MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

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DECISION NO: 305/03/117C

IN THE MATTER of the Medical Practitioners Act 1995

-AND-

IN THE MATTER of a charge laid by a Complaints Assessment Committee pursuant to Section 93(1)(b) of the Act against **JEFFERY NORMAN HARRILD** medical practitioner of Masterton

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Miss S M Moran (Chair)

Mr P Budden, Dr R J Fenwicke, Professor W Gillett, Dr U Manu (Members)

Ms K L Davies (Hearing Officer)

Ms G J Fraser (Secretary)

Mrs H Hoffman (Stenographer)

Hearing held at Wellington on Monday 31 May, Tuesday 1 June and Monday 12 July 2004

APPEARANCES: Ms K P McDonald QC and Ms J Hughson for a Complaints Assessment Committee ("the CAC")

Mr C J Hodson QC and Mr A Lewis for Dr J N Harrild.

Introduction

1. Dr Jeffrey Norman Harrild of Masterton is a Registered Medical Practitioner practising as an Obstetrician and Gynaecologist, both in the public and private sectors. On 12 January 2004 a Complaints Assessment Committee made a charge of professional misconduct against Dr Harrild.

The Charge

2. The charge alleged that on or about 8 October 1995 at Masterton Hospital, in the course of his clinical management and treatment of his patient, Tracey Maree Birchall (Mrs Birchall) the labour and the delivery of Samuel Jordon Birchall (baby Samuel):

   (i) prior to attempting delivery of baby Samuel, failed to perform an abdominal examination on Mrs Birchall to assess the amount of head palpable abdominally and thereby failed to assess adequately the descent of the presenting part; and/or

   (ii) when performing a forceps delivery of baby Samuel failed to observe and/or adequately observe the usual procedures consistent with a trial of operative vaginal delivery including failure to perform the delivery in a theatre in which caesarean section facilities were available; and/or

   (iii) performed an operative vaginal delivery of baby Samuel prior to full dilatation of Mrs Birchall's cervix and when the presenting part was at the level of station –1; and/or

(iv) at the time of delivery, failed to keep Mrs Birchall informed and/or adequately informed of the options for delivery and/or failed to obtain her informed consent to the forceps delivery he performed.

The conduct alleged in Particulars (i), (ii), (iii) and (iv) when each Particular is considered separately or two or more Particulars are considered cumulatively, amounts to professional misconduct.

3. Dr Harrild denied the charge.

4. The charge was heard in Wellington on 31 May, 1 June and 12 July 2004.

Witnesses for the Complaints Assessment Committee

5. Three witnesses were called on behalf of the Complaints Assessment Committee:
   (a) the complainant, Tracey Maree Birchall, Housewife of Masterton;
   (b) Raymond Wayne Birchall, General Hand and Machine Operator of Masterton and husband of Mrs Birchall;
   (c) John David Tait, Medical Practitioner of Wellington, vocationally registered in Obstetrics and Gynaecology. Dr Tait was called as an expert.

Witnesses for Dr Harrild

6. Dr Harrild gave evidence on his own behalf and called five witnesses:
   (a) Simon David Prior, Medical Practitioner of Masterton practising as a General Practitioner;
   (b) Wendy Anne Baird, Midwife of Masterton;
   (c) Patricia Anne Collins, Midwife of Masterton;
   (d) Jeanette Howard, Midwife of Masterton;
   (e) Peter Cuthbert Dukes, Medical Practitioner of Wellington having been vocationally registered as an Obstetrician and Gynaecologist until recent retirement. Dr Dukes was called as an expert.

Expert Witnesses

7. The Tribunal was appreciative of the helpful expert testimony provided by Dr Tait and Dr Dukes.

Legal Principles

Evidence and Submissions

8. While the Tribunal, in reaching its decision, has given full and careful consideration to all of the evidence presented to it together with the documents produced and the very helpful submissions of Counsel, for the sake of brevity it has not necessarily made reference to every aspect of them in this decision.

No Issues as to Credibility

9. The Tribunal was impressed by the honesty of all the witnesses. Where the Tribunal has rejected certain pieces of evidence or preferred the evidence of one or more witnesses over another, it is not to be taken as an adverse reflection on the witness or witnesses whose evidence has not been preferred. In some instances a witness might be adamant about an item of evidence yet have no recollection or a differing recollection about another item of evidence. In the Tribunal's view, this is a reflection that at the time of the hearing, the events under scrutiny were nearly nine years old. Where there has been any uncertainty, the benefit of the doubt, as the law requires, has been given to Dr Harrild.

Onus of Proof

10. The onus of proof is on the Complaints Assessment Committee whose Counsel accepted at the outset that it was for her to produce the evidence which proves the facts upon which the charge is based and to establish that Dr Harrild is guilty of the charge, that is, professional misconduct.

Standard of Proof

11. As to the standard of proof, the Tribunal must be satisfied that the relevant facts are proved on the balance of probabilities. The standard of proof varies according to the gravity of the allegations and the level of the charge. If the charge against the practitioner is grave then the elements of the charge must be proved to a standard commensurate with the gravity of what is alleged.

12. The requisite standard of proof in medical disciplinary cases was considered by Jeffries J in *Ongley v Medical Council of New Zealand* (1984) 4 NZAR 369 in which the High Court adopted the following passage from the judgement in *Re Evatt: ex parte New South Wales Bar Association* (1967) 1 NSWLR 609:

> *"The onus of proof is upon the Association but is according to the civil onus. Hence proof in these proceedings of misconduct has only to be made upon a balance of probabilities; Rejfek v McElroy: [1966] ALR 270. Reference in the authorities to the clarity of the proof required where so serious a matter as the misconduct (as here alleged) of a member of the Bar is to be found, is an acknowledgement that the degree of satisfaction for which the civil standard of proof calls may vary according to the gravity of the fact to be proved".*

13. The same observations were made by a full bench of the High Court in *Gurusinghe v Medical Council of New Zealand* [1989] 1 NZLR 139 at 163 in which it was emphasised that the civil standard of proof must be tempered "having regard to the gravity of the allegations". This point was also made by Greig J in *M v Medical Council of New Zealand (No.2)* (unreported HC Wellington M239/87 11 October 1990):

> *"The onus and standard of proof is upon the [respondent] but on the basis of a balance of probabilities, not the criminal standard, but measured by and reflecting the seriousness of the charge".*

In *Cullen v The Medical Council of New Zealand* (unreported HC Auckland 68/95, 20 March 1996) Blanchard J adopted the directions given by the legal assessor of the Medical Practitioners Disciplinary Committee on the standard required in medical disciplinary fora.

