RTI 2383 – Hospital and Health Service (HHS) Severity Assessment Code (SAC) 1 and SAC 2 clinical incidents occurring in a Maternity Ward during 2013

Purpose of report

This report provides all SAC 1 and SAC 2 clinical incidents reported as occurring in maternity wards in the 2013 calendar year in PRIME CI.

Interpretation notes

The vast majority of care delivered in hospitals and by other health services in Queensland is very safe and effective. However, despite excellent skills and best intentions of our staff, occasionally things do not go as expected. When this happens, it is distressing for patients, families and staff, particularly when the consequence is severe. Publicity around these events can also cause the community to lose trust in their healthcare system.

Queensland Health has worked hard to develop a patient safety culture that actively encourages staff to report clinical incidents and see these as opportunities to learn about and fix problems. The analysis of these incidents helps us better understand the factors that contribute to patient incidents, and implement changes aimed at improving safety. While some people may interpret reports of clinical incidents as a sign of poor safety, we view incident reporting as an indicator of a good patient safety culture that ultimately leads to better patient care i.e. staff are willing to report incidents to actively pursue implementation of actions in order to minimise the potential for the reoccurrence of a similar incident in the future.

Interpreting numbers of SAC1 or SAC 2 events, comparing the number of SAC1 or SAC 2 events between HHSs, or using the number of SAC1 or SAC 2 events as indicators of performance is not advised due to:

- a degree of clinical subjectivity in deciding whether an adverse outcome is a clinical incident i.e. what is reasonably expected is different from one clinician to the next, as well as what is expected by the patient/family. For example, a death may not have been reasonably expected and therefore met the definition of a SAC1 incident, but is later determined to have been the result of an underlying condition. Consistent with best practice across the world, it is important to us to have a reporting system that captures a broad scope of adverse patient outcomes that *could* be potentially preventable so that we can continue to learn and improve.
- Classification of an adverse patient outcome as a SAC 1 or SAC 2 event does not describe 'negligence' or 'fault' on behalf of our staff or systems.
- Not all SAC1 or SAC 2 events are preventable.
- Higher incident reporting rates are generally accepted as an indicator of a positive and transparent safety culture, rather than a marker of less safety care.
- SAC 2 incidents are not mandatorily required to be reported.

Data source

- The data presented in this report is extracted from PRIME CI and is self-reported by HHS staff;
- PRIME CI is the Clinical Incident component of the PRIME information system. It is designed to enable reporting, investigation and management of clinical incidents reported by HHS staff;
- The data was current in PRIME CI as of 24 July 2014 and is subject to change;
- Statewide data has been extracted by facility

Definitions

SAC 1 - Death or likely permanent harm which is not reasonably expected as an outcome of healthcare

SAC 2 - Temporary harm which is not reasonably expected as an outcome of healthcare

Data Extracted

- Time period: 1 January 2013 – 31 December 2013
- All state-wide SAC 1 and SAC 2 reports in the 2013 calendar year in PRIME CI where the incident occurred in a maternity ward.
- There were 16 SAC 1 clinical incidents and 118 SAC 2 clinical incidents reported.

Further background information

As required according to the Patient Safety Health Service Directive, all HHSs are required to report all SAC 1 clinical incidents in PRIME CI, and conduct a thorough analysis of all SAC 1 clinical incidents identifying a factual description of the event, the factors identified as having contributed to the event and recommendations to prevent or reduce the likelihood of a similar event happening again..

The Queensland Maternal and Perinatal Quality Council additionally undertake a clinical review of all maternal deaths (death of a woman while pregnant or within 365 days after the end of her pregnancy) and perinatal deaths in Queensland Health facilities. Information from the reviews is provided to HHSs and used to better understand the factors that contribute to patient incidents to enable changes aimed at improving patient safety.

Maternity Clinical Incidents 2013 Calendar Year

IncidentID	HHS	Facility Name	SAC	Patient Outcome	Date Of Incident	What happened	Action taken	Result of action
			SAC 2	Temporary Harm	/13	Artifical Rupture of Membranes to induce labour on woman with high fetal head Progressed to Cord Prolapse	Calling for Help was intitated Rang O&G reg three times- managed to raise the reg on third phone call, NICU doctors notified first call, resuscitaire taken to room. O&G RMO called several times - Obstetrican called and notified and asked to attend	Calling for Help was intitated Rang O&G reg three times- managed to raise the reg on third phone call, NICU doctors notified first call, resuscitaire taken to room. O&G RMO called several times - Obstetrican called and notified and asked to attend
			SAC 2	Temporary Harm	/13	Delay in 2nd stage needing assissted delivery. Excessive pulls with Vac Cup.(X6) Resulting baby needingi prolonged admission to SCN Extended Epsiotomy to 3b tear needing OT repair..	TL advised correct "pulling"techn.	TL advised correct "pulling"techn.
			SAC 2	Temporary Harm	/13	previous pregnancy complicated Presented in spontaneous labour at At approx PHO was informed by that patient had gone to PHO and T/L had not been informed of this plan prior to them leaving the birthsuite. this was unsafe and not routine practice for caring for labouring women so PHO phoned on call consultant and informed the issue. Consultant confirmed that this was not routine practice and that to considered it to be unsafe and not advisable. Additionally Consultant advised that the patient should be monitored continuously given her advanced gestation. PHo was instructed to go and speak to the patient and midwife and to document appropriately. . Patient refused CEFM. Also refused to leave or return to birthsuite.	see above	see above
						Both day and night PHOD attended with RMO and midwives on duty also attended.		

Maternity Clinical Incidents 2013 Calendar Year

IncidentID	HHS	Facility Name	SAC	Patient Outcome	Date Of Incident	What happened	Action taken	Result of action
						Baby was flat at delivery and immediately taken to resuscitaire.		
			SAC 1	Likely Permanent Harm	/13		An 'urgent' formal ultrasound was suggested and booked. There was a delay in ultrasound performance due to poor communication	it was determined that there was no fetal heart
			SAC 2	Temporary Harm	/13	post caesarean deterioration	Assessment and transfer to tertiary facility for specialist exploratory surgery	Assessment and transfer to tertiary facility for specialist exploratory surgery

Maternity Clinical Incidents 2013 Calendar Year

IncidentID	HHS	Facility Name	SAC	Patient Outcome	Date Of Incident	What happened	Action taken	Result of action
			SAC 2	Temporary Harm	/13	CONCERNS RE RELAY IN MEDICAL MANAGEMENT Dr notified by midwifery staff to come and assess straight away due to APH at 40+1. Dr in OT with consultant performing complex caesarean section.	Continued -staff wanting to go around to OT but advised by birth suite staff that a second theatre team was on its way and the patient could not go to theatre until theatre called. seen by anaesthetist in birth suite	Continued -staff wanting to go around to OT but advised by birth suite staff that a second theatre team was on its way and the patient could not go to theatre until theatre called. seen by anaesthetist in birth suite Pt given spinal anaesthetic. Team midwife unable to pick up fetal heart with doppler. Dr notified who requested the scanner. This had to come from birth suite. Pt swabbed down and draped. Dr said that would not start op until FH heard. CTG machine brought into OT. Explained to registrar that if the midwife was to listen for the fetal heart would be unsterilizing the abdomen which was prepared and draped. Midwife insisted that Dr start the caesarean section. This was also requested by other staff member in OT. Two paeds present for delivery. Caesarean commenced at . Live infant delivered , baby gasped at delivery but very bluish in colour. Taken by midwife straight over to resus trolley where oxygen was given. Apgar 5 and 9. PEEP given by paed. At 4 minutes baby taken out of OT to SCN.
							Pt given spinal anaesthetic. . Team midwife unable to pick up fetal heart with doppler. Dr notified who requested the scanner. This had to come from birth suite. Pt swabbed down and draped. Dr said that would not start op until FH heard. CTG machine brought into OT. Explained to registrar that if the midwife was to listen for the fetal heart would be unsterilizing the abdomen which was prepared and draped. Midwife insisted that Dr start the caesarean section. This was also requested by other staff member in OT. Two paeds present for delivery. Caesarean commenced at .Live infant delivered at , baby gasped at delivery but very bluish in colour. Taken by midwife straight over to resus trolley where oxygen was given. Apgar 5 and 9. PEEP given by paed. At 4 minutes baby taken out of OT to SCN.	

