

Inquest into the death of Nixon Martin Tonkin

Nixon Martin Tonkin died on 6 June 2014 at the Royal Brisbane Hospital. He died from head injuries caused during a caesarean section when the obstetric registrar performing the procedure unexpectedly came across a deeply impacted fetal head. Nixon suffered significant head injuries which most likely occurred when a midwife pushed Nixon's head in an attempt to disimpact from the pelvis.

Deputy State Coroner John Lock delivered his findings of inquest on 28 June 2017.

The Queensland Government responds to recommendations directed to government agencies at inquests by informing the community if a recommendation will be implemented or the reason why a recommendation is not supported.

Further information relating the implementation of recommendations can be obtained from the responsible agency named in the response.

Recommendation 1

The root cause analysis made a recommendation that any changes to the patients' plan of care or issues identified must be documented by medical staff in the medical and obstetric issues management plan in the pregnancy health record and the charts were to be randomly audited to measure compliance. The family has concerns regarding whether the decisions recorded in the medical and obstetric issues management plan are considered as there was some evidence it is not always looked at. I note this evidence and comment that the recommendation made in the root cause analysis does need to be reinforced with staff and audits should continue.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health.

On 9 April 2018 the Minister for Health and Minister for Ambulance Services responded:

The requirement for medical staff to document changes to the patient's plan of care or issues identified in the medical and obstetric issues management plan in the pregnancy health record was communicated via memorandum from the clinical director and was also discussed at the registrar and consultant meeting.

The standards for documentation and communication expectations are now included in the obstetric and gynaecology services manual/handbook.

The pregnancy health record is audited quarterly to monitor compliance. In May 2017, 95% of charts audited had an appropriately documented management plan. Women's and Newborn Services will continue to monitor compliance of documentation through the audit process and escalate any issues or concerns to the women and newborn services safety and quality committee.

Recommendation 3

In conjunction with the above recommendation [recommendation 2], and consistent with the evidence of the experts that this is an area where not enough is taught or practised, it is incumbent on those involved in national training programs of obstetricians and midwives, as well as within teaching hospitals such as the Royal Brisbane and Women's Hospital, to ensure there is ongoing training in simulated emergencies such as this event. I note staff spoke about receiving increased mandatory training in such topics as identifying obstructed labour, the use of fetal

pillows, simulated emergencies, cardiotocography (CTG Tracing) interpretation and Royal and New Zealand College of Obstetrics and Gynaecology (RANZCOG) workshops, and this training needs to continue. I accept there may be some resistance to mandating that midwives receive such training but ultimately this would be limited to midwives who are likely to be involved in emergency situations in theatre, rather than midwives generally.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health.

On 9 April 2018 the Minister for Health and Minister for Ambulance Services responded:

The Royal Brisbane and Women's Hospital (RBWH):

- undertakes regular multidisciplinary training and education to birth suite and perioperative midwives on dis-impaction of a deeply impacted foetal head during caesarean section.
- conducts obstetric emergency education sessions at weekly multidisciplinary education sessions during the monthly Practical and Obstetric Multi-Professional Training (PROMPT) Workshop and the midwifery staff's annual Mandatory Education Day.
- through the Women's and Newborn Services Safety and Quality Committee (WNS), developed an online education package on the interactive learning platform. A video featuring a simulated dis-impaction of the foetal head at a difficult caesarean section was produced and published online. The interactive learning package is available for all staff and can be accessed from work or home.

The maternity module of the clinical services capability framework v3.2 identifies that where birthing services are offered, multidisciplinary maternity staff have access to training including:

- electronic fetal monitoring (e.g. Royal Australian and New Zealand College of Obstetricians and Gynaecologists [RANZCOG] fetal surveillance education program or similar) at least 12 to 18 monthly
- maternity emergency training (e.g. advanced life support in obstetrics) at least three yearly, where possible
- neonatal resuscitation program or similar with a refresher at least two yearly.