> *"The MPDC's legal assessor, Mr Gendall, correctly described it in the directions which he gave the Committee:*
>
> > *"[The] standard of proof is the balance of probabilities. As I have told you on many occasions, … where there is a serious charge of professional misconduct you have got to be sure. The degree of certainty or sureness in your mind is higher according to the seriousness of the charge, and I would venture to suggest it is not simply a case of finding a fact to be more probable than not, you have got to be sure in your own mind, satisfied that the evidence establishes the facts."*

Professional Misconduct

14. The starting point for defining professional misconduct is to be found in the judgement of Jefferies J in *Ongley v Medical Council of New Zealand* (above) when he posed the test in the following way:

> *"Has the practitioner so behaved in a professional capacity that the established acts under scrutiny would be reasonably regarded by his colleagues as constituting professional misconduct? … The test is objective and seeks to gauge the given conduct by measurement against the judgment of professional brethren of acknowledged good repute and competency, bearing in mind the position of the Tribunal which examined the conduct."*

15. In *Pillai v Messiter* [No.2] (1989) 16 NSWLR 197 the New South Wales Court of Appeal took a slightly different approach to judging professional misconduct from the test formulated in *Ongley*. The President of the Court considered the use of the word "*misconduct*" in the context of the phrase "*misconduct in a professional respect*". He stated that the test required more than mere negligence. At page 200 of the judgement Kirby P. stated:

> *"The statutory test is not met by mere professional incompetence or by deficiencies in the practice of the profession. Something more is required. It includes a deliberate departure from accepted standards or such serious negligence as, although not deliberate, to portray indifference and an abuse of the privileges which accompany registration as a medical practitioner."*

16. In *B v The Medical Council* (unreported HC Auckland, HC11/96, 8 July 1996) Elias J said in relation to a charge of "conduct unbecoming" that:

> *"… it needs to be recognised conduct which attracts professional discipline, even at the lower end of the scale, must be conduct which departs from acceptable professional standards".*

Her Honour then proceeded to state:

> *"That departure must be significant enough to attract a sanction for the purposes of protecting the public. Such protection is a basis upon which registration under the Act, with its privileges, is available. I accept the submission of Mr Waalkens that a finding of unbecoming is not required in every case where error is shown. To require the wisdom available with hindsight would impose a standard which is unfair to impose. The question is not whether the error was made but whether the practitioner's conduct was an acceptable discharge of his or her professional obligation."*

Her Honour also stressed the role of the Tribunal and made the following invaluable observations:

> *"The inclusion of lay representatives in the disciplinary process and the right of appeal to this Court indicates the usual professional practice while significant, may not always be determinative: the reasonableness of the standards applied must ultimately be for the Court to determine, taking into account all the circumstances including not only usual practice, but patient interest and community expectations, including the expectation that professional standards are not to be permitted to lag. The disciplinary process in part is one of setting standards."*

17. In *Staite v Psychologists Board* (1998) 18 FRNZ 18 Young J traversed recent decisions on the meaning of professional misconduct and concluded that the test articulated by Kirby P in *Pillai* was the appropriate test for New Zealand.

18. In referring to the legal assessor's directions to the Psychologists Board in the *Staite* case, Young J said at page 31:

> *"I do not think it was appropriate to suggest to the Board that it was open, in this case, to treat conduct falling below the standard of care that would reasonably be expected of the practitioner in the*

> *circumstances – that is in relation to the preparation of Family Court Reports as professional misconduct. In the first place I am inclined to the view that "professional negligence" for the purposes of Section 2 of the Psychologists Act should be construed in the Pillai v Messiter sense. But in any event, I do not believe that "professional negligence" in the sense of simple carelessness can be invoked by a disciplinary [body] in [these] circumstances …".*

19. In *Tan v Accident Rehabilitation Insurance Commission* (1999) NZAR 369 Gendall and Durie JJ considered the legal test for "professional misconduct" in a medical setting. That case related to the doctor's inappropriate claims for ACC payments. Their Honours referred to *Ongley* and *B v Medical Council of New Zealand.* Reference was also made in that judgement to *Pillai v Messiter* and the judgement of Young J in *Staite v Psychologists Registration Board.*

20. In relation to the charge against Dr Tan the Court stated at page 378:

> *"If it should happen that claims are made inadvertently or by mistake or in error then, provided that such inadvertence is not reckless or in serious disregard of a practitioner's wider obligations, they will not comprise "professional misconduct". If however, claims for services are made in respect of services which have not been rendered, it may be a reasonable conclusion that such actions fell seriously short of the standard required of a competent and reasonable practitioner. This may be especially the case if such claims are regularly made so as to disclose a pattern of behaviour".*

21. In the Tribunal's view, the test as to what constitutes professional misconduct has changed since Jefferies J delivered his judgement in *Ongley*. In the Tribunal's opinion the following are the two crucial considerations when determining whether or not conduct constitutes professional misconduct:

(a) There needs to be an objective evaluation of the evidence and answer to the following question:

(b) Has the doctor so behaved in a professional capacity that the established acts and/or omissions under scrutiny would be reasonably regarded by the doctor's colleagues and representatives of the community as constituting professional misconduct?

(c) If the established conduct falls below the standard expected of a doctor, is the

departure significant enough to attract a disciplinary sanction for the purposes of protecting the public and/or maintaining professional standards, and/or punishing the doctor?

22. The words *"representatives of the community"* in the first limb of the test are essential because today those who sit in judgement on doctors comprise three members of the medical profession, a lay representative and chairperson who must be a lawyer. The composition of the medical disciplinary body has altered since Jeffries J delivered his decision in *Ongley* in 1984. The new statutory body must assess a doctor's conduct against the expectations of the profession and society. Sight must never be lost of the fact that in part, the Tribunal's role is one of setting standards and that in some cases the community's expectations may require the Tribunal to be critical of the usual standards of the profession: *B v Medical Practitioners Disciplinary Tribunal* (above). In *Lake v The Medical Council of New Zealand* (unreported High Court Auckland 123/96, 23 January 1998, Smellie J) the learned Judge stated: *"If a practitioner's colleagues consider his conduct was reasonable the charge is unlikely to be made out. <u>But</u> a Disciplinary Tribunal and this Court retain in the public interest the responsibility of setting and maintaining reasonable standards. What is reasonable as Elias J said in <u>B</u> goes beyond usual practice to take into account patient interests and community expectations."*

23. This second limb to the test recognises the observations in *Pillai v Messiter, B v Medical Council, Staite v Psychologists Board* and *Tan v ARIC* that not all acts or omissions which constitute a failure to adhere to the standards expected of a doctor will in themselves constitute professional misconduct.

24. In the recent High Court case of *McKenzie v MPDT and Director of Proceedings* (unreported High Court Auckland, CIV 2002-404-153-02, 12 June 2003), Venning J endorsed the two question approach taken by this Tribunal when considering whether or not a doctor's acts/omissions constitute professional misconduct. He stated at para 71 of his judgement:

> *"[71] In summary, the test for whether a disciplinary finding is merited is a two-stage test based on first, an objective assessment of whether the practitioner departed from acceptable professional standards and secondly, whether the departure was significant enough to attract sanction for the purposes of protecting the public. However, even at that second stage it is not for the Disciplinary Tribunal or the Court to become engaged in a consideration of or to take into account subjective consideration of the personal circumstances or knowledge of the particular practitioner. The purpose of the disciplinary procedure is the protection of the public by the maintenance of professional standards. That object could not be met if in every case the Tribunal and the Court was required to take into account subjective considerations relating to the practitioner."*

Summary of Evidence for Complaints Assessment Committee

Mrs Birchall and the medical records

25. Mrs Birchall became pregnant with baby Samuel in late December 1994/early January 1995 with an expected delivery date around 5 October 1995. Mrs Birchall was then aged 28 years. This was her first pregnancy. Mrs Birchall said it was a normal pregnancy and she was fit and healthy and able to exercise throughout it.

26. Her general practitioner was Dr Simon Prior of Masterton who had a shared care arrangement with Ms Emily Mason, Mrs Birchall's independent midwife.

27. During the week prior to baby Samuel's birth, Mrs Birchall visited Dr Prior. She said he told her he thought she was probably overdue and was concerned that the baby had a high foetal head. He recommended that she visit Dr Harrild, a specialist obstetrician and gynaecologist.