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						Phone discussion between registrar and consultant. – Pt fully prepared for OT at this time.		
			SAC 2	Temporary Harm	/13	. QAS responded to call and contacted birthing suites who advised they would accept the patient. On QAS arrival at they were advised that birthing suites were full and no medical staff could see the patient and instructed to transport the patient to Despite the patient becoming extremely distressed, QAS proceeded code 1 to which increased the patient assessment time in maternity by a further 40mins.	Patient was transfered by QAS	Patient was transfered by QAS
			SAC 1	Likely Permanent Harm	/13	patient presented for Induction. CTG on admission was not favourable.	Reported to pt's GP. All escalation processes followed.	There was a delay in C/S proceeding.
			SAC 2	Temporary Harm	/13	CTG monitoring removed for toileting, not replaced for 45 min. Fetal bradycardia found on recommencement	help called VE/ARM/FSE Dr notified, pushing commenced	help called VE/ARM/FSE Dr notified, pushing commenced
			SAC 2	Temporary Harm	13	Patient had emergency LUSCS at full dilatation for failed vacuum for brow presentation.	Gritty adherent placenta delivered manually.	Gritty adherent placenta delivered manually.
			SAC 2	Temporary Harm	/13	Transferred to birth suite from the ward and progressed quickly to full dilatation with an ARM augmentation. The CTG abnormal and increased lower pelvic pain. VE performed & Reg notified. FHR remained 70 bpm.Decided on a forceps delivery followed by a severe shoulder dystocia lasting 5 minutes. Baby was born with very poor apgars and transferred to ICN. Paed team in attendance at birth. Suspected - taken to theatre and was confirmed.	Reg/ Team Leader notified of abnormal CTG throughout labour. Position changes, FSE applied and IVT commenced. Reg and team leader in attandance when FHR dropped to 70bpm and informed of scar pain. Team quickly proceeded to prepare for instrumental delivery. Reg delivered head by forceps. Shoulder dystocia indentified by Reg - Suprapubic pressure and delivery of the posterior arm used to birth the baby. Baby immediately taken to resuscitaire and paeds commenced resuscitation. Perineum stutured, IDC inserted. Postnatal one on one midwifery care and regular observations undertaken. Taken to theatre for repair	Reg/ Team Leader notified of abnormal CTG throughout labour. Position changes, FSE applied and IVT commenced. Reg and team leader in attandance when FHR dropped to 70bpm and informed of scar pain. Team quickly proceeded to prepare for instrumental delivery. Reg delivered head by forceps. Shoulder dystocia indentified by Reg - Suprapubic pressure and delivery of the posterior arm used to birth the baby. Baby immediately taken to resuscitaire and paeds commenced resuscitation. Perineum stutured, IDC inserted. Postnatal one on one midwifery care and regular observations undertaken. Taken to theatre for repair

Maternity Clinical Incidents 2013 Calendar Year

IncidentID	HHS	Facility Name	SAC	Patient Outcome	Date Of Incident	What happened	Action taken	Result of action
			SAC 1	Death	/13		The patient attended the birth suite in the early hours of the 2013 and advised she had not felt any foetal movements An ultrasound determined there was no detectible foetal heart rate and an intrauterine foetal death was diagnosed.	
						The foetal movements were monitored and were noted to be within normal range r routine follow up monitoring.		

Maternity Clinical Incidents 2013 Calendar Year

IncidentID	HHS	Facility Name	SAC	Patient Outcome	Date Of Incident	What happened	Action taken	Result of action
			SAC 2	Temporary Harm	/13	Fetal bradycardia, emergency bell sounded, registrar present Not recovering so dr's decision to attempt vacuum. Dr shouting orders at everyone and no effective communication to staff or to lady or her partner. Heartrate recovered whilst in anaesthetic room so decision by dr to attempt vaccum in theatre. Dr shouting orders at theatre staff and midwives, ineffective communication to woman. One pull attempted and then decision to perform caesarean under GA.	Debrief offered and given,	Debrief offered and given,
			SAC 2	Temporary Harm	/13	Pre-labour rupture of membranes Induction of labour/syntocinon commenced Active management of 3rd stage. Placenta and membranes delivered by controlled cord traction Heavy blood loss . Blood loss settled for a few minutes only. haemmorhage was in progress. I took over the fundal 'rubbing' and found the fundus was high and deviated to the right. Call bell pressed for assistance.	I instructed student to inspect the placenta= complete. Student asked to prepare for indwelling urine catherter (IDC). answered call bell, entered the room at had not been previously informed of the PPH.	I instructed student to inspect the placenta= complete. Student asked to prepare for indwelling urine catherter (IDC). answered call bell, entered the room at had not been previously informed of the PPH.
			SAC 2	Temporary Harm	/13	Presented to MAU for routine IOL post dates following uneventful pregnancy. C/O decreased FM 24/24, unable to locate FHR, formal scan confirms IUFD		
			SAC 2	Temporary Harm	/13	Patient admitted with contractions. Long latent phase of labour. , Dr not called to discuss LSCS. .Progressed to forceps delivery with third degree tear. Has subsequently developed . Advised latter stress induced and feels it could have been avoided if analgesia/intervention sooner.		

Maternity Clinical Incidents 2013 Calendar Year

IncidentID	HHS	Facility Name	SAC	Patient Outcome	Date Of Incident	What happened	Action taken	Result of action
			SAC 2	Temporary Harm	/13	pt was discharged by o&g consultant with medication script on 2013. pt reported that the nursing staff member who was organising this pt's d/c dispensed these medications from the ward supply - pt was unclear about doseage and directions on when to take this medication. required readmission to ward.		and readmitted to ward
			SAC 2	Temporary Harm	13	/2013 , mother was told that baby had a .On reading baby chart it was recorded at with no apparent follow up recorded or handed over .	Contacted Paed who was present at the birth	Contacted Paed who was present at the birth
			SAC 2	Temporary Harm	/13	Unsuccessful attempt at forceps delivery for pathological CTG. Proceeded to cat 1 lscs. Baby born in poor condition with ? compressed skull fracture. Transferred to	Secondary PPH in ward MET call made but staff did not inform O&G team on duty.	Secondary PPH in ward MET call made but staff did not inform O&G team on duty.
			SAC 2	Temporary Harm	/13	nfant born Baby was apparently blue and not breathing spontanously. As per current protocol, midwife staff began resuscitation and tried to call for the paediatric registrar by ringing the paediatric registrar phone. This line was engaged at the time as the registrar was on the line with outside calls and the ED department. The reg phone then rang. . By the time this call was recieved, the baby was now 6-7 mins old. We immediatly ran together from the paediatric office to the birth suite. Upon arrival, the midwife staff were delivering IPPV in 21% FIO2. The baby was not moving, blue in colour, and not breathing spontaneously. commenced CPR. The rate at which CPR was commenced was inappropriately slow, but Dr. encourage to speed it up and did. CPR was delivered for approximately 2 mins.	Expressed concern to for the need for an emergency phone/Met pager to be held by paediatric registrar and consultant. This way there is no danger of the phone being engaged at the time of emergency calls. There was also concern raised to Dr. (about the quality of resuscitation being delivered by the midwife staff. The FIO2 being delivered at the time of our arrival was only 21%, not 100%. CPR had not been commenced.	Expressed concern to d for the need for an emergency phone/Met pager to be held by paediatric registrar and consultant. This way there is no danger of the phone being engaged at the time of emergency calls. There was also concern raised to Dr. (about the quality of resuscitation being delivered by the midwife staff. The FIO2 being delivered at the time of our arrival was only 21%, not 100%. CPR had not been commenced.
						There continued to be no respiratory effort and Dr. wanted to intubate the baby. There was a delay in doing this as the resus station was not stocked with a stylet and a midwife had to leave the room to retrieve one. The first intubation attmept was unsucessful and IPPV was recommenced. Heart rate was reassessed by myself and was found to be less than 60. CPR was again recommenced by the midwife.		
						At this stage I left the room to retrieve one of paediatric consultants. The consultants do not hold an on call phone and I felt that running to get them would be faster than trying to be put through to their cell phone by switch. I ran back to the Paediatric consultant office and found Dr. (consultant). We both ran back to the maternity ward together where we found Dr. again attempting intubation. was successful with intubation this time and ventilation was commenced. At this stage the HR was above 100.		
						Over the next five minutes the baby became vigorous with sponatenous movements, and spontaneous breathing.		
						The baby was extubated and transferred to the special care nursary.		
			SAC 2	Temporary Harm	/13	birth 2019 PPH PPH protocol followed.Obestric team in ot with emergency C/S. off duty but still in b/s asked to review pt,	AS ABOVE	AS ABOVE

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			SAC 1	Likely Permanent Harm	/13	Prolonged 2nd Stage, delayed management due to other emergencies in b/s.Emergency C/S complicated by PPH atonic uterus.	See above	See above
			SAC 2	Temporary Harm	/13	Suction was not available until about 10 mins of life when the staff brought another resus trolly into the room which had working suction. This resulted in delay of suction being delivered to the baby.	The staff was notified that the suction was not working. There was concern expressed to the that the resus stations were not being adequatly checked prior to deliveries.	The staff was notified that the suction was not working. There was concern expressed to the that the resus stations were not being adequatly checked prior to deliveries.
			SAC 2	Temporary Harm	/13	Patient at 34 weeks twins admitted established labour and was transferred to Birth Suites. Care was provided in BS by junior midwife and O&G registrar.	while emergency LSCS was organised.Transferred to OT at and baby born at	emergency LSCS was organised.Transferred to OT and baby born at
			SAC 2	Temporary Harm	/13	. Once the placenta was delivered a perineal assessment was performed and it was noted a fourth degree tear had occurred.	Obstetric Registrar notified performed by O&G registrar.	Obstetric Registrar notified and performed by O&G registrar.
			SAC 2	Temporary Harm	/13	Hot pack used during labour.	Medical staff reviewed. Cold pack and shower.	Medical staff reviewed. Cold pack and shower.

