not seem to know much about what to do. Complainant unhappy with delay and that treatment wasn't very good.
0170/07/dm	05-Apr-2007	30-May-2007	Patient about 4 weeks pregnant, was at work and then got stomach pains and collapsed. Crew arrived and were rude and unsympathetic. Crew gave no assistance to the patient and when she was sick said 'oh another van to clean'. Patient feels the crew showed no interest and felt that she was exaggerating. Patient lost the baby.
0182/07/jh	16-Apr-2007	18-May-2007	Patient complained to hospital and also mentions LAS delay. Patient taken in twice, first time was fine but second time patient states there was a delay. Patient was having a miscarriage and had to undergo an emergency operation.
0205/07/smc	01-May-2007	29-May-2007	Patient in third trimester of pregnancy, she became unwell on train and collapsed to the floor and was unconscious for 10 minutes. Crew did ob's and she was given a sugary drink. Patient not given choice to go to hospital and husband who is a Dr is concerned with what the crew have recorded on the PRF and still they did not convey her.
0244/07/jh	24-May-2007		Hospital looking into clinical incident re patient being brought in, the Consultant Gynaecologist is concerned that the patient who was known to be pregnant but with an empty uterus (therefore an ectopic until proved otherwise) Waited an hour for an ambulance when she developed abdominal pain.

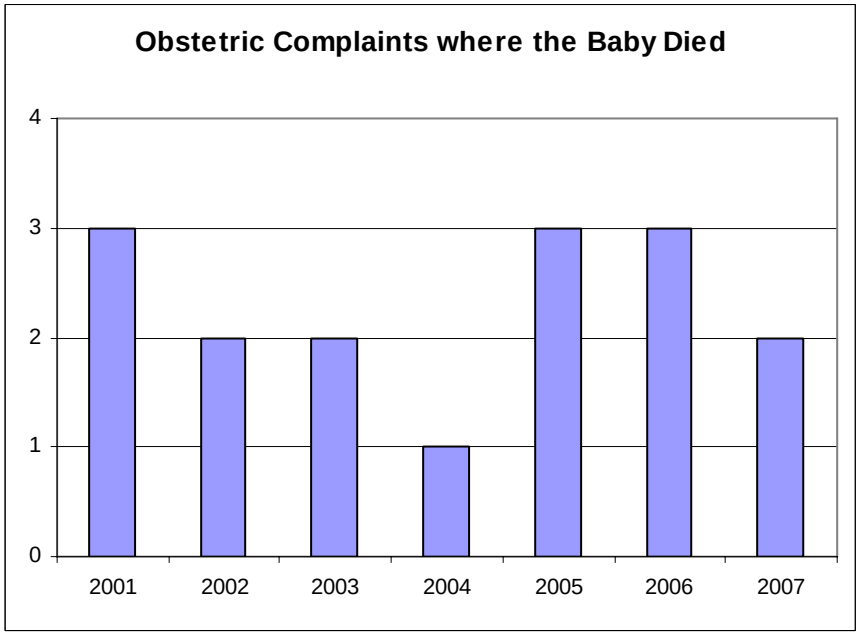
Complaint Subject		Treatment	Brain Damage	Walking	Fell (walking)	Placenta Abrupta	Baby Died	Premature	Delayed Response	BBA	Attitude or Comments	Not taken to hospital of choice	Not conveyed	Taken to A&E	Non securing of baby
2007	**1**	1							1	1					
	2								1						
	3						1		1						
	4								1		1				
	5			1							1				
	6										1		1		
	7						1				1				
	8	1							1	1					
	9	1					1				1				
	10						1		1						
	11	1											1		
	12								1						
Total		**2**	**0**	**1**	**0**	**0**	**2**	**0**	**5**	**2**	**5**	**0**	**1**	**0**	**0**