28. On Friday 6 October 1995, Mrs Birchall saw Dr Harrild in his rooms at Masterton, where he examined her.

29. Mrs Birchall said Dr Harrild told her she would be having a big baby; that he undertook an ultrasound scan as he wanted to find out whether she was overdue; that when he was undertaking the ultrasound scan he told her that he thought she was overdue; that he discussed with her how her baby might be delivered (as the baby was large, had a high

foetal head and she was overdue); told her that if she had not gone into labour by Sunday 8 October then she would be admitted to Masterton Hospital and would be induced; told her that she might well end up having a caesarean section; and said that the baby would have to be monitored throughout her labour.

30. Dr Harrild wrote that day to Dr Prior reporting on the consultation.

31. His letter noted there was some minor problem with Mrs Birchall's glucose tolerance test which suggested that she may have a minor problem with high blood sugars but there did not appear to be any other ante natal concerns. On examination of Mrs Birchall, it was his clinical judgment that the baby was large with a reduced liquor volume. He therefore performed an ultrasound scan and described in his letter the ultrasound changes which were consistent with post maturity. This included recording the ultrasound estimated foetal weight as 4.046kg but he thought it might be an underestimation.

32. He concluded in his report to Dr Prior:

> *"In view of this I have discussed the possible means of delivery and we have agreed to admit her on the 08 10 95 for the induction with the warning that she may well end up with a caesarean section and that she will need to be monitored throughout the labour."*

33. Mrs Birchall said that shortly after she got home she started to feel unwell with pain which increased during the afternoon and by the following morning, Saturday 7 October, she was having continuous contractions. That evening Mrs Birchall's midwife, Ms Mason, visited her and advised her to go to hospital.

34. The medical records show that Mrs Birchall was admitted to Masterton Hospital at 12.20am on Sunday 8 October 1995 accompanied by her husband and Ms Mason. Dr Prior was notified.

35. Dr Prior saw Mrs Birchall at 8.10am on 8 October and recorded that the contractions were still irregular and infrequent.

36. At 10.15am a review showed that the contractions were relatively unchanged and the cervix was only 3cm.

37. By 11.35am an epidural was effective and syntocinon (a contraction agent) was started. Dr Prior saw Mrs Birchall again. At 1pm Dr Prior was notified regarding progress. At 2.30pm contractions were recorded as being "double barrelled" and as a result the syntocinon infusion was reduced.

38. At 3.15pm Dr Prior saw Mrs Birchall again to review her. He recorded, among other things, that the contractions were regular and the foetal heart satisfactory. The baby was still at station -2. He discussed the situation with Dr Harrild at that stage and it was decided to carry on with the augmentation.

39. Dr Prior saw Mrs Birchall again at 6.45pm. The cervix was recorded as being 8cm with the baby's head still at station -2 and 1+ of caput. Dr Prior thought that the baby's position was direct occipito-anterior. The foetal heart was recorded as being satisfactory. Dr Harrild was again consulted when it was decided to continue with the labour. It was at this time that the anaesthetist reviewed the epidural and increased the infusion of it to improve pain relief.

40. The notes record further review detail at 7.40pm and, at 8.15pm, Ms Mason handed over the care of Mrs Birchall's labour to the hospital midwife, Ms Patricia Collins.

41. At 8.35pm Ms Collins noted there were two large foetal heart dips and although there was no sensation of pushing she believed Mrs Birchall might be fully dilated. She notified Dr Prior who attended and reviewed the situation again. By now the cervix was found to be 9cm with the station -1 with 1+ of caput. The foetal heart was recorded as being satisfactory.

42. Mrs Birchall said in evidence that it was around this time she was becoming anxious as there did not seem to be any progress.

43. Dr Prior had a further discussion with Dr Harrild when it was agreed that Dr Harrild should be contacted again if delivery had not taken place within the following two hours.

44. At 10.45pm the records show that Dr Prior again reviewed Mrs Birchall. The labour had progressed. He found that there was a rim of cervix palpable posteriorly and that the foetal heart was satisfactory.

45. Dr Prior spoke to Dr Harrild who agreed to come into the hospital to review Mrs Birchall himself.

46. Dr Harrild arrived at 11.10pm. According to Mrs Birchall she said he did a very quick vaginal examination and the next thing she knew was that she was being wheeled out of her room and into the delivery suite (of the Maternity Annexe) nearby. She said she gained the impression Dr Harrild was not happy by his attitude and the way in which he dealt with some utensils which were on the trolley and which he threw on the floor and which she thought might have been set up incorrectly.

47. Mrs Birchall said her husband and Ms Mason were present. The medical records show that the hospital midwives, Ms Wendy Baird and Ms Patricia Collins (both of whom gave evidence before the Tribunal) were also present.

48. Mrs Birchall said that Dr Harrild sat on a stool with his eyes closed to commence the delivery; and that he then knelt, swaying backwards and forwards with his eyes closed as if he were praying. During this time she said his hands were inside her trying to rotate the baby and that she was starting to panic.

49. She said she distinctly remembered Dr Harrild saying with reference to the baby "*He's not the way I thought he was"*.

50. Mrs Birchall's medical records show that once in the delivery suite, Dr Harrild attempted a vaginal delivery of baby Samuel. The document entitled "Abnormal Delivery Summary" indicates that Dr Harrild attempted a manual rotation and ventouse. The indication for ventouse noted by Dr Harrild was "posterior lip of cervix. Direct OP". Dr Harrild

recorded the head at station –1 but also recorded it as a "medcavity" (meaning mid-cavity) situation. Dr Harrild then sought to deliver baby Samuel by Kielland forceps and then used Anderson forceps and also undertook an episiotomy when the baby was delivered in an occipito-posterior position.

51. Baby Samuel was born at 11.37pm that evening, weighing 3.83kg with Apgar scores of 9 and 10 at 1 and 5 minutes respectively. Apart from facial bruising, he was in good condition.

52. The placenta was delivered by controlled cord traction. Blood loss was recorded as 300mls.

53. Mrs Birchall sustained cervical, vaginal and perineal tears which were sutured. Mrs Birchall said this took approximately 1 hour or more by which time the epidural was wearing off and she commenced to feel pain.

54. Mrs Birchall was very unhappy with Dr Harrild's manner and the way in which he delivered baby Samuel. She described the experience as *"horrific"* and *"very traumatic"*.

55. Following baby Samuel's birth, Mrs Birchall remained in Masterton Hospital until 31 October 1995 due, in particular, to the breakdown of her perineum which had still not healed at the time of discharge.

56. During this period in Masterton Hospital, both she and baby Samuel were transferred to Wellington Hospital for a day and night (22/23 October 1995) as the baby had suspected neonatal meningitis.

57. On 23 July 2001 Mrs Birchall complained in writing to the Health & Disability Commissioner about Dr Harrild and the Wairarapa District Health Board staff. She annexed a statement she had prepared on 13 November 2000 regarding her concerns about her and baby Samuel's care while a patient at Masterton Hospital in October 1995. Mrs Birchall's concerns related not only to Dr Harrild but also to most of the nurses

charged with her care whose comments or actions Mrs Birchall variously represented as being indifferent, uncaring or lacking professionalism.

58. With regard to particular (i), Mrs Birchall said that Dr Harrild did a very quick vaginal examination but did not remember him doing an abdominal examination of any kind.

59. With regard to particular (ii), she stated that baby Samuel was delivered in a delivery suite in the Maternity Unit and not in the main hospital theatre where she had been told she would be taken if she were having a caesarean.

60. With regard to particular (iii), Mrs Birchall stated it was her understanding that she was not fully dilated when Dr Harrild delivered baby Samuel by forceps.