Maternity Clinical Incidents 2013 Calendar Year

IncidentID	HHS	Facility Name	SAC	Patient Outcome	Date Of Incident	What happened	Action taken	Result of action
			SAC 2	Temporary Harm	/13	Baby birthed Noted retained placenta called Registrar, who was in OT repairing Midwife did not go down with patient. Transferred to OT trolley. Patient waiting in OT from till taken into OT. At this stage a further 600mls? (Registrar) had been lost. Ultimately in total	see above	see above
			SAC 2	Temporary Harm	/13	Pt admitted with requiring multiple Antibiotics, times has been adjusted by pharmacy so that infusions did not overlap. As patient did not receive level the following day was subtherapeutic (10).	Medical and Infectious Diseases teams notified, ID consultant explained importance of treatment to nursing staff - lack of treatment can cause pt to have a stroke, suggested possiblity of moving patient to medical ward	Medical and Infectious Diseases teams notified, ID consultant explained importance of treatment to nursing staff - lack of treatment can cause pt to have a stroke, suggested possiblity of moving patient to medical ward
			SAC 1	Death	/13	Post insertion of prostins for IOL routine CTG normal reactive trace However at repeat examination 6 hrs later FH unable to be detected	Team leader and Obstetric Registrar informed and bedside Scanner suggested Fetal Demise	Patient sent for formal scan to confirm findings of fetal demise

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IncidentID	HHS	Facility Name	SAC	Patient Outcome	Date Of Incident	What happened	Action taken	Result of action
			SAC 1	Death	/13	pregnant with baby. Antenatal care Noted to have and referred to for review. . No other risk factors identified. Foetal movements and Foetal heart auscultated at visits.	Medical review was requested. Obstetrician on call notified and came in. Sonographer notified and USS requested.	
			SAC 2	Temporary Harm	/13	pathology results indicated was a gestation diabetic. But Was told by a mw that her results were normal (her words). Also results dont appear to have been followed up by her GP that ordered the tests.	I asked if she was GDM and she replied that she wasnt and as had no further follow up distpite having a known large for gestation baby. Reg on duty informed of findings	I asked if she was GDM and she replied that she wasnt and as had no further follow up distpite having a known large for gestation baby. Reg on duty informed of findings
			SAC 2	Temporary Harm	/13	Difficult vacuum extraction for suspected fetal compromise. Consultant was not readily available to provide assistance. The baby was eventually delivered, however, required significant resuscitation.	Attempts to contact another consultant who is usually available for emergencies at short notice.	Attempts to contact another consultant who is usually available for emergencies at short notice.
			SAC 2	Temporary Harm	/13	Staff was discharging baby and had ID labels on desk. Staff noticed Paed on ward and went over to see if she could sign it off as we had been waiting for them to arrive on the ward to do so. The form needed to be signed for an for baby . Form signed but staff put baby label on form instead of Baby ID label. came out to find out why her baby was having blood taken . Staff arrived to find baby already bled.	baby had small stab from lancet. baby settled and BF. I said that I would do a Prime and explained what this was. Both parents were understanding of situation.	baby had small stab from lancet. baby settled and BF. I said that I would do a Prime and explained what this was. Both parents were understanding of situation.
			SAC 2	Temporary Harm	/13	IUFD 21/40	IUFD 21/40	IUFD 21/40

Maternity Clinical Incidents 2013 Calendar Year

IncidentID	HHS	Facility Name	SAC	Patient Outcome	Date Of Incident	What happened	Action taken	Result of action
			SAC 2	Temporary Harm	/13	Pt has identified: ? Gross neglect ? Information provided by staff about risks, safety, staff levels and treatments ? Staffing capacity to provide required cares (pre and post partum) ? Delay in provision of treatment (epidural) ? Delivery resulting in perineal tears ? Management at birth of baby ? To OT for repair of perineal tears and delay to treatment ? Unsupported post delivery ? Communications by staff ? Haemorrhage post partum and management of PPH ? Lack of intervention and support post delivery and during treatment ? Post discharge treatment/access to ongoing specialist care Ongoing complications resulting from perineal tears – access to ongoing surgical treatment	Pt Medical Record sent to external medical expert for clincial review.	Pt Medical Record sent to external medical expert for clincial review.
			SAC 2	Temporary Harm	/13	During second stage of labour baby was delivered with compound presentation and an explosive push by patient whereby I was unable to properly control the delivery of the baby's head and a third degree tear resulted.	After checking perineum and recognising extent of tear O & G Reg was notified. Discussed findings with patient prior to transfer to theatre for suturing.	After checking perineum and recognising extent of tear O & G Reg was notified. Discussed findings with patient prior to transfer to theatre for suturing.
			SAC 2	Temporary Harm	/13	Admitted for regular after fetacide for fetal anomaly	Admitted for regular	Admitted for regular
			SAC 2	Temporary Harm	/13	Mainline fluids complete, synto infusion continued. When mainline bag changed over and fluid restarted, pt inadvertantly recieved a bolus of synto which had backed up into the mainline. New supply of carefusion extension set does not have return valve to stop backflow. Baby sustained a 7 minute bradycardia.	Drip discontinued and disconnected immediately upon hearing fetal bradycardia. Extension tubing removed, replaced with a not return extension set.	Drip discontinued and disconnected immediately upon hearing fetal bradycardia. Extension tubing removed, replaced with a not return extension set.
			SAC 2	Temporary Harm	/13	Patient labouring and inadequate observations performed.	Maternal and fetal observations performed.	Maternal and fetal observations performed.
			SAC 2	Temporary Harm	/13	fetus developed severe bradycardia - immediately transferred to Ot	Patient Transferred to OT	Patient Transferred to OT
			SAC 2	Temporary Harm	/13	Contact made by Audiology stating they had not received referral to audiology in 2012 when baby had failed hearing screen Clients chart screen and referral form states referral was sent 12 (but there is no confirmation fax for this evident). GP contacted and there has been no contact from client with hearing problems. Baby had presented in immunization only. Audiology state they have no record of this child. and referral resent to Audiology).		
			SAC 2	Temporary Harm	/13	Asked to attend baby at 20 minutes of life due to grunt and significant work of breathing. Had been grunting since birth without paediatric notification. Risk factors of maternal temp to 38 without notification to paediatric staff.	Baby was taken to the intensive care nursery and placed on CPAP immediately, bloods taken and IV antibiotics initiated	Baby was taken to the intensive care nursery and placed on CPAP immediately, bloods taken and IV antibiotics initiated
			SAC 2	Temporary Harm	/13	UNEXPECTED NEONATAL OUTCOME FOLLOWING DELIVERY	NEONATAL EMERGENCY PROCEDURE ACTIVATED	NEONATAL EMERGENCY PROCEDURE ACTIVATED
			SAC 2	Temporary Harm	/13	pt had idc removed 13. pt had not been able to pass urine. this was brought to my attention pt had been trying to pass urine with nil success and was most uncomfortable.	bladder scanner attended 1200ml urine drained within 30mins.	bladder scanner attended - 1200ml urine drained within 30mins.
			SAC 2	Temporary Harm	13	Admission for PPPROM confirmed at k17	Treated conservatively.	Treated conservatively.