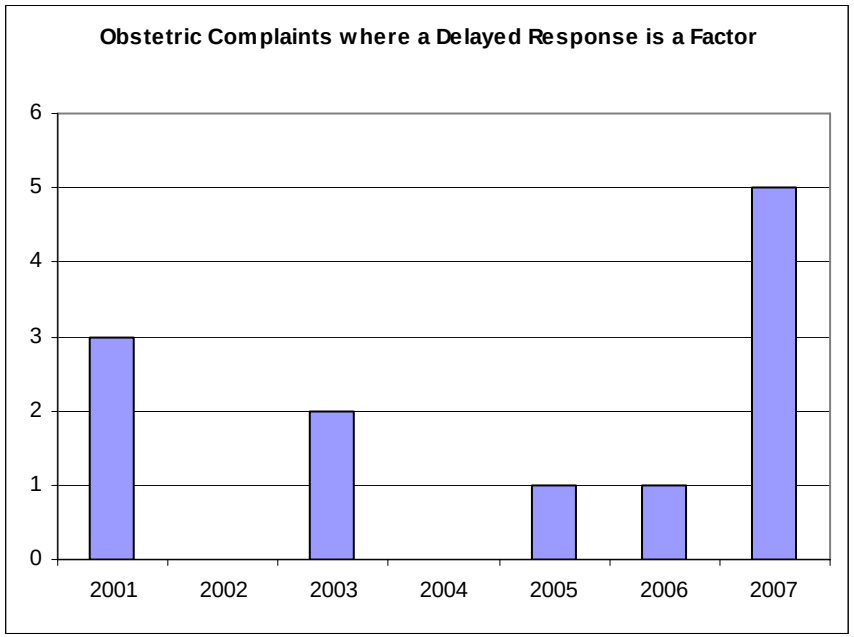
	Treatment	Brain Damage	Walking	Fell (walking)	Placenta Abrupta	Baby Died	Premature	Delayed Response	BBA	Attitude or Comments	Not taken to hospital of choice	Not conveyed	Taken to A&E	Non securing of baby
2001	1	1	2	1	1	3	1	3	2	2	2	0	0	0
2002	2	0	3	1	1	2	0	0	0	4	1	1	0	0
2003	3	0	1	1	0	2	0	2	2	2	0	0	1	0
2004	3	0	0	0	0	1	1	0	0	4	1	0	0	0
2005	0	0	1	0	0	3	0	1	0	6	0	2	0	0
2006	3	0	1	0	1	3	0	1	0	8	0	1	0	1
2007	2	0	1	0	0	2	0	5	2	5	0	1	0	0
Totals	**14**	**1**	**9**	**3**	**3**	**16**	**2**	**12**	**6**	**31**	**4**	**5**	**1**	**1**

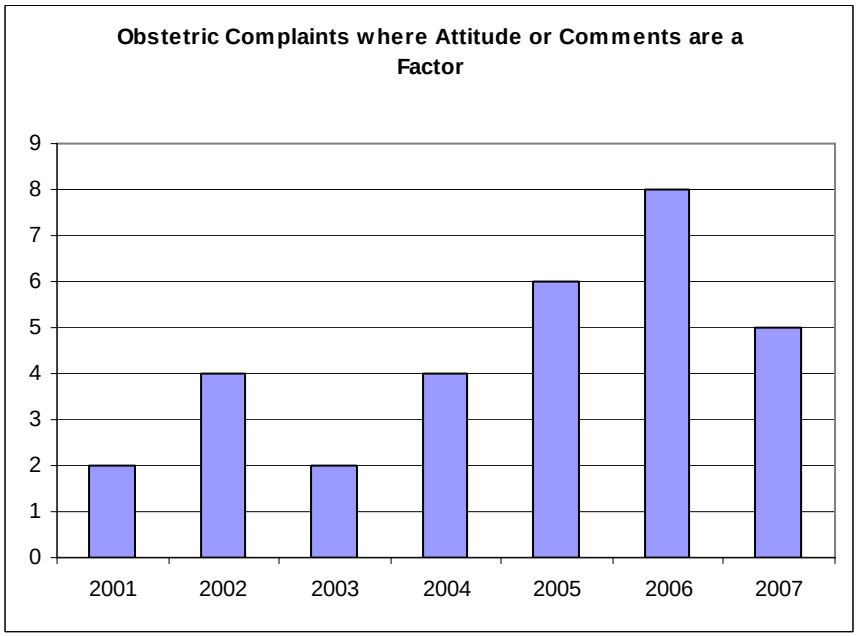

Obstetric Complaints Where Treatment is a Factor
5
4
3
2
1
0
2001
2002
2003
2004
2005
2006
2007

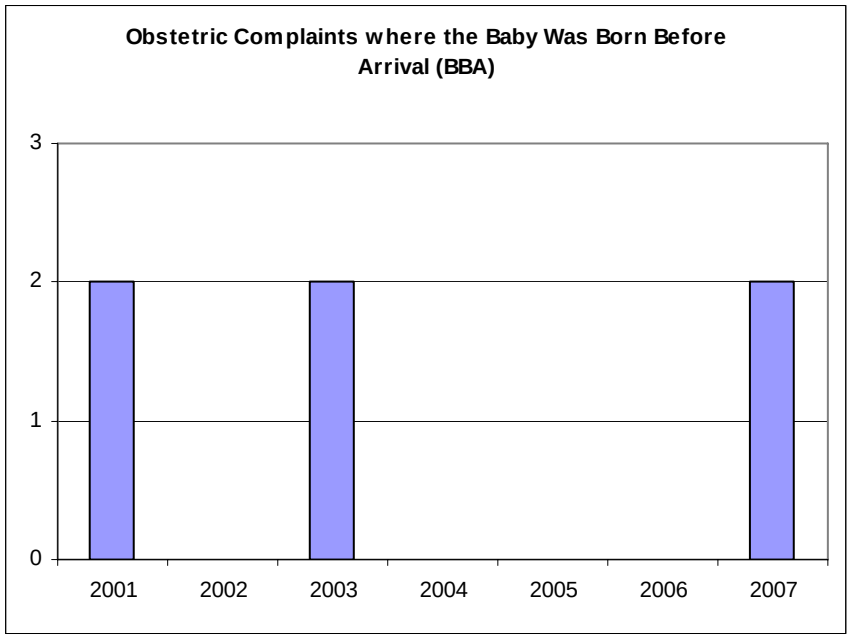

Obstetric Complaints Where Walking is a Factor
4
3
2
1
0
2001
2002
2003
2004
2005
2006
2007