61. With regard to particular (iv), Mrs Birchall stated that she had had no discussions with Dr Harrild about delivery options during her labour and baby Samuel's delivery. She stated she was never given a say in how the baby would be delivered and was given no opportunity or had no say in the decision about being wheeled into the delivery suite when Dr Harrild commenced a forceps delivery almost immediately. She said this amazed her because after her consultation with Dr Harrild on 6 October 1995 she was under the impression that if there were any problems with her labour then it would be more likely that she would have a caesarean.

62. After the birth, baby Samuel had a haematoma on the right side of his head. Mrs Birchall said he could not turn his head but can now although she is still taking baby Samuel to a chiropractor regarding his head and neck. Mrs Birchall stated that her son is profoundly deaf.

63. With regard to Samuel's deafness, counsel for both parties agreed that there was no evidence before the Tribunal as to its cause and, in any event, it was not part of the charge.

64. In cross-examination, Mrs Birchall confirmed that her preference was to have her baby delivered vaginally if that were practical and conveniently possible. In answer to a member of the Tribunal, Mrs Birchall confirmed that she did antenatal classes at her home with her

midwife who had explained to her that caesareans are sometimes needed and that forceps deliveries are sometimes needed. She agreed she had an understanding from this of what a forceps delivery was and the need for it.

Mr Birchall

65. Mr Birchall confirmed that he accompanied his wife to hospital and was with her during Sunday 8 October 1995. He said that his wife spent most of the day dozing on and off. He mostly sat around and chatted with other people who were with his wife including his wife's mother and sister and three of her friends. Mr Birchall was present when Dr Harrild arrived and during baby Samuel's birth and confirmed Mrs Birchall's account regarding these particular aspects of her evidence. He was not present when Mrs Birchall consulted Dr Harrild on Friday, 6 October.

66. In his written brief of evidence Mr Birchall said he was surprised when his wife's bed was wheeled into the delivery suite rather than in the opposite direction towards the main theatre. This was because he had understood from Dr Prior that it appeared his wife would be having a caesarean section as labour was not progressing.

67. Mr Birchall stated that at the time of delivery there was no discussion at all about the options for delivery and that neither he nor his wife received any explanation why Dr Harrild was doing a forceps delivery and not a caesarean.

Dr Tait

68. Dr Tait was called as an expert. He qualified in 1975. In 1985 he became a Fellow of the Royal Australia and New Zealand College of Obstetricians and Gynaecologists and in 1994 a Fellow of the Royal College of Obstetricians and Gynaecologists. He has held since 1985 and presently holds registration in obstetrics and gynaecology. Among his other positions of responsibility Dr Tait is presently Director of Matpro Wellington and Clinical Leader Gynaecology and Clinical Director Women's Health Service Capital Coast Health.

69. With regard to particular (i) Dr Tait stated that prior to attempting an operative vaginal delivery it was standard practice to perform an abdominal examination on the patient to assess the amount of foetal head palpable abdominally. This enabled the practitioner to determine the degree of engagement of the foetal head. He stated that, as an alternative, it was acceptable to perform a combined abdominal/vaginal examination but it was never acceptable not to perform an abdominal examination at all and particularly where a practitioner was contemplating the vaginal delivery in a patient whose cervix had not fully dilated.

70. Dr Tait stated it was accepted practice that when attempting delivery with a ventouse, the practitioner must ensure that none or, at the most, one fifth of the foetal head was palpable abdominally, that is, that it was fully engaged. Normal prerequisites for delivery with a ventouse were full dilatation of the cervix and full engagement of the foetal head. He stated it might be acceptable to perform a ventouse prior to full dilatation if it was considered that the baby was in significant distress. A vaginal delivery by forceps would not normally be considered if there was head palpable or more than one fifth palpable. That was why an abdominal examination was necessary before an attempt to deliver a baby vaginally was commenced.

71. Dr Tait said there was no record in Mrs Birchall's medical notes of the degree of head palpable abdominally in the time period when Dr Harrild became involved, that is, from 11.10pm through to delivery of baby Samuel at 11.37pm.

72. It was Dr Tait's opinion that if Dr Harrild failed to perform an abdominal examination of Mrs Birchall prior to attempting delivery it was unwise for him not to have done so and would not have been in accordance with acceptable practice at the time of the events in question.

73. With regard to particular (ii), he stated that if Mrs Birchall's evidence were accepted that the main theatre where caesarean section facilities were available was approximately 5 minutes walk away from the delivery suite in another part of the hospital and that no caesarean section facilities were available in the delivery suite where baby Samuel was delivered, then, in his opinion, Dr Harrild failed to observe the usual procedures consistent

with a trial of operative vaginal delivery. He stated that it would be prudent practice if it was considered that the operative delivery was going to be difficult, to do the delivery in a caesarean section theatre.

74. Dr Tait added that while he is frequently involved in deliveries at Wellington Hospital (a tertiary hospital) he does not practise in a provincial or small town hospital. He said he made that comment because there may have been problems with the main theatre at the time of baby Samuel's delivery which may or may not have impacted on Dr Harrild's decision to perform an operative vaginal delivery in an area other than the main theatre.

75. He concluded that if there were no problems with the main theatre being available then, in his opinion, it would have been wise for Dr Harrild to have performed the forceps delivery in the main theatre where caesarean section facilities were available rather than in the delivery suite in the maternity annex. He could then have performed a caesarean section when it became clear that an operative vaginal delivery was likely to be problematic.

76. A member of the Tribunal asked Dr Tait whether all forceps deliveries were done in an operating theatre with caesarean facilities or in the delivery suite of a maternity unit. Dr Tait replied that any forceps deliveries which a practitioner would have concerns about would be done in a caesarean theatre and that that would be the view taken although perhaps not so in 1995. If there were any doubt at all and if the practitioner could not see the baby's head and it was definitely not occipito anterior then the delivery would be done in a caesarean theatre. He added that would certainly be the practice now though perhaps not all were done in a caesarean theatre in 1995.

77. He agreed that the decision as to where the baby was delivered would vary according to the experience of the obstetrician.

78. With regard to particular (iii), Dr Tait stated that although the delivery was described in the medical notes as "mid-cavity" on the Forceps Delivery Form, the station was recorded as "station –1" indicating that the delivery was almost certainly above mid cavity.

79. He said that unless there was a sudden emergency situation for the foetus it would not have been normal practice in 1995 (and is not now) to perform an operative vaginal delivery if there was not yet full engagement of the foetus despite a lengthy labour and/or if the patient's cervix had not been fully dilated. He also emphasised that in this regard Dr Harrild was dealing with a nulliparous patient, that is, a woman who had not yet produced a child.

80. Dr Tait said the CTG traces available, which he reviewed, only covered the period up to 4.50pm on Sunday 8 October 1995. He did not see any traces for the remainder of Mrs Birchall's labour which concluded at 11.37pm when the baby was delivered. On the traces which he saw, there was no sign of any foetal heart rate problems.

81. Further, he said there was no problem with the foetal heart rate up to 9.35pm on the Partogram which he reviewed.

82. Dr Tait stated that if the records were correct then, as there were no problems with the foetal heart rate and no other signs of foetal distress, in his opinion, there was no urgent indication for an operative vaginal delivery.