Maternity Clinical Incidents 2013 Calendar Year

IncidentID	HHS	Facility Name	SAC	Patient Outcome	Date Of Incident	What happened	Action taken	Result of action
			SAC 2	Temporary Harm	/13	pateint clearly noted to have elective lscs at 36/40 as pper consultant due to previous LSCS x 2 and previous ruptured uterus,and LSCS not booked patient came in labour at 38+3.	Emergency LSCS and rupture noted	Emergency LSCS and rupture noted
			SAC 2	Temporary Harm	/13	Pt states given an injection overnight - Pt not prescribed an injection but Pt in next bed prescribed clexane 80 mg	Neonatology and Obstetrics and Gynae advised - Pt advised of the apparent drug administration error and reassurred following discussions with Medical Dr's -	Neonatology and Obstetrics and Gynae advised - Pt advised of the apparent drug administration error and reassurred following discussions with Medical Dr's -
			SAC 2	Temporary Harm	/13	Pt birthed via Vacuum Extraction under the care of Midwifery Group Practice. Transferred to OT for repair of 3rd degree tear. . No handover was given to me by staff or to staff by MGP midwife that mother was GDM diet controlled. Baby did not feed after the birth. . Special Care Nursery should have been notified by MGP that baby needed BSL's.	. SCN staff state that low BSL's and need for IV glucose may have been avoided had baby had an adequate breastfeed and BSL's soon after birth.	SCN staff state that low BSL's and need for IV glucose may have been avoided had baby had an adequate breastfeed and BSL's soon after birth.
			SAC 2	Temporary Harm	/13	patient sustained 3rd tear secondary to large baby and shoulder dystocia	patient taken to theatre for suturing of peri under anaesthetic	patient taken to theatre for suturing of peri under anaesthetic
			SAC 2	Temporary Harm	/13	Patient recieved a 3degree tear, due to inadequate assessment of the perineum and poor communicatoion from staff.	informed patient of tear by reg and prepared for OT	informed patient of tear by reg and prepared for OT
			SAC 2	Temporary Harm	/13	throughout delivery maternal heart rate was documented between 70 - 100bpm. Aproximately 1/2 hour after delivery the patient's heart rate was noted to be 190 bpm. A MET call was not placed and a medical review was requested. The patient was reviewed . The patients heart rate remained at aproximately 190 bpm throughout the 2 hour period, . Observations were completed at 20 minute intervals troughout this time	RMO asked to review patient who then further requested a cardilogy review	RMO asked to review patient who then further requested a cardilogy review
			SAC 1	Likely Permanent Harm	/13	Unexpected outcome	Full resusciation measures undertaken	Transfer to Special Care Nursery
			SAC 2	Temporary Harm	/13	SVD following spontaneous labour at term. Unexpected admission to ICN. On review CTG not able to be interpretted. Possibly maternal pulse recorded.	Paediatric team alerted and attended	Paediatric team alerted and attended

Maternity Clinical Incidents 2013 Calendar Year

IncidentID	HHS	Facility Name	SAC	Patient Outcome	Date Of Incident	What happened	Action taken	Result of action
			SAC 1	Death	/13	NVB of infant . At 90 seconds baby taken to resus as apgar 6, baby not breathing effectively or responding to stimulation. Baby stimulated by tactile when given to mother but weak cry and shallow breathing. Baby taken to Resus by RM , care and resus taken over by RM .	Active Resuscitation. Met call for assistance Retrieval team contacted . No	Neonatal Death.
			SAC 2	Temporary Harm	/13	PATIENT ACUTELY UNWELL. 1 HOUR POSTNATAL BP ELEVATED . DOCTOR ORDERED 5MG IV HYDRALIZINE. : REBOUND HYPOTENSION: BP REDUCED SUDDENLY TO 110/60 AND DOCTOR ORDERED FLUID BOLUS. PATIENT RESPONDED WELL.	DR AND DR ALERTED AND FLUID BOLUS ORDERED. DID NOT GIVE HYDRALAZINE INFUSION AS HAD PLANNED. AFTER HOURS MANAGER ALERTED.	DR AND DR ALERTED AND FLUID BOLUS ORDERED. DID NOT GIVE HYDRALAZINE INFUSION AS HAD PLANNED. AFTER HOURS MANAGER ALERTED.
			SAC 2	Temporary Harm	/13	DRUG CONTRA INDICATED . SERETONIN SYNDROME A RESULT.	PT ALSO BEING INVESTIGATED FOR PET AS HYPERTENSIVE PRIOR TO ADMINISTRATION OF	PT ALSO BEING INVESTIGATED FOR PET AS HYPERTENSIVE PRIOR TO ADMINISTRATION OF
			SAC 2	Temporary Harm	/13	3B perineal tear	sutured in OT	sutured in OT
			SAC 2	Temporary Harm	/13	This baby was born at 0207hrs. A BSL was done at 1 hr and it was 1.6. No istat was done as per workplace instruction. Birth Suite staff contacted Special care Nursery staff who said the baby needed to be brought down to the unit. The baby did not come down for another 15 minutes - a SCN staff member came down to Birth Suite to collect the baby. The baby arrived in SCN at 0350 hrs. The baby's temperature was 36.1c, the istat BSL was 1.6. The baby was cannulated and IV therapy commenced. Cannulation was difficult as the baby was peripherally shut down.	The baby was warmed up and had IV therapy commenced.	The baby was warmed up and had IV therapy commenced.
e t d . r e			SAC 2	Temporary Harm	/13	Buzzer went off at approx /2013 where answered. Mother stated she had dropped her baby.	Baby was picked up off the floor very slowly and carefully by staff, placed into cot and taken to special care nursery. Limbs moving freely and head turned slightly to the right but seemed to have full movement. paediatric registrar contacted and he arrived to special care nursery around 20 minutes after the incident. Mother then settled with support of staff members.	Baby was picked up off the floor very slowly and carefully by staff, placed into cot and taken to special care nursery. Limbs moving freely and head turned slightly to the right but seemed to have full movement. paediatric registrar contacted and he arrived to special care nursery around 20 minutes after the incident.

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IncidentID	HHS	Facility Name	SAC	Patient Outcome	Date Of Incident	What happened	Action taken	Result of action
			SAC 2	Temporary Harm	/13	Patient admitted in labour to birth baby. Assessed to be 9cm dilated - ARM performed as per standard midwifery care at cord on view	Met call to registrar who was in theatre. RV by Reg present and attempt at Vacuum at . Trnasferred to ORS @ . Baby born at	Met call to registrar who was in theatre. RV by Reg present and attempt at Vacuum at . Trnasferred to ORS @ . Baby born at
			SAC 2	Temporary Harm	/13	G2 P1 attended ORC in established labour at . Short 10 min CTG normal on admission, FHR 150Bpm. Transferred to birth suite for further management at . FHR 160bpm. Head born. Loose nuchal cord around neck. Thick blood loss seen. SVD APGAR O @1 Minute. Baby to resus room. Unable to collect paired blood gases at time of birth. EBL 600ML 1 DEGREE TEAR	Paeds called. Full resus commenced APGAR 1 @ 5 Min,	Paeds called. Full resus commenced APGAR 1 @ 5 Min,
			SAC 1	Likely Permanent Harm	/13	A live born by emergency caesarean section under spinal anaesthetic following a failed vacuum, has been found unresponsive at	The mother activated the nurse call buzzer at hours. No heart rate was heard or felt by the midwife at hours. The midwife commenced ECM and transported the baby to the 'cosy cot' and called for assistance. A NICU MET call was made and the MET team arrived. ECM and neopuff ventilation via an LMA was conducted.	ROSC was recorded at hours. The baby was transported to the NICU ventilated and active cooling commenced
			SAC 2	Temporary Harm	/13	Patient presented to ED with PV bleeding found to have legs in vagina on USS. Up to Birth suite where found bulging membranes on VE. Syntocinon infusion commenced.	When found fully dilated - ARM attended	When found fully dilated - ARM attended
			SAC 2	Temporary Harm	/13	patient had an IVC inserted in her arm, it became infected and had to be removed	Ivc removed, ice pack applied,	Ivc removed, ice pack applied,
			SAC 1	Likely Permanent Harm	/13	Diagnosis of obstructed labour. Multiple hours wait for available OT.	Massive transfusion protocol initiated.	Massive + ICU admission + return to OT and hysterec
			SAC 2	Temporary Harm	/13	patient pushed fetal head up to perineum. perineum seen to begin to blanch, before episiotomy could be cut pt pushed head out uncontrolled despite hands on support/counter pressure and strong encouragement to breathe and not push	review by reg and to OT for repair once baby and placenta delivered	review by reg and to OT for repair once baby and placenta delivered
			SAC 2	Temporary Harm	/13	PT CANNULA TISSUED WITH EXTRAVASION INTO HAND AND FOREARM.	IVC REMOVED. SENIOR MIDWIFE NOTIFIED. DR NOTIFIED.	IVC REMOVED. SENIOR MIDWIFE NOTIFIED. DR NOTIFIED.
			SAC 1	Death	/13	Minimal/no antenatal care. Multiple complex care entries in the chart. Baby admitted to ED deceased 2 days after discharge from ward. Coroners case.	Nil. Referred to coroner.	Nil at time of writing
			SAC 2	Temporary Harm	/13	Baby required a full resuscitation in theatre and was transferred to SCN.	Baby transferred to SCN	Baby transferred to SCN