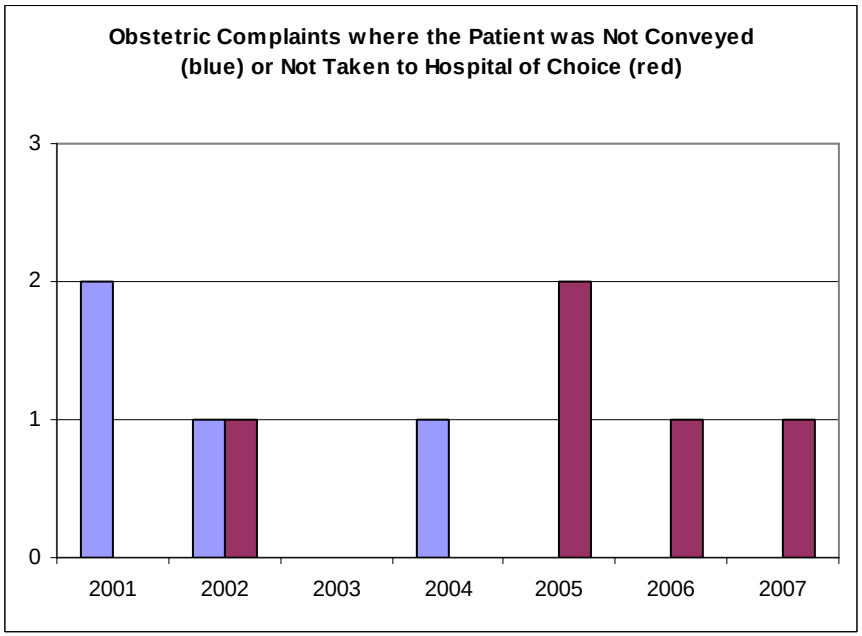

Obstetric Complaints where Placenta Abrupta is a Factor
3
2
1
0
2001
2002
2003
2004
2005
2006
2007


Obstetric Complaints where the Baby Died
4
3
2
1
0
2001
2002
2003
2004
2005
2006
2007


Obstetric Complaints where a Delayed Response is a Factor
6
5
4
3
2
1
0
2001
2002
2003
2004
2005
2006
2007


Obstetric Complaints where Attitude or Comments are a Factor
9
8
7
6
5
4
3
2
1
0
2001
2002
2003
2004
2005
2006
2007


Obstetric Complaints where the Baby Was Born Before Arrival (BBA)
3
2
1
0
2001
2002
2003
2004
2005
2006
2007


Obstetric Complaints where the Patient was Not Conveyed (blue) or Not Taken to Hospital of Choice (red)
3
2
1
0
2001
2002
2003
2004
2005
2006
2007

2. OBSTETRIC INCIDENTS AND CLAIMS

2.1 Introduction

This section provides an analysis of the obstetric incidents and claims notified to the LAS and recorded on Datix.

All of the cases have been reported to the Clinical Risk Group and Risk Management Group, or Clinical Governance Committee.

Many of the files have been destroyed because limitation has been reached and / or the claim has been closed. The date of incident on four cases predated the LAS becoming a Trust (on 1 April 1996). Where the files have been destroyed the information in this report is taken from Datix alone.

2.2 Themes

Appendix 1 provides details of all of the obstetric incidents and claims recorded. Datix has been upgraded over time and some of the data recorded now was not entered and documents were not attached electronically to provide a case history.

2.3 Investigations

The investigations of claims and potential claims are governed by the Claims Policy and Procedure. It has been a requirement of the NHS Litigation Authority that Trusts follow the rules of the indemnity schemes and compliance has been tested in the Risk Management Standards assessments. The current Claims Policy and Procedure states that The Medical Director has a key role in determining the extent to which LAS employees may have caused or contributed to a particular injury or loss to enable the claim to be managed in accordance with the civil litigation rules and NHS Litigation Authority's CNST Reporting Guidelines. In addition the Head of Education and Development provides an assessment of the care and assistance provided by staff and whether this was in accordance with the Trust's protocols, procedures, training, or with National Clinical Guidelines and whether or not the care provided fell below an acceptable standard leading to the allegations made.

In the cases that proceeded to litigation or an indication was given that was given that litigation may occur and satisfied the claim reporting criteria of the NHS Litigation Authority the opinions of the Medical Director and Head of Education and Development were sought.