83. Dr Tait understood that Dr Harrild had advised the Complaints Assessment Committee when it interviewed him as part of its investigation that the reason he attempted a ventouse/forceps delivery was because of a "persistent lip of cervix and [the] occipito-posterior position of the foetus". Dr Tait stated that this was consistent with what was recorded in the Abnormal Delivery Summary and in the Forceps Delivery document in Mrs Birchall's medical records. He said they were not usual indications for an operative vaginal delivery. He added that what a practitioner wanted was for the cervix to be fully dilated and the head engaged unless there was a situation where it was considered that the baby needed to be delivered urgently and there was no other option.

84. Dr Tait said that although it had been recorded that practitioners have used the ventouse to dilate the cervix it was not normal practice unless there was a problem with the foetus.

85. Dr Tait said that according to the medical notes of Mrs Birchall which he had read there was not full dilatation and the baby's head was not engaged.

86. Dr Tait concluded under this particular that in his opinion if there was in fact no urgent indications for delivery then it was not normal or acceptable practice for Dr Harrild to have performed the operative vaginal delivery which he performed and that, in doing so, he fell below accepted standards.

87. He added that with the poor progress of Mrs Birchall's labour the options available were to do a caesarean section or possibly wait longer if there was no foetal compromise.

88. Dr Tait was asked by a member of the Tribunal how easy it was to actually feel the station. Dr Tait replied it could be extremely difficult and it was a matter of experience as to where the practitioner thought the baby's head was. He said it was normally a combination of feeling vaginally where the practitioner thought the head was in relation to the ishial spine and also feeling abdominally at the same time to get an idea of how much head was above that one could palpate abdominally. He stated that there may well be considerable variations.

89. He agreed that station –1 could be for another practitioner station 0 or station –2.

90. Dr Tait stated that in Mrs Birchall's situation he would have performed a caesarean section given the vaginal findings of station –1. He was asked what other features he would have been looking for to assess whether the baby could be deliverable vaginally. Dr Tait said the degree of moulding and the degree of caput and whether the practitioner thought he could rotate the baby and bring it down a little would be factors to take into account. He also agreed that other factors like the space in the pelvis and the descent with contractions would be relevant. He agreed that in Mrs Birchall's situation there could have been a lot of room and that Dr Harrild could have felt there was enough room to deliver the baby vaginally.

91. He agreed that in fact there was sufficient room to deliver the baby vaginally because that was what Dr Harrild achieved.

92. With regard to particular (iv), Dr Tait said that if Mrs Birchall's evidence were accepted that she was not kept informed of delivery options during her labour and was not asked to consent to a forceps delivery, then the implication was that Dr Harrild had failed to obtain her informed consent to the performance of a forceps delivery. If that were the case, then in Dr Tait's opinion, Dr Harrild's failure to do so fell below acceptable standards.

Summary of Evidence for Dr Harrild

Dr Harrild

93. Dr Harrild graduated in 1971 from the University of London; obtained a Diploma in Obstetrics from the Royal College of Obstetricians and Gynaecologists in England in 1974; has been a Member and Fellow of the Royal College of Obstetricians and Gynaecologists since 1978 and 1990 respectively; and has been Fellow of the Australian and New Zealand College of Obstetricians and Gynaecologists since 1982. He came to New Zealand in 1980 where he was employed at Wairarapa Hospital as a consultant.

94. With regard to his training, he explained that as a result of his overseas experience he used both ventouse and forceps for delivery and practised under a number of different surgeons in the use of those techniques. While no one person taught him how to use those instruments, in 30 years of obstetric and gynaecology practice and experience he said he had developed the skills and the "touch" to use them. He identified a number of experienced practitioners who were involved in his training in ventouse deliveries.

95. He said that part of his training showed him that the ventouse could be very effective to eliminate a persistent lip of cervix which could then be followed by forceps for delivery if the head had not descended far enough to utilise the ventouse completely for extraction.

96. Dr Harrild said he had no recollection at all of Mrs Birchall's delivery (having occurred in 1995) and therefore could only talk about it in terms of what his usual practice was with deliveries such as this, and in reliance on the medical records including his letter of 6 October 1995 to Dr Prior.

97. With regard to the 6 October consultation, Dr Harrild described in some detail (more particularly in his oral evidence) what his normal practice was in 1995. He said that after he examined Mrs Birchall he would have discussed with her what would happen during the induction on 8 October and how the induction might progress; what the induction involved and that it may take time; that she would be monitored throughout her labour; that it was possible that during the labour process he may have to trial ventouse and forceps before proceeding to a caesarean section; and would have explained the increased risks with any instrumental delivery.

98. During his examination on 6 October 1995 he detected that the baby's head was palpable. He explained that when he was asked this question by the Complaints Assessment Committee (at an earlier time) he understood that they were asking about the ante natal assessment on 6 October 1995 and not the assessment two days later that he made at 11.10pm on 8 October 1995.

99. Dr Harrild explained that when he sees a patient ante natally for consultation, he would perform a full abdominal examination to decide the height of the fundus, the lie of the baby, the presentation and the position of the foetal head and its relationship to the material pelvis and listen to the foetal heart.

100. With regard to his attendance at Masterton Hospital at 11.10pm on 8 October 1995, Dr Harrild said his usual practice would have been to do a vaginal examination with his hand on the mother's abdomen to see if he could palpate the head. He found that there was a lip of cervix.

101. Having examined the patient, he would normally say to her that he felt with the duration of time that had passed and the lack of progress it was time that they got the baby delivered and felt that they could reasonably attempt to deliver the baby vaginally with forceps or ventouse and that they would transfer her to the delivery suite or words to that effect.

102. Dr Harrild said he would not normally flatten the bed to perform an abdominal examination on its own when he had already performed an abdominal examination as he did not believe it appropriate to flatten the bed unnecessarily because of the risk of hypotension from

compression of the vena cava. He added that the hospital now has a more modern delivery bed (which may or may not have been introduced at the time of Mrs Birchall's labour).

103. His usual practice was to put his hand on the abdomen during the vaginal examination as he thought this obtained the information he needed (a bi-manual examination as explained by Dr Tait).

104. In his experience, it would not have been reasonable to delay the delivery any longer as Mrs Birchall had been sitting at 8+ cm dilated for some time and she and her family were encouraging the staff at the hospital to get things moving. In his experience the longer the labour progresses the more likelihood there is of distress to the baby.

105. He noted from the medical records that there was no evidence of acute foetal distress when he assessed Mrs Birchall at 11.10pm but there was evidence of mild, minor distress earlier in the day with three type 1 dips at 1.05pm and two large foetal heart dips at 8.35pm.

106. When asked by his counsel what degree of urgency he felt at the time, Dr Harrild stated that while he could not now be absolutely certain as to what he thought in 1995, he understood from the medical records and from what others had said that there was a significant time from 8 to 9 centimetres dilatation without any significant progress and that he knew progress was much more likely once the lip of cervix had disappeared and the foetal head had rotated. He believed it was reasonable to progress at that time.

107. He did not agree with Mr Tait's opinion that a ventouse delivery would not be attempted if more than one fifth of the foetal head was palpable abdominally. He said it depended on what the practitioner was attempting to do with the ventouse. He had no intention of trying to deliver the baby with the ventouse but was simply trying to eliminate the lip of cervix.

108. He could not now recall why a theatre with caesarean facilities was not used for the delivery but it may have been that the theatre was in use at that time. A search had been undertaken for the 1995 theatre records but had been unsuccessful. His recollection was

that there was only one theatre available at nights (and still is) and that it may have been that there was an emergency using the theatre at that time. After all these years and with no success in obtaining a search of the theatre records he could not now be certain. Dr Harrild said another possibility may have been that he felt that the baby could be delivered vaginally without incident and without the need to be in theatre.