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IncidentID	HHS	Facility Name	SAC	Patient Outcome	Date Of Incident	What happened	Action taken	Result of action
			SAC 2	Temporary Harm	/13	Patient presented in early labour Commenced on partogram and examined. Assessed as being in early labour however not established in labour. Partogram ceased and commenced on early labour record. Admitted to the maternity ward to await progress. patient was reassessed a number of times and at the decision was made to deliver the baby by LSCS due to lack of progress despite: 1. No record of when established labour began. 2. Partogram was not re-commenced. 3. Inadequite recording of contractions prior to decision to perform LSCS. 4. No attempt to augment labour (ARM & Synto) despite inadequite contractions and a favourable cervix. 5. Continued with LSCS despite spontaneous rupture of membranes between decision to LSCS at and delivery without a further vaginal examination to assess progress.	Notified A/DON and A/NUM of concerns regarding appropriateness of LSCS.	Notified A/DON and A/NUM of concerns regarding appropriateness of LSCS.
			SAC 2	Temporary Harm	/13	Very quick second stage, 3 contractions in total, unable to put on sterile gloves for hands on/guard perineum. Head and body advancing very quickly, not able to do head control.	Perineum reviewed, unsure of tear, asked O & G Reg to Review	Perineum reviewed, unsure of tear, asked O & G Reg to Review
			SAC 2	Temporary Harm	/13	. PATIENT HAD BEEN HYPERSTIMULATED AND MOTHER AND BABY WHERE TACHYCARDIC. PATIENT WAS REVIEWED AND ASSESSED . PLAN CAT 1 C/SEACTION DUE TO MATERNAL AND FETAL TACHYCARDIA. PATIENT WAS TRANSFERED TO O/T. PATIENT WAS IN ANAESTHETIC BAY BEING ASSESSED AND GIVEN TOP UP BY ANAESTHETIST. . . PROCEEDED TO DO V/E IN ANESTHETIC BAY. STATED THAT WANTED TO DO A FORCEPS DELIVERY. MINIMAL/IF ANY EXPLANATION TO PATIENT. HAD FORCEPS IN POSITION. THEN PROCEEEDED TO GET ASSISTANCE FROM THREATRE STAFF TO MOVE PATIENT DOWN THE THREATRE TROLLEY BED. AND PREOCEEDED TO DO A VACUUM WHILE THEATRE STAFF WERE HOLDING HER LEGS. LEFT AND THEN ANOTHER DOCTOR ATTEMPTED TO SUTURE AGAIN WHILE IN THE ANESTHEIC BAY. .	ASKED THEATRE STAFF WHY ARE WE NOT GOING INTO THE AWAITING THEATRE???	ASKED THEATRE STAFF WHY ARE WE NOT GOING INTO THE AWAITING THEATRE???
			SAC 2	Temporary Harm	/13	threatened premature labour , the helicopter was unable to land	Medical / nursing staff were notified of the issues as soon as we landed and asked to contact SMO ,on call to inform him of the situation ,	Medical / nursing staff were notified of the issues as soon as we landed and asked to contact SMO ,on call to inform him of the situation ,

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IncidentID	HHS	Facility Name	SAC	Patient Outcome	Date Of Incident	What happened	Action taken	Result of action
			SAC 2	Temporary Harm	/13	The patient presented to birth suite in early labour	Fetal bradycardia on ascultation: CTG commenced, assistance from O&G Reg summoned. Paed Reg and SCN called to attend birth. Baby transferred to SCN	Fetal bradycardia on ascultation: CTG commenced, assistance from O&G Reg summoned. Paed Reg and SCN called to attend birth. Baby transferred to SCN
			SAC 1	Death	/13	The baby was delivered flat, unresponsive and no heart rate detected.	Immediately the baby received assistance with breathing using intermittent positive pressure ventilation and chest compressions were commenced.	After a short period of cardiopulmonary resuscitation there was a spontaneous return of circulation, the baby did not make any respiratory effort and the baby was intubated prior to transfer to Special Care Nursery.
			SAC 2	Temporary Harm	/13	Psatient presented in spontaneous labour and progressed to an SVD with an unexpected fetal asphyxia requiring a full resuscitation.	Resuscitation measures initiated by staff and paediatrician called immediately, intubated, ventilated and transferred to SCN.	Resuscitation measures initiated by staff and paediatrician called immediately, intubated, ventilated and transferred to SCN.
			SAC 2	Temporary Harm	/13	patient had a 550ml secondary PPH on the ward since transfer from theatre . O&G sighted PV loss, inserted second IV site and ordered syntometrine and misoprostil and left ward. Bleeding continued after medication administration, T/L notified O&G Reg. Speculum done by O&G Reg on ward O&G Brown ordered blood transfusion and carboprost to be administered. Patient continued to loose 20-30ml of blood every 15 mins for45 mins before O&G Reg and O&G Reg returned to ward to perform second speculum examination O&G team decided to transfer patient to theatre at 0230. Multiple requests were made by T/L, during this incident, for patient to be taken to BS for appropriate one-to-one care.	Urgent staff assist called and T/L notified O&G reg. Syntometrine administered of PR misoprostil administered Blood transfusion commenced Carboprost administered by T/L	Urgent staff assist called and T/L notified O&G reg. Syntometrine administered at of PR misoprostil administered Blood transfusion commenced Carboprost administered by T/L
			SAC 2	Temporary Harm	/13	Client birthed baby at home, after calling QAS who were present at birth.	Birthed baby at home QAS to PPH of approxmiately 2200-2500 mls.	Birthed baby at home QAS to PPH of approxmiately 2200-2500 mls.

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IncidentID	HHS	Facility Name	SAC	Patient Outcome	Date Of Incident	What happened	Action taken	Result of action
			SAC 2	Temporary Harm	/13	Decision to vacuum on woman with previous 3rd degree tear. Cap on flexion point, synto increased, 1st pull good descent, noted tear at fourchette, episiotomy cut, R mediolateral with quick delivery of head. Body delivered with next contraction. Perineum noted to have 3A tear	Prepared for OT. Right mediolateral episiotomy repair, plus seperatate 3A perineal tear repair	Prepared for OT. Right mediolateral episiotomy repair, plus seperatate 3A perineal tear repair
			SAC 2	Temporary Harm	/13	Patient had a spontaneous vaginal birth of live infant, . Placenta still retained 25 minutes after birth, EBL 500mls. O & G Registrar notified to review, which he did at 0735hrs. Doctor also tried controlled cord traction, no sign of separation. Doctor asked that a syntocinon infusion be commenced and he advised midwifery staff that she could have up to an hour to birth the placenta. Advised the Mediacal officer that an oxytocinon infusion was not a recognised management of retained placenta. Highlighted again to the medical officer that the patient had already had 500mls of blood loss and her Hb was 104 prior to birth. She had also continued to have a small trickle while the doctor was present. The medical officer asked that we insert and IDC and he left. 12g folley IDC inserted. Midwifery staff prepared the patient for OT. Tried to assist placental separation while waiting i.e baby breastfed etc. Patient was awake and lucid during this time. Phoned O&G doctors phone to have patient reviewed again as placenta still retained and pt still had a constant slow trickle. Another Doctor reviewed the patient, notified that patient was still bleeding and midwifery staff asked if we were going to OT. The Doctor asked for a second cannula to be inserted. contacted the Doctors phone again to see if OT organised and what was happening. Pt seen by a Consultant at , advised that patients EBL was now approx 1400mls - for OT. Patient was already prepared for OT. at	Immediate actions to assist third stage - Called medical Officer to review again and ensure OT organised. Called medical officer back to complete consent form.	Immediate actions to assist third stage - Called medical Officer to review again and ensure OT organised. Called medical officer back to complete consent form.
			SAC 2	Temporary Harm	/13	Patient seen twice by midwifery staff with inadequate consultation and referral	Pt admitted on following third presentation with leg swelling.	Pt admitted on following third presentation with leg swelling.
			SAC 2	Temporary Harm	/13	Waterbirth so hands off technique being employed. Rapid descent of baby's head from SROM to Birth. Mother calm, in control - receiving verbal instructions from me to breathe out baby's head. Shoulders birthed easily, but baby's hands were noted to be up beside face immediately following birth.	On inspection the perineum was noted to be a 3rd degree tear.	On inspection the perineum was noted to be a 3rd degree tear.
			SAC 2	Temporary Harm	/13	I was asked to review the baby when it was ~30 mins old due to concerns from the midwife about increased work of breathing. I attended the baby soon after this call	.The baby was then brought over to a table in the birth centre room. The baby was noted to be grunting +++, was very pale and cold to touch. I asked for resus equipment (specifically monitoring and the midwife who delivered the baby said that this was not available in the room). Another midwife went to get the equipment (outside the room)and then came back to say that it was not working.	.The baby was then brought over to a table in the birth centre room. The baby was noted to be grunting +++, was very pale and cold to touch. I asked for resus equipment (specifically monitoring and the midwife who delivered the baby said that this was not available in the room). Another midwife went to get the equipment (outside the room)and then came back to say that it was not working.