I have reviewed the files held in store that have been closed and ascertained that :

LC734

The first notification about the call came as a solicitor enquiry in July 1999. There was no prior record of a complaint or LA52 report. A microfilm copy of the call records were obtained and preserved. Witness statements were obtained from the crew. The Medical Director reviewed the papers and advised that the double technician crew conveyed the patient to hospital as quickly as they could, that they were not able to site an intravenous infusion or give fluids, that their treatment with oxygen and the institution of CPR when the patient suffered a cardio-respiratory arrest was entirely correct and according to protocol. The case was reported to the NHSLA as a potential claim in June 2000 but in the absence of communication from the claimant's solicitor the file was closed in July 2004.

PC 885

Notification about the case came as a solicitor application for records in January 2002. There was no prior record of a complaint or LA52 report. The case was reported to the NHSLA as a potential claim and in view of the potential criticisms being investigated panel solicitors were instructed. Detailed witness statements were obtained from the crew and the opinion of the Medical Director was obtained. The crew witness statements confirmed that they followed the LAS protocols and that it was appropriate to ask for the midwife to attend. When the midwife attended it was her decision that the mother should be taken to hospital for the birth. The conclusion reached by the panel solicitor which reflected independent expert advice was that there was no reason to believe that the actions of the ambulance technicians or the midwife could be criticised. Independent evidence on causation was also favourable to the other NHS bodies. The crew were advised that the claim is not being pursued against the LAS.

PC878

Notification came in May 2002 from solicitors acting for the claimant advising that they were investigating a potential claim arising from the treatment and conveyance to hospital by an ambulance crew on 17 March 2002. There is no prior record of a complaint or LA52 report on file. Witness statements were obtained from the crew and these were passed to the Medical Director and Head of Training to review.

The Medical Director noted that the RRU arrived on scene four minutes after the ORCON start time. There was little detail on the RRU patient report form. The transcript of the calls indicated that the RRU was concerned that if the ambulance failed to arrive he might be faced with an imminent delivery. The ambulance had difficulty in finding the exact location of the patient's location and there was a problem with opening the rear doors of the ambulance but this was soon rectified. The Medical Director advised that it was current practice to encourage women in labour to stay mobile and the allegation that the crew were wrong to encourage the patient to walk was incorrect. The Medical Director concluded that the crew had acted in accordance with their protocols and that their assessment of the patient was as detailed as LAS protocols allowed.

The Head of Training drew attention to some shortcomings in the detail recorded on the patient report forms and that information included in the witness statements was not on the patient report form. The Head of Training concurred with the opinion of the Medical Director about walking a woman in labour.

Based on the opinions of the Medical Director and Head of Training a detailed reply to the areas on concern about not taking the patients symptoms seriously, failing to undertake an examination of the patient, encouraging the patient to walk, and problems with the opening of the rear doors of the ambulance was sent to the Claimant's solicitor in September 2002 and after confirming that they would take their client's instructions nothing further was heard.

PC1052

Notification of a potential claim was received in March 2005 by solicitors requesting the Trust's records, including a transcript of the calls, and protocols for obstetric cases. The solicitor advised that it was not possible to state the nature of the infant's longer term condition and that there were other potential NHS claimants. The infant suffered severe hypoxic ischaemic encephalopathy at birth. The case was reported to the NHSLA. Witness statements were obtained and the views of the Medical Director and the Head of Education and Development were sought. The Medical Director reviewed the call handling and the actions of the ambulance crews on scene. With regard to the call handling the Medical Director advised that she was not satisfied that the first call was prioritized correctly as vital pieces of information were missing. The circumstances of the call were difficult in part through having to use a third party through language line. The call handling on the second call 17 minutes after the start of the first call was of a high standard with an attempt to deliver the emergency child birth instructions in accordance with protocol.

The actions and documentation of the ambulance crews on scene appeared to be appropriate and professional who were faced with an unexpected breech delivery and neonatal cardiac arrest.

In June 2005 the solicitors acting for the family advised that the infant had died and the parents did not wish to pursue the matter further.

PC1074

Notification of the case was received in an application for records in June 2005. There was no prior LA 52 report or PALS enquiry or complaint. The opinions of the Medical Director and Educational Standards Manager were sought and in view of the potential quantum of a claim the case was reported to the NHSLA.

The Medical Director noted that it was likely the patient suffered an ante partum haemorrhage at 36 weeks and around the time the first call was made. The Medical Director considered that the call handling was prompt. In 1998 the LAS had not introduced AMPDS and so the call taking was less structured nevertheless the problem was established and the response time of 16 minutes was reasonable. No structured pre-arrival instructions were given as AMPDS was not in place, but the call handler offered appropriate advice to the caller.

The Medical Director noted that oxygen was not administered contrary to the protocols in place at the time. Removal to the vehicle was rapid but blue lights and sirens were not used. The maternity unit were not pre-warned of the patient's arrival however, in 1998 there was not a dedicated telephone line and so the maternity unit might not have had time to prepare for an obstetric emergency arriving in less than ten minutes.