109. He was asked by his counsel whether there was any fixed practice regarding vaginal deliveries. He stated there was not. He added that if he thought that a vaginal delivery was very likely then he may well have made the attempt in the delivery suite at that stage and at that time.

110. Dr Harrild was asked to explain the separate components of ventouse, manual, Kielland and Anderson and the order in which those components would have been used.

111. Dr Harrild said that while he had no direct memory of this particular delivery he would expect that he followed his normal practice which was first to use the ventouse to see whether he could eliminate the lip of cervix and whether rotation occurred with the ventouse as it sometimes does as the foetal head comes down. If he thought there was inadequate progress he would then have examined Mrs Birchall again and if the cervix were fully dilated try for a manual rotation. If the cervix was still not fully dilated after the ventouse then he would normally stop at that point and make arrangements for a caesarean section. With a recorded station of –1 before the use of the ventouse, he would be hopeful of moving the baby down.

112. After the use of the ventouse the baby's position seemed to still have been at station -1. Dr Harrild explained that as he did continue with a vaginal delivery he must have thought at the time that he could still successfully rotate and deliver the baby.

113. The next step therefore was to proceed with manual rotation. When he was unsuccessful with that he proceeded to apply a pair of Kielland forceps to try and rotate the baby. He may have thought that he had succeeded in rotating the baby. He said he personally did not try and deliver babies with a Kielland forceps. It was his invariable practice that after

rotating with the Kielland forceps, he changes to Andersons forceps for delivery and applies traction to see whether the baby's head will come down and deliver simply.

114. With regard to the entry in Mrs Birchall's medical notes that the rotation with Kielland forceps had failed Dr Harrild said this was written after the delivery when he found at delivery by Andersons forceps that the baby had not rotated.

115. With regard to the opinion Dr Tait had expressed in his written brief of evidence, Dr Harrild said he had a different view of the assessment made by Dr Tait of the indications for performing the instrumental delivery when the station was recorded as "-1".

116. Dr Harrild explained that assessment of the station is a very subjective feeling. To his mind a "-1" station is mid cavity and not "above mid cavity" as Dr Tait had described.

117. Dr Harrild said the objection to the use of ventouse by some obstetricians and gynaecologists was often dependent on experience, training and confidence of the ventouse operator. He was very confident that his training and experience in ventouse permitted him to use ventouse in situations when many other obstetricians and gynaecologists would not. He said he had never had an adverse outcome from a ventouse.

118. Dr Harrild was asked to explain comments made by Mr Birchall that Dr Harrild was sitting on a stool with his eyes shut and then on his knees when delivering baby Samuel and had said "he (meaning Dr Harrild) seemed to be really concentrating" and that if he (Mr Birchall) were to "drop dead … Dr Harrild wouldn't even know". Dr Harrild said he did not normally sit on a stool when he was doing those sorts of deliveries but may have been on a stool for part of the time although this was not normally so. When he does manual rotation he said it is all done by feel and he may well have had his eyes partially closed as he would be trying to feel what was going on.

119. When this was happening, he did not normally engage in very much conversation but might ask the mother to push with the contraction. However, if somebody else was controlling that and feeling for the contractions then he would leave that to the person who was palpating the mother's abdomen.

120. Asked by his counsel whether it was common in his experience for a patient in doubt or for any other reason at that late stage in labour to ask questions, Dr Harrild said some do but most do not. He added that he was very happy to answer questions if he were asked.

121. Dr Harrild was cross-examined at some length and in some detail by Ms McDonald.

122. With regard to undertaking an operative vaginal delivery in the delivery suite rather than in a caesarean theatre, Dr Harrild stated that many forceps deliveries were carried out without being in a theatre without caesarean facilities but that if the practitioner thought that a caesarean section was very likely then it should be done in such a theatre.

123. He accepted that with any delivery there was always a possibility that a caesarean would be necessary.

124. When it was put to him that he had already indicated to Mrs Birchall that she might well end up having a caesarean, Dr Harrild said that he always indicates to any patient who he is inducing that there is a significant possibility that she would have a caesarean section.

125. With regard to his usual practice, he stated that if he felt he had a good chance of being able to deliver the baby vaginally he would not normally contact the operating theatre at 11.30 at night.

126. When asked what would have happened if he had got into difficulties, Dr Harrild replied that if he thought that they could not get rid of the lip of cervix then he would have proceeded at that stage to arrange a caesarean section.

127. It was put to him that after applying the ventouse he did not know whether or not he had got rid of the lip of cervix at that stage, Dr Harrild replied that he had got rid of the lip of cervix with the ventouse. He knew that because he would not have tried to rotate the baby if the lip had still persisted.

128. When asked to explain his evidence-in-chief that he would have attempted a ventouse delivery and then proceeded to a forceps delivery, Dr Harrild replied that if the lip of cervix had disappeared and the foetal head had rotated and come down simply and easily

with the ventouse, then he would have been happy to deliver the baby with a ventouse but that was not or is not always his intention.

129. He added that he found that even with rotation sometimes the ventouse is not suitable for completing delivery. If so, then he is content to change from the ventouse to a pair of forceps if he is concerned about the ventouse application or his capability of delivering the baby with a ventouse.

130. He explained that he would have delivered the baby using the ventouse if everything had gone smoothly and easily. He said his main requirement for the ventouse was to get rid of the lip of cervix.

131. With regard to the medical records, he said the entry that the ventouse failed was not that the lip of cervix had not disappeared but that the ventouse delivery had failed.

132. He emphasised that his commitment was to get rid of the lip of cervix with the use of the ventouse, which he had achieved.

133. He stated that if he thought things were not progressing adequately then he could have stopped and arranged to take the patient to the operating theatre for a caesarean section.

134. When pressed as to what would have happened if an emergency situation had developed in the process of doing the delivery, Dr Harrild replied that it was a bonus if you could do the deliveries always in an operating theatre with caesarean section facilities. He acknowledged that he had looked at the literature which had been produced at this hearing.

135. He agreed that anybody who was having a delivery should have a caesarean section capability available and certainly with forceps deliveries, but he did not think that meant they necessarily needed to be delivered in a caesarean section theatre if one was not available on the delivery suite.

136. He said he could not say what was in his mind at the time but if he aimed to deliver Mrs Birchall in the delivery suite then there must have been very little doubt in his mind at that

time that he could deliver her vaginally. However, after nine years he could not say precisely what he was thinking at the time.

137. He said that he did not elect to do a caesarean section when he assessed Mrs Birchall at 11.10pm on Sunday 8 October 1995 as there was only a posterior lip of cervix and he felt that he could successfully and safely deliver her vaginally.

138. He added that the first he would have known that he had failed to rotate the baby with the use of the Kiellands would be when he was actually finishing the delivery. He may have felt that he had rotated the baby with the Kiellands before changing them to the Andersons forceps but he could not say now.

139. He did not agree that it would have been reasonable to have moved to a caesarean section in 1995 after the use of the ventouse had failed to deliver and there had been no further descent from the baby which was still at station –1.

140. Dr Harrild said that dilatation was completed once he had used the ventouse. When it was put to him that was not shown on the partogram, Dr Harrild explained that was so because he did not go back retrospectively after finishing the delivery and put it on the partogram.

141. With regard to the particular form of document in question, he said it was not normally his role to fill out the time of full dilatation on it.