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IncidentID	HHS	Facility Name	SAC	Patient Outcome	Date Of Incident	What happened	Action taken	Result of action
			SAC 2	Temporary Harm	/13	Decision by Dr to transfer to OT as soon as possible, Transfered to theatre total blood loss Manual removal of placenta in theatre under GA estimated total blood loss incuding theatre ? HB next day 6.9 blood transfusion given	Team leader informed at of snapped cord Dr informed at but in OT, Reviewed by Registrar and MROP in OT Attempted maternal effort, bladder emptied, rubbed up uterine contractions, breastfeeding to help seperation of placenta prior to Dr attending	Team leader informed at of snapped cord Dr informed at but in OT, Reviewed by Registrar and MROP in OT Attempted maternal effort, bladder emptied, rubbed up uterine contractions, breastfeeding to help seperation of placenta prior to Dr attending
			SAC 2	Temporary Harm	/13	During a spontaneous vaginal delivery a perineal tear which involved the anal spincter was sustained (3B)	Patient taken to Birth Suite and perineum inspected arrangements to repair the tear in OT .IV canula inserted ,explanation given to patient and consent obtained	Patient taken to Birth Suite and perineum inspected arrangements to repair the tear in OT .IV canula inserted ,explanation given to patient and consent obtained
			SAC 2	Temporary Harm	/13	Underwent emergency caesarean section, difficult procedure & resultant infected haematoma requiring re-operation. Developed bacteraemia related to the surgical site infection.	Re-operation e of infected haemaotoma. Treatment of blood stream infection	Re-operation for drainage of infected haemaotoma. Treatment of blood stream infection
			SAC 2	Temporary Harm	/13	Premature rupture of membranes at 36+/40 . spontaneous labour and delivery aided with episiotomy. Baby born in poor condition Apgar 3 @ 1min 6 @5 min. Unexpected admission to ICN.	Neonatal resusitation team at delivery	Neonatal resusitation team at delivery
			SAC 2	Temporary Harm	/13	Infant was being nursed by its mother, mother was sitting on the edge of the bed. Mother reported to staff Staff was attending to pt in the next bed. Infant was vigorous, crying, alert on initial assessment. Peads reg assessed infant by 3mins of incident. Hourly observations TPR and HC attended for 4 hours.		

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IncidentID	HHS	Facility Name	SAC	Patient Outcome	Date Of Incident	What happened	Action taken	Result of action
			SAC 2	Temporary Harm	/13	Pt was transferred from Hospital with threatened prem labour @ wks gestation. . Baby pronounced deseased at hrs.	As above	As above
			SAC 2	Temporary Harm	/13	I came to assist with the birth as the second midwife in the Room. The primary Midwife left the room to arrange an urgent transfer to Birth Suite for the client for Fetal Tachycardia. The mother then birthed her baby into my hands on the next contraction.	Mother moved to lying position and once third stage complete her perineum was inspected by her primary carer, The client moved to Birth Suite for suturing. The registrar diagnosed the Third degree tear.	Mother moved to lying position and once third stage complete her perineum was inspected by her primary carer, . The client moved to Birth Suite for suturing. The registrar diagnosed the Third degree tear.
			SAC 1	Likely Permanent Harm	/13	Post dates induction of labour. Baby born flat with no respiratory effort or tone. Apgar 2 at 1 minute, 3 at 5 minutes and 3 at 10 minutes.	Baby stimulated, resuscitated and intubated. Baby retrieved to the	Possible Pulmonary Hypotension. Cooling protocol instuted at
	h		SAC 2	Temporary Harm	/13	Episiotomy sutured post birth /13. Pain and dishesion noted 13. Lack of deep suturing.	Review by registrar.	Review by registrar.
			SAC 2	Temporary Harm	/13	Patient with failed ventouse who had Neville Barnes forceps delivery resulting in third degree tear.	Obstetric Register aware as performed NBF delivery.	Obstetric Register aware as performed NBF delivery.
			SAC 2	Temporary Harm	/13	See previous entry	Reg notified	Reg notified
			SAC 2	Temporary Harm	/13	Vulval haematoma following Ventouse, delay in going to OT for evacuation of Haematoma. Listed as CAT 3 <4 hours, went to OT at .	Perineal tear sutured, O&G reg aware. Theatre Booked.	Perineal tear sutured, O&G reg aware. Theatre Booked.

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IncidentID	HHS	Facility Name	SAC	Patient Outcome	Date Of Incident	What happened	Action taken	Result of action
	M		SAC 2	Temporary Harm	/13	SVB - episiotomy cut by Dr and delivery also performed by same. Post delivery perineum inspected and 3rd degree tear noted.	Theatre booked and pt transfered when available.	Theatre booked and pt transfered when available.
			SAC 2	Temporary Harm	/13	Normal Vaginal Birth that resulted in a 4th degree tear	During birth the perineum was 'guarded' and gentle flexion of the head was done, at no time the perineum looked blanched or too tight. Perineum was soft and stretchy. Birth was not preciptate.	During birth the perineum was 'guarded' and gentle flexion of the head was done, at no time the perineum looked blanched or too tight. Perineum was soft and stretchy. Birth was not preciptate.
			SAC 2	Temporary Harm	/13	Lack of communication regarding mums blood results. Undiagnosed potentially harmful condition to baby. Mum should have received high risk care	baby required immediate admission to ICN requiring immediate exchange transfusion	baby required immediate admission to ICN requiring immediate exchange transfusion
			SAC 2	Temporary Harm	/13	Secondary PPH 2/7 days post SVD. PPH 2 litres requiring EUA, bakari balloon and 4 units of blood. Retained products found on EUA	Tranferred to BS	Tranferred to BS
			SAC 2	Temporary Harm	/13	33/40 gestation spontanoeous labour SVD sustained 3rd degree tear followed by a 1.8litre PPH	Chart not avaiable at time of PRIME reported	Chart not avaiable at time of PRIME reported
			SAC 2	Temporary Harm	/13	Antenatal mother not diagonosed with IUGR during antenatl period. Seen by Studebnt midwfe at last visit and not countersigned by Registered Midwife. mother measuring 3cms less than dates with 5/5th's head above brim. MOther delivered via emergnecy lscs at of a kg baby at term.	Advised O and G consultant and Birth Suite NUM of concerns	Advised O and G consultant and Birth Suite NUM of concerns
			SAC 2	Temporary Harm	/13	G1P0 had SVD sustained significant perineal trauma no doctor notified and tear not sutured. Subseqently reviewed days post delivery, tear gapping poor healing.	Perineum examined antibiotics given explained tear and follow up - including review at hospital next week and review in gynae clinic in weeks. Discussed posibility of need for secondary repair after this review if issues	Perineum examined antibiotics given explained tear and follow up - including review at hospital next week and review in gynae clinic in weeks. Discussed posibility of need for secondary repair after this review if issues
			SAC 2	Temporary Harm	/13	Pt admitted via QAS to ED after MVA. Staff member from ED phoned Birth Suite . Advised staff member is ED that patient will need to come up for a 4 hour trace.	Patient arrived on QAS trolley from ED to Birth Suite	Patient arrived on QAS trolley from ED to Birth Suite
			SAC 1	Likely Permanent Harm	/13	Primip K32+3 PPROM, transverse lie, cord presenting. Patient pressed nurse call first and was promtly followed by the emergency buzzer as instruced by midwifery staff	Midwife, registrar attended immediately, cord prolapse identified, Registrar performed VE and lifted presenting part off the presenting cord. Cord . Immediate transfer to OT for emergency Cat C/s. Position of mother changed to head down with Registrar still holding presenting part off presenting cord. Transferred to OT with Registrar on bed insitu	
			SAC 2	Temporary Harm	/13	baby sustained a fractured during birth by elective caesarean section.	Abnormality of noted whilst still in theatre, but fracture not suspected due to rarity of injury of this nature. However, documented and for observation during day.	Abnormality of noted whilst still in theatre, but fracture not suspected due to rarity of injury of this nature. However, documented and for observation during day.