It appeared that the crew recognised that the amount of pain was not due to normal contractions but failed to recognise the symptoms were indicative of a placental abruption.

In March 2006 the solicitors acting for the claimant advised they were no longer proceeding with the case.

LC375
The first notification about the case came in July 1994 as an enquiry to the Patient Services Bureau from a senior midwife at the Whittington Hospital requesting the LAS records to be held in case the hospital received a formal complaint from the parents. A copy of the patient report form was filed with that request. A tape of the telephone calls was not taken.

Grace Barry v NHS Litigation Authority was litigated and heard in the High Court between 20 and 28 February 2002. It was the Claimant's case that the severe damage to parts of the brain was due to a delay in transferring Grace's mother by ambulance from her home to hospital following a prolapse of the umbilical cord and that without the delay the damage would not have occurred.

The judgment by Mr Justice Roderick Evans
Within moments of arrival the crew recognized that it was not a BBA call but a prolapsed cord. No member of the crew (there were 3) had experience of dealing with a prolapsed cord, but they had had training and knew it was an emergency and that the patient had to be removed to hospital as quickly as possible. Advice was passed to the crew from the Registrar in Obstetrics and Gynaecology about the position the patient was to be conveyed to hospital. The crew's evidence was that they gave careful thought to the removal to the ambulance and made sure that each knew what the other was doing.

The contemporaneous records Form LA4 Emergency and Urgent Assignment record and form LAS 26 testified that the attendant had carried out the advice of the Registrar to keep the baby's head off the cord. The advice given was also recorded in the hospital notes.

The evidence of the LAS driver about the route taken to hospital was accepted and the evidence put on behalf of the claimant was rejected.

It was not possible to be precise about the time the ambulance arrived at hospital but it was concluded that this 3 – 4 minutes later than the time recorded on the Form LA4.

The judge concluded "I am satisfied that this was a crew of competent ambulance men. There was no evidence that they engaged in activities that were not immediately connected with the patient's welfare. While it is possible that another crew might have performed the tasks in a shorter time I am not persuaded that the crew was in any way negligent." The claimant had not established that the ambulance crew were in breach of their duty of care and the claim failed. The outcome was reported to the Trust Board and the crew were thanked by the Medical Director.

2.4 Outcomes
Most of the cases did not proceed to litigation. One case was heard in the High Court and judgment was given in favour of the Trust. Leave to appeal to the Court of Appeal was refused.

Damages were paid in two cases and an ex-gratia payment was made on one case following a meeting with the claimant and solicitor, the Medical Director, Head of Training, and Head of Legal Services.

Treatment protocols governing obstetric emergencies were revised and have been supplemented by National Clinical Guidelines.

2.5 Conclusions and Recommendations
Civil claims involving obstetric emergencies, where there may be substantial claims for future care, potentially are the most expensive claims a Trust can face. The LAS has reviewed the procedures and training for staff following the claims and potential claims notified. The crew who attended Mrs B had received training in obstetric emergencies.

However, if the closed files reviewed are a representative sample it is clear that untoward incident reporting has not been good. Opportunities to collect evidence before memories faded in some instances were lost together with the opportunity to conduct a wider investigation than required for an actual or potential civil claim.

There have been significant changes in Control Services and in communication between Control and crews following the introduction of AMPDS and mobile data terminals.

The Clinical Governance Committee is asked to Note the findings from the report and to consider whether the governance arrangements in place enable the Trust to learn from and act upon untoward incidents involving obstetric cases.