142. When it was put to him that station –1 was not consistent with full engagement (of the baby's head), Dr Harrild replied that the particular form which was used at Masterton Hospital in 1995 (which he had brought from the Cardiff University Hospital of Wales) referred to mid-cavity and station 0 to –1. It appeared that the word "medcavity" was misspelt on the form and should be mid cavity.

143. Dr Harrild said it was his understanding that station –1 was mid cavity and he would consider that there was engagement at that level.

144. He was asked whether he thought this was consistent with usual practice and usual interpretation of those stations. He stated that it was consistent with the normal practice and the situation in Cardiff University Hospital where he had trained.

145. When asked about the usual practice in New Zealand in 1995, Dr Harrild replied that he had only practised in Masterton. He had not practised in any other maternity units in New Zealand. He said he had not had any disagreements with any of the people with whom he had worked at Masterton, be they locums or consultants who have been there permanently as to station –1 being interpreted as mid cavity and engaged.

146. He said he was not aware that by 1995 when he had been in New Zealand for 15 years there was a different view across the country to those terms.

147. With regard to the issue of informed consent, Dr Harrild said that he did not accept at that time in 1995 with the patient having her legs in the lithotomy position and being prepared for delivery was the right time to be discussing that sort of situation with them. He said he had already mentioned the possibilities of a forceps delivery at the ante natal visit on 6 October and that in 1995 that was accepted as a reasonable degree of information.

148. With regard to what he should have discussed with the patient prior to undertaking the delivery on 8 October 1995, Dr Harrild said he would normally say to the patient that he thought he could safely deliver the patient vaginally and that they would take her into the delivery suite to perform a ventouse or forceps delivery.

149. When challenged that this would not mean much to the ordinary lay person about the advantages or disadvantages and possible risks even in a general way, Dr Harrild replied that the patient having gone through the pregnancy and having spoken to her lead maternity caregiver about the options and so forth for delivery, he would have hoped that by the time it came to the actual delivery the patient had asked enough questions and received enough information about the various forms of delivery available.

150. He thought these matters would certainly have been brought out in ante natal classes and was the sort of thing that he expected the lead maternity caregiver to talk to the patient

about. He thought that by the time they reached the point of delivery, those questions would have been asked and answered.

151. He said that when he had the opportunity he gives that information ante-natally.

152. He could not say what pressures he felt prior to taking Mrs Birchall to the delivery suite in 1995.

153. Nowadays, he certainly tries to give as much information as he feels the patient is willing and able to accept.

154. With regard to Mr Birchall, he could not say how he got the idea that a caesarean section was what was being proposed, but accepted it had been mentioned as a possibility in his letter of 6 October to Dr Prior.

155. Dr Harrild said he does his best to advise patients about the complications of any delivery.

156. With regard to the use of the ventouse, he said he was not sure that he makes any specific statements about the complications of its use but does mention the fact that there is going to be a swelling on the foetal head from the caput that is brought up. He mentioned that it is not as easy to deliver but rotation can occur spontaneously or during delivery with a ventouse.

157. He said he did not make any specific statements about the risks of forceps delivery, in particular, Kiellands forceps but he does say sometimes the baby can end up with forceps marks and that if there is a problem with rotation they will be abandoned. He says he normally mentions that he does not normally deliver with Kiellands but changes to Andersons to do the actual delivery.

158. With regard to a caesarean, he said that if a patient made a specific request for a caesarean section delivery as a preference then, after discussion about the pros and cons, he would be willing to perform one.

159. When it was put to him that he did not give that option to Mr and Mrs Birchall on 8 October 1995, Dr Harrild said that if they had asked for a caesarean section or if the lead maternity caregiver had indicated that a caesarean section was preferred then he would have given that request due consideration and probably performed one.

160. With regard to what options were discussed with Mr and Mrs Birchall, Dr Harrild said that normally he would have said to them that he felt he could safely deliver her vaginally and that was the intention when they took her through to the delivery suite. When pressed about this by Ms McDonald, he said he could not now have specific recollection of a conversation nine years ago.

161. At the conclusion of the cross-examination Dr Harrild accepted that looking back nine years later, with the information about how the delivery progressed and what happened, then he would have done things differently.

162. Dr Harrild was questioned further by certain members of the Tribunal, in particular, Professor Gillett who is an obstetrician and gynaecologist.

163. Dr Harrild was questioned, in particular, about the document in Mrs Birchall's medical records dated 8 October 1995 and entitled "Forceps Delivery".

164. With regard to his use of the Anderson forceps, Dr Harrild said he would always apply them directly in the position that he is expecting to deliver the baby, that is, the forceps would be put on in one position and not moved around.

165. With regard to Kiellands forceps he said there are two options. They can be applied by the operator either directly to the foetal head in the position in which it was thought that the foetal head was, or they can be applied in the normal way that one would expect to deliver the baby, and then move the forceps around the foetal head into the position that the operator feels fits with the position of the foetal head.

166. At the time in question, he thought that the foetal head was directly occipito-posterior. He therefore applied the Kiellands forceps directly in the way that he thought would be the

most appropriate for delivery of that baby by rotating it and then delivering it. According to the medical notes made at the time he believed that he had rotated the baby with the Kiellands forceps. When asked how he could explain this, Dr Harrild replied that he knew he had failed with the manual rotation but thought he had succeeded with the Kiellands forceps. As it turned out, he said he was wrong.

167. He accepted from Professor Gillett that there was a third possibility that he tried the rotation and failed and therefore did not rotate. However, he added that he does not normally deliver a baby direct occipito-posterior. It was possible that the baby was occipito-anterior and he rotated it to occipito-posterior.

168. With regard to the word "rotation", he recorded the word "failed" on the "Forceps Delivery" form because when the baby came out it was direct occipito-posterior and to succeed when coming out he would have expected it to have been direct occipito-anterior. He did not accept the third possibility that the baby was occipito-posterior and he failed to rotate it and that is why he recorded it as "failed". He said the reason for this is that he does not normally deliver babies direct occipito-posterior, even with forceps. He said that there had only been two or possibly three occasions in his career when he had done so and it was normally when he had been mistaken when rotating the babies.

169. He said that in 1995 he was experienced in the use of Kiellands rotation forceps and normally found rotation straightforward.

170. With regard to the categories of traction as being "easy" or "moderate" or "difficult" on the "Forceps Delivery" form (it being circled as "difficult" in this particular delivery), Dr Harrild explained that traction was easy if the baby came out without any traction at all. If it was moderate then there was a small degree of traction required. If it was difficult then it required a more significant degree of traction. He said he would describe this delivery as a difficult one because of all the problems he had to that point.

171. It was also established during the questions and answers between Professor Gillett and Dr Harrild that in fact there had been full dilatation following the use of the ventouse. This is recorded in the medical records of Mrs Birchall entitled "Abnormal Delivery Summary".

172. Dr Harrild did not know who had designed this particular form. It was already in existence at the time he arrived at Masterton Hospital in 1980.

173. Professor Gillett referred Dr Harrild to the section of the form headed "Ventouse" under which it set out indications for initial and final dilatation. Professor Gillett suggested that the fact that the "dilatation" was to be recorded under "ventouse" would suggest that the ventouse was sometimes to be used for an undilated cervix and asked Dr Harrild whether that were a correct assumption. Dr Harrild replied that he had used the ventouse for that purpose. He presumed that other operators had done so as well but he did not know how the form of this particular document had come to be prepared or who had initiated it.

174. Dr Harrild was asked how commonly he used the ventouse for the anterior lip for an undilated cervix and whether this was a fairly common practice. Dr Harrild said he could only guess at how many times he might use it in a year and would not say it was a common practice but that for his own part if there were just a small lip of cervix left then he was content to apply the ventouse to see if he could get rid of it.