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IncidentID	HHS	Facility Name	SAC	Patient Outcome	Date Of Incident	What happened	Action taken	Result of action
			SAC 2	Temporary Harm	/13	LEFT MEDIOLATERAL EPISIOTOMY CUT FOR FETAL BRADYCARDIA. ePISIOTOMY THEN EXTENDED INTO 3RD DEGREE TEAR	PATIENT INFORMED AND TRANSFERRED TO OT FOR REPAIR	PATIENT INFORMED AND TRANSFERRED TO OT FOR REPAIR
			SAC 2	Temporary Harm	/13	WOMAN PRESENTED TO B/SUITE IN SPONTANEOUS LABOUR ON ARRIVAL BP ELEVATED. BLOODS SENT AND IVC INSERTED. ECLAMPTIC SEIZURE OCCURED. CODE BLUE CALLED. DELAYED RESPONSE BY SWITCH BOARD. SUCCESSFUL RESUS, PT TRANSFERRED TO OT. DOCTOR NOT INFORMED IMMEDIATELY AS ELEVATED BP X1 INITIALLY. PT TRANSFERRED TO B/SUITE FOR FURTHER ASSESSMENT, BLOOD AND IVC INSERTED AND COMPLETED. ECLAMPTIC SEIZURE OCCURRED APPROX 25MINS OF ARRIVAL TO B/SUITE.	EMERGENCY BELL RUNG, CODE BLUE CALLED. STAFF ARRIVED IN ROOM VERY QUICKLY. O2 10LTR ADMIN VIA HUDSON MASK. AIRWAY SUPPORT GIVEN WITH JAW THRUSH AND CHIN LIFT COMPLETEDWITH GOOD EFFECT. CONTINUOUS CTG MAINTAINED, STAFF ATTENDING PUT O2 SAT'S MONITOR ON, BP TAKEN, 2ND IVC INSERTED. IV MAGNESIUM SULPHATE, HYDRALAZINE, AND MIDAZOLAM ADMIN, BEFORE TRANSFER TO OT.	EMERGENCY BELL RUNG, CODE BLUE CALLED. STAFF ARRIVED IN ROOM VERY QUICKLY. O2 10LTR ADMIN VIA HUDSON MASK. AIRWAY SUPPORT GIVEN WITH JAW THRUSH AND CHIN LIFT COMPLETEDWITH GOOD EFFECT. CONTINUOUS CTG MAINTAINED, STAFF ATTENDING PUT O2 SAT'S MONITOR ON, BP TAKEN, 2ND IVC INSERTED. IV MAGNESIUM SULPHATE, HYDRALAZINE, AND MIDAZOLAM ADMIN, BEFORE TRANSFER TO OT.
			SAC 2	Temporary Harm	/13	Third degree tear.		
			SAC 2	Temporary Harm	/13	Third degree tear sustained during SVD. Also Pt had to wait transfer to OT for repair for over three hours.	Perineal inspection + registrar R/V + pack into vagina + patient continue to use epidural for relief	Perineal inspection + registrar R/V + pack into vagina + patient continue to use epidural for relief
			SAC 2	Temporary Harm	/13	Anticipated difficult caesarean for a growth restricted breech baby in labour with ruptured membranes at full dilatation. Despite GTN infusion prior to uterine incision the surgery required an extended "J incision' to the lateral uterus to extract the baby gently. During the incision extension the was transected	The was reanastomosed.	The was reanastomosed.
			SAC 2	Temporary Harm	/13	a patient in labour who was being managed by a private midwife, approached Dr and Dr to inform them that she was present on the birthing suite. The patient had had no vaginal examinations at this time. During this conversation informed Dr and Dr When Dr attempted to inform of the risks of this she interrupted stating "It will be fine" and that "There are books written about this". Our concern is that the midwife did not give the impression that the patient had been adequately informed by the midwife of the risks of this management to her future pregnancies. This is also against the current QLD statewide/Red Cross and RANZCOG guidelines. We feel that if the midwife did not understand the significance and risk then she could not have appropriately informed the patient. There are other concerns with the management of this patient. Secondly the patient had no vaginal examinations until giving the midwife no way to monitor her progress in labour prior to this.	NIL	NIL

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IncidentID	HHS	Facility Name	SAC	Patient Outcome	Date Of Incident	What happened	Action taken	Result of action
						After our discussion I reviewed the patient myself. . I discussed the case with Dr (consultant on call) who's plan was for syntocinon immediately, recommended analgesia and Registrar review in 2 hours.		
						I passed this plan on to . I found a public midwife and asked her to draw up the medication and provide it to , which she did.		
						I then handed over care to Dr , from what I understand there was a significant delay in the syntocinon commencing, despite medical recommendation.		
			SAC 2	Temporary Harm	/13	Baby having bradycardic episode, fully dilated and review by Dr . Decision for Neville barnes forceps - forceps applied and baby out.	R/v by dr - Assessed as 3A tear of perineum	R/v by dr - Assessed as 3A tear of perineum
			SAC 2	Temporary Harm	/13	was in spontaneous labour with her child, she was full term. . I asked the patient to push and with two contractions the head was on view. There was minimal recovery of FHR. A paed Reg was called into the room. MW who was now in the room) asked me to let take over the birth. I was hesitant to do this, however I had been informed previously that the patients are under the care of the private midwife, so felt this was expected of me.	PRIME	PRIME
						I stood back and held a cord clamp ready for the birth, saw me holding the cord clamp and stated "if the baby cries we will be practicing delayed cord clamping". I said nothing to this.		

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IncidentID	HHS	Facility Name	SAC	Patient Outcome	Date Of Incident	What happened	Action taken	Result of action
						The delivery was slow with very controllled delivery of the head, I did not feel such a slow delivery was appropriate given the fetal bradycardia that was largely unrecovered.		
						After delivery of the head there was slow restitution and turtle sign with the fetal head retracting into the perineum. I recognised this as a sign of shoulder dystocia, I flattened the bed and placed the patient in [redacted]. I began applying suprapubic pressure when [redacted] stated that [redacted] had delivered the posterior shoulder.		
						[redacted] then lay the baby onto [redacted] mother and both [redacted] and [redacted] were about to stimulate the baby with towels at which point I stated "Stop, it's Mec" and approached with a cord clamp. [redacted] stated "wait" and I replied "No [redacted] you don't stimulate Mec". I then cut and clamped the cord and gave the baby to the Paed Reg.		
						The baby's gases were 7.18 Arterial pH showing an acute acidosis likely secondary to fetal bradycardia and shoulder dystocia.		
						After the delivery [redacted] approached me to explain why she wanted delayed cord clamping, stating this was because "new research" suggests that "delayed cord clamping and stimulation" are good for babies with mec because it allows them to get "oxygen from the cord".		
						When I wrote my notes on this patients delivery I also noted that [redacted] birth note simply states "SVD" with no mention of the shoulder dystocia or the midwives request for delayed cord clamping.		
						Of note is the fact that the baby suffered respiratory distress.		
						I have significant concerns about the management of this patient, especially the fact that a health care professional (i.e the Private Midwife) is not practicing evdence based care (e.g delayed cord clamping of meconium neonates) and is therefore putting lives at risk.		
[redacted] .	[redacted]	[redacted]	SAC 2	Temporary Harm	[redacted]/13	Location: Maternity Inpatient Unit (Ward [redacted]) [redacted]	Medication chart and bottle of Paracetamol found unattended on nursing desk. Handed both to postnatal ward team leader and requested baby be administered Paracetamol immediately and given further Paracetamol if signs of pain or if mother requesting for baby.	Medication chart and bottle of Paracetamol found unattended on nursing desk. Handed both to postnatal ward team leader and requested baby be administered Paracetamol immediately and given further Paracetamol if signs of pain or if mother requesting for baby.
						[redacted]		
						[redacted] Requesting medical review and analgesia for baby. Reviewed by paeds reg, notes written in eMR and midwife informed regarding assessment. Pain present, likely due to birth trauma. Needing pain relief. Charted for PRN Paracetamol on medication chart. Medication chart handed to midwife and requested baby be given some Paracetamol now and PRN overnight. If worsening pain, for further medical review. Would be reviewed again by paeds in the morning.		

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IncidentID	HHS	Facility Name	SAC	Patient Outcome	Date Of Incident	What happened	Action taken	Result of action
						Midwife caring for baby and mother initially refused to administer Paracetamol to baby, stating that she does not give Paracetamol to babies, needs to be given by Special Care Nursery staff. [redacted] I explained that Paracetamol is allowed to be given by midwife on postnatal ward, already checked with SCN and postnatal ward team leaders. Happy for Paracetamol bottle to be taken from SCN as unlikely to stock Paracetamol suspension on postnatal ward. Midwife uncomfortable with prescribing but team leader also present in room and was happy to take medication chart and have Paracetamol given by midwife on postnatal ward.		
						On review next morning ([redacted], mother commented that baby had been in pain a lot of the night, waking regularly, crying inconsolably. [redacted]. When asked if baby had been offered Paracetamol, she stated she was told baby didn't need it and not to give it. [redacted].		
[redacted]	[redacted]	[redacted]	SAC 2	Temporary Harm	[redacted]/13	Midwife from incident not working today, so unable to feed back directly to her. NBF due to fetal bradycardia. episiotomy cut. 1.3L PPH wt, from tear post partum. Episiotomy repaied in BS. Repair of suturing needed in OT as edges of wound not approximating. Heamatoma seen below sutures [redacted].	Informed [redacted] consultant informed and asked for R/V	Informed [redacted] consultant informed and asked for R/V
[redacted]	[redacted]	[redacted]	SAC 2	Temporary Harm	[redacted]/13	I was called to attend resuscitation of a baby delivered by the [redacted] Midwives team at [redacted]. I was called at ~3 mins 40 secs of life, arrived at 4 mins and commenced apgar timing on the resuscitaire. On arrival the baby was blue, had sporadic gasping respirations, and was being administered PEEP by the [redacted] Midwife staff member. I noted sporadic & ineffective attempts at IPPV. The neopuff mask was not held with a good seal on the neonate's face. HR >100. I was informed that prior to my arrival, the staff assist button had been pressed at 3 mins 30 secs, & birth suite staff MW had assisted the [redacted] Midwife staff MW to suction the mouth of the baby & to hold the mask correctly. I have a faint memory of being told that the HR was <100 when the staff member attended prior to suctioning but further clarification would have to be sought with that staff member.	Resuscitation commenced with IPPV. Ineffective rise & fall of the chest, suspected obstruction, oropharynx was suctioned & moderate amounts of clear fluid (assumed to be bathwater) was removed. Good response to IPPV following. PEEP incr to 8cm & oxygen commenced & continued for ~2 mins.	Resuscitation commenced with IPPV. Ineffective rise & fall of the chest, suspected obstruction, oropharynx was suctioned & moderate amounts of clear fluid (assumed to be bathwater) was removed. Good response to IPPV following. PEEP incr to 8cm & oxygen commenced & continued for ~2 mins.
						[redacted]		
						My primary concerns with these events are the time taken to seek assistance, and evidence of lack of skills/ineffective resuscitation being performed by the [redacted] Midwife team, who has responsibility for resuscitating babies if there are complications during home births.		
						An additional factor of concern flagged by the birth suite MW staff was the lack of two experienced midwives present at the birth. When the baby was brought to the resuscitaire, both the [redacted] Midwife staff member and the student attending the birth went over to the resuscitaire, leaving the mother [redacted] unattended.		