Obstetric claims, potential claims and incidents

Ref	Incident date	Opened date	Description	Outcome	Closed date
PC1074	13/12/1998	30/06/2005	Mother alleges the LAS were called three times as she was suffering heavy bleeding. Took 30 mins to arrive. No lights or sirens during conveyance. Call not treated as urgent. Alleged delay in reaching the patient, and conveying to hospital. Alleged ambulance report mislaid.	WITHD	17/03/2006
LC577	07/11/1997	22/07/1998	Patient who was in labour complained that a crew that were requested to attend did not carry her to the ambulance and that she had to walk down a staircase. The baby was in part delivered before arrival at hospital. The baby died 7 days later and the complainant believes this was due to the treatment received. 3/8/98 LBA received from solicitors acting for plaintiff. Claim form issued 3/11/2000 forwarded to Capsticks. Consent Order requires the claimants to serve a schedule of special damages by 1/2/2001 and amended particulars of claim by 1/4/2001. Notice of discontinuance served 10/7/2001.	WITHD	03/05/2001
UI424	12/03/1997	08/12/1999	Patient in labour. Baby very brain damaged. Also see SOL/ENQ/1913.		15/02/2006
LC375	10/06/1994	17/06/1996	This case concerns the allegation that the LAS failed to treat Mrs. B as an emergency, she was pregnant with the plaintiff and had suffered a prolapsed cord. It is alleged that there was no further advice was given, once the CAC operative had asked Mr. B to feel the cord for a pulse. 16/11/96 a Consultant Obstetrician at Lewisham Hospital prepared a report on the results of the investigation which concluded that the LAS did all that was possible and the poor outcome for the baby was a consequence of the medical problem and not the way that the incident was managed.	DISM	23/06/2004
LC429	25/05/1996	04/04/1997	Plaintiff claims that due to not being carried to an ambulance in a carrying chair she suffered a miscarriage. A letter has been sent to the plaintiff denying liability. Advice obtained from the Medical Director that the actions of the crew had no bearing on the outcome of the pregnancy.	DORM	05/07/1999
LC870		11/04/2002	Particulars of claim not notified but concerned the medical treatment which resulted in heart failure, admission to hospital and the still birth of the baby. Dates not given.	LIMIT	27/09/2002
PC950	26/08/2000	19/11/2003	Patient 25 weeks pregnant in labour. Being transferred by LAS to another hospital for delivery. On arrival baby was dead. Alleged delay of 75 minutes between hospitals.	WITHD	30/04/2004
PC1052	20/02/2004	24/03/2005	Delay in arrival of ambulance to lady in labour at 10 months gestation. Baby delivered by crew at home in breech position. Baby suspended and resuscitated by crew before conveying to hospital.		16/08/2005
LC626	01/12/1996	13/01/1999	Alleged failure by CAC to refer to the patient having a prolapsed cord, and the delay in the crew ascertaining this condition, alleged failure of the crew to comply with the relevant treatment protocol and training, alleged delay in conveying the patient to hospital and to place the patient in the correct position, and incorrectly identifying that one of the crew was a paramedic.	POC	28/11/2000

Ref	Incident date	Opened date	Description	Outcome	Close
LC395	12/07/1996	15/08/1996	The plaintiff claims damages for negligent treatment given by the ambulance crew who attended the call. The allegations are that there was a delay in taking the patient from home to ambulance, a further delay on the journey to hospital. Failure to put patient on a drip whilst in the ambulance, failure to alert Ashford Hospital of the arrival of an emergency, which resulted in further delay to assemble medical team at the hospital. Protocols were not followed in treating the patient. The result of which plaintiff has suffered great distress and baby suffered neo-natal death. Investigation to be undertaken. Letter from Graham Bash and Co stating that they are without instructions. 19/1/98 advised Capsticks that the HSC was considering whether to investigate a complaint against the LAS about the handling of a complaint and the former should close their file. Claimant instructed Stone Rowe Brewer Solicitors. Allegation that the LAS's actions led to claimants further psychological distress.	PBP	21/09/1999
LC585	13/09/1991	18/08/1998	Letter before action received from solicitors stating that the LAS attended the plaintiff when she was in labour. There was a delay in an ambulance attending and that the crew did not treat the incident as a medical emergency. The baby was delivered by caesarian section, and suffered from cerebral palsy and subsequently died in 1997. At this stage we have written back to the plaintiffs solicitors asking for more details to allow us to trace the incident.	DORM	04/09/2002
PC885	03/03/1998	12/08/2002	Alleged unnecessary and negligent delay in providing an ambulance for patient in labour, 40 minute delay from origin to arrival of ambulance as initial ambulance broke down en route to the call. Further delay on scene of an hour waiting for midwife. Emergency caesarean section resulting in baby being born with brain damage.	WITHD	15/03/2004
LC861	05/11/2001	06/03/2002	Alleged that the ambulance response was delayed by 45 minutes, significant blood loss, and was not conveyed to the nearest obstetric department. Independent medical report indicated that causation would not be established therefore the claim will not proceed under the RESOLVE pilot scheme .	EXGRAT	26/09/2003
PC1094		07/09/2005	No specific allegations of negligence at this point. However allegations of delay in ambulance arriving and delays in conveying the patient to hospital once the crew had arrived on scene.		
LC384	11/04/1994	23/07/1996	Solicitors acting for the family claim that over a period of two hours several calls were made requesting an ambulance for the mother who was in labour. An ambulance did not arrive and the mother was taken to Hospital by a neighbour. No request for an ambulance could be found for the date and time given 20/8/96. A different location was provided and the records were obtained and sent to plaintiffs solicitors. Following an investigation by the CAC complaints department it has been found that available ambulance crews were over looked prior to an ambulance eventually being allocated.	DORM	04/09/2002
LC734	14/09/1996	20/04/2000	Claim by minors (in respect of the death of the mother G D) against Marie Stopes & Camden & Islington HA. Ectopic pregnancy. Claiming LAS did not set up IV drip on route to hospital following cardiac arrest by patient.	DORM	26/07/2004
PC878	17/03/2002	28/06/2002	Patient was in labour. Alleged that crew made patient walk to ambulance, ambulance doors would not open, failed to examine the patient, no blue lights to hospital, patient was made to get off the stretcher unaided and crew were rude. Baby was delivered within 10 minutes of arrival at A&E	WITHD	16/07/2004

Ref	Incident date	Opened date	Description	Outcome	Close
			and required resuscitation.		
UI82	18/09/1997	08/10/1997	Patient 31 weeks pregnant and was diagnosed by locum GP as having a separating placenta. Obstetric consultant recommended immediate transfer to hospital at 19:50. Patient arrived at St Georges at 20:32 via casualty. Crew had difficulty finding the labour ward. By this time the baby was dead. Enquiry originally to PSB by the mother who wished to know what instruction was given to the crew and whether they knew the urgency of the call	DIED	27/07/2004

Total number of records 18

3. INCIDENT REPORTING

Obstetric Related Incident Summary 2002 to Date

The following is a summary of all the incidents reported and entered on Datix in regard to obstetric incidents entered since 2002. The summary is based on the data entered at the time of the incident.
As can be seen from table 2, of the 35 incidents 20% were related to delay in treatment. The blanks in the table relate to items where crews have either not provided any information or these incidents occurred at a time when the free text was not entered onto Datix.
Of interest is also the fact that 6 of the 35 incidents related to issues that occurred at hospitals e.g. crews reporting poor communication or support when on scene at the Hospital.
One incident related to availability of Drugs and the Others category includes issues such as family or relatives affecting care delivery.

Table 1 - Incident Grading

Number of incidents	Grading based on New Matrix Grading	Grading As Entered on Datix using Old matrix Grading
14	Low	Insignificant
14	No grading	No grading
7	Moderate	Low

Table 1 shows that 14 of the incidents were graded as low (insignificant) and 7 as moderate (low). The remaining 14 had no grading entered as these were entered when the Datix system was introduced and when grading was not entered on the system.

Table 2 - Breakdown Table of Maternity Incidents

	Broad Category	No
1	Mat Delay	7
2	Blanks	13
3	Mat Equipment	4
4	Mat Hosp	6
5	Mat Other	4
6	Mat Drug	1

4. EDUCATION AND TRAINING

The Department of Education & Development currently facilitates training in Obstetric and Gynaecological emergencies to the following groups of staff.

4.1 Emergency Medical Technician (EMT) 2

All new staff attending an EMT2 training course receive a formal one day training session on the topic of Obstetric and Gynaecological emergencies. The training session is led by a practising Midwifery tutor and addresses both the theoretical and practical elements relevant to the staff grade. Further reinforcement and support is then provided by the course tutors throughout the remainder of the programme.

The subject of Obstetrics is a mandatory element of the course. As a consequence, all training objectives and assessments are developed on a national basis by the Institute of Health Care & Development (IHCD). (See references)

4.2 Paramedic

Similar to EMT2's, trainee Paramedic staff undertake IHCD training relevant to their role which once again is led by a practising Midwifery tutor and addresses both the theoretical and practical elements relevant to the staff grade. However, the duration of this training is two days.

The traditional three yearly Paramedic Recertification courses (which in the past included an obstetrics update session) has recently been withdrawn. It is being replaced by a series of new 'Modular' Continuous Professional Development (CPD) days, which will include a specific Obstetrics module in due course.

4.3 A&E Support & PTS

Although we do not offer specific training to either of these staff groups, all students are provided with guidance on the actions required in the event of becoming involved in an obstetrics case.

Staff from A&E Support and PTS are not ordinarily deployed to such cases, so any intervention would normally arise from being summoned in a public place etc.

References

Ambulance Service Basic Training Manual (Ambulance Staff Training to National Standard) 3rd Edition 2003 updated April 2006 Section 15 pages 1-13.

- Section 15.1 Maternity (updated October 2004)
- Section 15.2 Pre-Term Babies and Incubators (updated October 2004)

Ambulance Service Paramedic Training Manual (Ambulance Staff Training to National Standard) 2003 Emergency Obstetrics & Early Pregnancy Problems

- Section 9.1, General & Local Organisation of Obstetrics and Gynaecological Services
- Section 9.2, Anatomical, Physiological and Pathological Changes during Pregnancy
- Section 9.3, Assessment and Examination of the Pregnant Woman
- Section 9.4, Normal Labour
- Section 9.5. Abnormalities in Pregnancy and Labour (Updated Dec 04)
- Section 9.6, Resuscitation in Pregnancy

UK Ambulance Service Clinical Practice Guidelines (2006) Issued October 2006 JRCALC / ASA Section 5 Obstetrics and Gynaecological Emergencies Pages 1-9

- Birth Imminent (normal and delivery complications)
- Effects of Pregnancy on maternal resuscitation
- Haemorrhage during pregnancy (including miscarriage and ectopic pregnancy)
- Pregnancy induced hypertension (including eclampsia)
- Vaginal bleeding; gynaecological causes (including abortion)

Complaints Received by the Service That Relate to Obstetric Issues

The Service receives an average of 500 – 600 complaints each year a small proportion of which relate to obstetric cases. Pregnancy and birth can for many be a joyous, magical event. However, in the small number of cases where difficulties arise, the experience can be devastating. This is particularly so when the problem results in the death of the unborn or newly born baby. Such tragedies, although comparatively rare often result in a complaint as the family try to make sense of their loss. Lack of examination/treatment, unhelpful and apparently uncaring comments or attitudes by staff frequently add to the pain and anguish felt by the patient and family and contribute to the belief that an act or omission resulted directly or indirectly in the loss of the baby.