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IncidentID	HHS	Facility Name	SAC	Patient Outcome	Date Of Incident	What happened	Action taken	Result of action
			SAC 2	Temporary Harm	/13	Baby endured grazed head due to vacuum extraction.	n/a	n/a
			SAC 1	Likely Permanent Harm	/13	P2 patient in obstructed labour at 8cm for over 2 hours with concurrent complex variable FHR decelerations. Proceeded to emergency CS but concurrent requirement for emergency ventouse delivery which O&G consultant proceeded to perform devolving the responsibility for above CS to GP Upskiller whom deemed competent (staffing short & 1 specialist took emergency leave . It became apparent that a wound closure in 2 layers as per usual & anterior vaginal tear was closed after bladder dissection. Cystoscopy performed but was suboptimal due to blood staining but 1 ureteric jet was visualised. patient transferred to & subseq radiology showed left ureteric obstruction & hence transfer to for stenting; Ongoing Obstetric debriefing & mangemnt & ongoing urological input re development of vesicovaginal fistula.	advised is to no longer perform Caesarean Deliveries or instrumetnal Vaginal Deliveries in our Unit; Specialist & Registrar staff advisised of this Review of Upskiller roles & responsibilities in our Department & subsequent development of new template for GP Upskilling in our Department with concurrent writtent delineation of their role & responsibility in our department	These actions should mitigate the problem from 2 an Significant curtailment of the scope of practice of the nvolved in above case in terms of limiting the procedures is able to undertake & hence insuring practice is safe + ongoing supervision of practice Clarifying the role of GP Upskillers in our Obstetric Unit & increasing their supervision from Consultant level should hopefully minimise the risk of recurrence of such an issue where responsibility has been inappropriately transmitted to a staff member who doesn't have the abilities to perform the task
			SAC 2	Temporary Harm	/13	Vacuum delivery performed by Registered Midwife.	No clear documentation as to reason vacuum perfomred by Registered Midwife instead of medical officer.	No clear documentation as to reason vacuum perfomred by Registered Midwife instead of medical officer.
			SAC 2	Temporary Harm	/13	Induction of labour for post dates with cervidil and PGE2, and augmenatation of labour with syntocinon with delay in the 1st stage of labour requiring LSCS which then lead onto a PPH of EBL after LSCS 2500mls but had to return to threatre for EUA which proceeded to a Hysterectomy	The incident happened in threatre and so prompt management was applied. The consultant was called and attended.	The incident happened in threatre and so prompt management was applied. The consultant was called and attended.
			SAC 2	Temporary Harm	/13	Patient sustained a 3A perineal tear during the birth. Semi recumbant position.	Registrar review and tear repair in Birth suite. IVAB's. Continence referral and review. Physio referral and review.	Registrar review and tear repair in Birth suite. IVAB's. Continence referral and review. Physio referral and review.

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IncidentID	HHS	Facility Name	SAC	Patient Outcome	Date Of Incident	What happened	Action taken	Result of action
			SAC 2	Temporary Harm	/13	Pt arrived form OT following 3 degree tear and repair under spinal, with no IDC inserted.	Looked for IDC, no IDC inserted. bromage very dense R=L=3. IDC inserted.	. Looked for IDC, no IDC inserted. bromage very dense R=L=3. IDC inserted.
			SAC 2	Temporary Harm	/13	Delay in appropriate blood tests performed as change in Blood pressure not recognised early.	Patient developed PET symptoms and further blood test revealed Pre-eclampsia.	Patient developed PET symptoms and further blood test revealed Pre-eclampsia.
			SAC 2	Temporary Harm	/13	Presented to ORC 16 days post delivery with increased pv bleeding, proceeded to have 2.5L PPH	Appropiate team notified, taken to OT for management. See medical chart for detailed management.	Appropiate team notified, taken to OT for management. See medical chart for detailed management.
			SAC 2	Temporary Harm	/13	Delay in delivery of placenta attempts made to deliver but unsuccessful Taken to theatre for manual removal of placenta. Placenta adherent to uterine wall	Consultant called to theatre placenta removed in pieces Bakri balloon inserted 4 units Red Blood cells given Taken to ICU Central line insitu Intubated ? for return to theatre	Consultant called to theatre placenta removed in pieces Bakri balloon inserted 4 units Red Blood cells given Taken to ICU Central line insitu Intubated ? for return to theatre
			SAC 2	Temporary Harm	/13	presented to the Emergency Department after delivering a gestation foetus at home.	Admitted and transfered to BS for ongoing care and management.	Admitted and transfered to BS for ongoing care and management.
			SAC 2	Temporary Harm	/13	presented with severe abdominal pain @ 40,history previous classical c/s. assess:rigid abdomen ,pain score 10/10, tachypnoea. Phoned ND registrar to r/v.Registrar in AM handover , message given to am registrar attended after handover .Patient R/V 30 mins after initial request.	R/V ,Consultant contacted,also R/V patient recommended urgent caeserean section same attended	R/V ,Consultant contacted,also R/V patient recommended urgent caeserean section same attended
			SAC 2	Temporary Harm	/13	rang ORC phone for advice, contracting and waters have broken. Advised to come to hospital. . Unable to talk through contractions, advised to call ambulance if thinks birth immenent. Spoke to at , she called ambulance at , baby born at . sustained a third degree tear. states that there was no guidance from ambulance officers at delivery, states was told to "just go for it". There was no hands on for the delivery.	arrived with placenta insitu. Placenta delivered, perineum inspected.	arrived with placenta insitu. Placenta delivered, perineum inspected.
			SAC 2	Temporary Harm	/13	Baby born in poor condition following emergency caesarean for fetal distress.	Paeds at delivery. Babe ventilated. Required cardiac massage. Paediatric code blue called. Transferred to SCN. IV line/ IV Ab's. Respiratory support.	Paeds at delivery. Babe ventilated. Required cardiac massage. Paediatric code blue called. Transferred to SCN. IV line/ IV Ab's. Respiratory support.
			SAC 1	Death	/13	Patient in patient . Planned appointment for Amniodrainage for polyhydramnious at /40. Procedure commenced . Procedure stopped at Patient's request due to experiencing nausea and needle immediately removed. On USS of baby post procedure FH down to 80bpm.	Immediate actions commenced to improve FH and immediate review by Consultant. CAT 1 C/S called.	. Baby passed away /13 at .
			SAC 2	Temporary Harm	/13	see previous field	pain relief iv theraphy abdo xray abdo cat scan idc	pain relief iv theraphy abdo xray abdo cat scan idc
			SAC 2	Temporary Harm	/13	REPORTED TO HAVE SROM ON WARD , PT STARTED ON SYNTOCINON INFUSION WITHOUT CONFIRMATION OF SROM ON SPEC, PATIENT SROM CAN NOT BE CONFIRMED, CHECKED AT AFTER 3.5 HOURS OF SYNTOCINON	SYNTOCINON INFUSION CEASED AND INDUCTION OF LABOUR STOPPED. DEBRIEF OF PATIENT AND FAMILY REGARDING EVENTS	SYNTOCINON INFUSION CEASED AND INDUCTION OF LABOUR STOPPED. DEBRIEF OF PATIENT AND FAMILY REGARDING EVENTS

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IncidentID	HHS	Facility Name	SAC	Patient Outcome	Date Of Incident	What happened	Action taken	Result of action
			SAC 2	Temporary Harm	/13	Forceps birth. 3 Pulls	Baby delivered in poor condition, apgars 3 and 6. Resusistation commenced. Transfered to ICN for CPAP. Skin injuries noted as part of secondary survey.	Baby delivered in poor condition, apgars 3 and 6. Resusistation commenced. Transfered to ICN for CPAP. Skin injuries noted as part of secondary survey.
			SAC 2	Temporary Harm	/13	Decision made for vacuum delivery. Episiotomy cut by medical officer. Episiotomy extended to third degree tear during assisted delivery.	Taken to theatre for repair of tear.	Taken to theatre for repair of tear.