The following is a synopsis of some of the complaints relating to obstetric issues that have been received in the past five years. There is no judgement made on the merit of each complaint or of the eventual outcome. They are reproduced so that staff may reflect on the way that they respond to such incidents and consider what impact their own actions may have on the mother and family in such extremely difficult circumstances. It should be noted that the following complaints should be viewed in the context of the number of letters of thanks received from people following the highest standard of care they received from staff when faced with an obstetric emergency.

- Family unhappy with the way her baby was managed by ambulance crew, believe that the baby suffered brain damage and this was related to the way the crew handled their child.
- Patient was made to walk down 3 flights of stairs, wasn't helped and fell. Crew did not report this to the hospital staff - patient also pregnant.
- Patient 38 weeks pregnant, called for an ambulance. It was suggested that she should make her own way to hospital. Ambulance was sent - crew assumed pains were normal labour pains but were in fact due to placenta separating. Baby died.
- Complainant gave birth to premature baby, an ambulance was delayed in responding to her '999' call and baby later died.
- Complainant unhappy with the attitude of the crew that attended her pregnant friend. They apparently told her that the call was a waste of their time.
- Delayed response of an emergency ambulance, then crew took her to the wrong hospital, delivered a stillborn baby by Caesarean Section.
- Crew refused to take a pregnant woman to the hospital she requested then discussed the patient with one of her neighbours.
- Patient states baby's head must have been showing at her home, ambulance crew made her walk - no evaluation was carried out by the ambulance crew that attended to her.
- Patient pregnant and was worried that she was going to lose her baby. Female member of the crew was rude and told her if her husband was following in the car he should have driven her to the hospital and not called an ambulance.
- Patient pregnant and felt male member of crew was very rude and didn't want her to touch him when she went to hold his hand when she was in pain.
- Pregnant woman fell, crew did not convey to hospital.
- Patient believes that the crew did not treat her situation as an emergency. She was pregnant and was experiencing continuous abdominal pain (suggestive of Placental Abruption). The baby was later stillborn.
- Pregnant patient booked into St Thomas, taken to Kings College and left in the A&E.
- Patient was 35 wks pregnant, suffering from severe stomach pains. Crew failed to recognise obstetric emergency. Walked patient to ambulance and drove with no urgency. Patient suffered a placental abruption. Delivered stillborn baby girl few hours later
- Crew took pregnant woman with PV bleed to A&E instead of delivery suite.
- Complainant unhappy with the crews attitude to being called out to his pregnant wife. She had high blood pressure. Later had a premature birth.
- Parents concerned about the treatment offered to new born baby. Baby subsequently died.

- Patient unhappy with crew's attitude following her calling them out to her when she was vomiting, had severe back ache, was pregnant and concerned for her unborn child. Patient kept in hospital for 3 days and given morphine for pain relief.
- QEH not happy that patient was brought to their hospital, when she was in fact booked into Lewisham and QMS was nearer if the patient had complications. Maternity unit was stretched to cope.
- Woman pregnant with twins, in labour. Delay (30-45 mins) for ambulance, crew members offered no assistance and did not examine patient. On arrival at the hospital discovered that babies were dead.
- Patient 24 weeks pregnant, waters broke and she was bleeding. Crew told her they were not a taxi service and that she should have paid for a cab. Patient lost her baby.

It is sad to note that, of the 22 complaints cited above, the death of the baby featured in eight.

There are some emerging trends suggested in these complaints and lessons that may be learnt:

- Whilst childbirth is a perfectly natural event, it is frequently a painful, traumatic experience to the mother.
- Whilst the vast majority of births are relatively straightforward, things can and do go wrong. The results can then be devastating.
- Our words and actions can be construed as extremely hurtful and distressing, whether or not they were intended as such.
- All patients should receive a thorough clinical examination, observations taken and recorded and treatment initiated when indicated.
- Staff must acknowledge that they are not experts in this area. It is for the specialist to decide whether a problem exists and ambulance staff should refrain from making comments that the patient should not have called for an ambulance and other related observations.
- Staff should endeavour to be part of the positive experience that childbirth is to the majority of women and should not contribute in a negative manner in the small number of cases that result in trauma or tragedy.
- The patient is often extremely vulnerable, frequently emotional, in pain, fearful that the baby will arrive fit and healthy and, being in the hands of experts, their lives are out of their control. The aim should be to recognise and alleviate the negatives and provide professional caring support.
- Constant abdominal pain experienced by a pregnant woman may be an indication of a Placental Abruption which carries a very poor prognosis.

27-07-07
R Morris