175. Dr Harrild was asked what he looked for apart from the station in terms of assessing whether he could achieve a delivery vaginally.

176. Dr Harrild replied that he normally made an assessment as to whether he thought abdominally the foetal head was in a reasonable position and descended. He would make an assessment on vaginal examination of the station of the foetal head, the position of the foetal head, the state of the cervix, the size of the maternal pelvis and would look to the foetal status to see whether the baby was in good condition and whether he thought it was in a reasonable condition to cope with the vaginal delivery.

177. Normally he also took into account anything which he had been told about the patient's wishes and so forth.

178. He was also guided by progress. Once he had started the vaginal delivery he would change from the ventouse if progress was not being adequately made and, if not, then he would stop.

179. With regard to Mrs Birchall's situation, the time involved between his initial examination and the delivery (which included performing the vaginal examination, moving her into the delivery suite and getting it set up, getting scrubbed and proceeding to perform the delivery) would suggest to him that progress was made. The total time was 27 minutes (including all of those matters) which he did not think was excessive.

180. In answer to another member of the Tribunal, Dr Harrild said that in 1995 he expected the majority of his deliveries were vaginal deliveries. In 2004, it was more likely that half his deliveries were by vaginal delivery and half by caesarean section.

181. Over the years, everybody's practice in New Zealand had changed.

Dr Prior

182. Dr Prior confirmed that he was Mrs Birchall's lead maternity caregiver. Having read the obstetric notes for Mrs Birchall dated 8 October 1995 he had no recollection of the birth at all.

183. He explained that according to his standard practice, he saw Mrs Birchall for a six week post natal check on 16 November 1995 and at no stage did she indicate she was unhappy with any of the treatment she received from Dr Harrild, the nurses at Masterton Maternity or himself. He said that had she raised any concerns with him then he would, first, have recorded them and, secondly, taken steps to see what could be done to address her issues. He felt disappointed that he had been denied the opportunity.

184. He said his lack of recollection about the birth suggested to him that there was nothing significant or of concern about it.

185. According to the medical records, Dr Prior saw Mrs Birchall on Sunday 8 October 1995 at 8.10am, 10.15am, 11.40am, 3.15pm, 6.45pm, and 10.45pm. (Dr Tait commented that this showed a very acceptable standard of care.)

186. Dr Prior said he was a general practitioner with 20 years experience in obstetric care and, in his opinion, it was reasonable practice to use a ventouse if a rim of cervix remained.

Often that was sufficient to fully dilate the cervix. He himself uses a ventouse as a result of experience he has gained over the years.

187. With regard to a suggestion that Dr Harrild's manner was cavalier, he said that this had never been his experience of him. He said that Dr Harrild had assisted him by delivering a large number of births since 1985 and, in Dr Prior's opinion, although Dr Harrild preferred to deliver babies vaginally he was never reckless in his preference. From what Dr Prior had observed, each case was evaluated on clinical grounds and the decision was made with a great deal of skill and experience.

188. According to Mrs Birchall's medical records, Dr Prior had consulted Dr Harrild throughout the labour and, as Dr Harrild was better at forceps delivery, involved him.

189. Dr Prior pointed out that his notes did not reflect that he called Dr Harrild with an expectation of a caesarean section.

190. He said he was certain that he would not have given such an indication to Mrs Birchall. It would be improper to do so. His intention would be to ask Dr Harrild to come in to assess Mrs Birchall and for Dr Harrild to make appropriate decisions and to get the baby delivered. He said that was all he would communicate to the family.

191. He said he could also add that in the light of his findings on examination he would not have discounted a forceps delivery at the time he asked Dr Harrild to come in and to help with the delivery.

192. In 1995, he said the maternity unit was in the old wing of the hospital. Today, their practice is always to take such patients to the main theatre in case they need to proceed to a caesarean section but in those days that was not the practice unless there was some indication for urgency. He noted that in this case the baby's CTG trace was not of concern.

193. As he had no particular memory of this case he said it was difficult for him to comment fully but that his lack of memory was consistent with him not having a concern about Dr Harrild's decision.

Ms Baird

194. Ms Baird is a midwife. She said she had looked at the obstetric notes for Mrs Birchall for 8 October 1995 which recorded that she was in attendance at 11.10pm. However, she had no recollection of Mrs Birchall or her attendance at the delivery.

195. The records showed that when she first attended at 11.10pm Mrs Birchall had a small posterior lip of the cervix felt on examination. She said in many cases applying the ventouse would finish dilating the cervix by bringing down the baby's head. She would not have expected Dr Harrild to attempt the delivery without Mrs Birchall being fully dilated but would expect she was fully dilated after application of the ventouse.

196. Her notes recorded that Dr Harrild assessed the patient and that she normally used the word "assess" to mean a full examination that included abdominal and vaginal examinations.

197. Had she any concerns about the birth, obstetric care, the clinical decisions made or the outcome then she would have expected information about the birth to have stuck in her mind. She said she had no memory whatsoever of the birth which was consistent with her not having concerns.

198. With regard to Dr Harrild, she said she had worked with him for 11 years and would describe him as "rather shy".

199. She said that he was for her and also for many midwives, certainly the first choice of obstetrician. She would recommend him without hesitation and regarded him as highly competent. She said without exception he was always approachable and happy to discuss issues and concerns. He would also attend at hospital without hesitation and was happy to be telephoned. She never felt any need to hesitate to disturb him about a reasonable concern. She added that although he lived within minutes of the hospital he would stay for

as long as required until the staff were comfortable with the care of a patient. Overall, in her opinion, she thought his conduct reflected strong commitment to patient care and dedication to patient safety.

Ms Collins

200. Ms Collins is a midwife at Masterton Hospital having worked with Dr Harrild for 24 years. She stated that despite considerable thought and having reviewed Mrs Birchall's notes for 8 October 1995 she was not able to recollect either Mrs Birchall or the delivery of baby Samuel.

201. Ms Collins stated that other than what was referred to in the notes and general practice, she could not comment on the particular issue. However, having read the notes, and in particular Dr Harrild's notes, she had no concerns about the actions that he took.

202. Ms Collins added that the fact she had no recollection was consistent with her not having any concerns at the time or being aware of any concerns held by others. If there were any issues that arose from a birth, she said they were usually discussed and therefore tended to stick in her memory.

Ms Howard

203. Ms Howard is a midwife practising in Masterton, having worked with Dr Harrild for 14 months (at the time of the hearing) and having provided shared care for complicated cases.

204. Ms Howard was not present at the birth of baby Samuel and could not comment on it. Her evidence amounted to character testimony as to her observations of Dr Harrild since she has worked alongside him.

205. In summary, as an obstetrician she described Dr Harrild as someone who did not take unnecessary risks; who was cautious, professional and highly technically skilled and had a good threshold for caesareans. With regard to his professional manner, she described him as very direct and open with his patients providing them with the appropriate level of information and informing them of options. She stated that he would stay for as long as he

was needed even if the hours were unsociable, that he was always calm and contained and that she had never heard him raise his voice.

Dr Dukes

206. Dr Dukes was called as an expert. He gave evidence by video link as he was overseas at the time. He was vocationally registered as a specialist obstetrician and gynaecologist in November 1973 and has been in private practice in Wellington from 1975 until recent retirement. He has been visiting Obstetrician and Gynaecologist to Wellington Hospital from 1975 until retirement and Clinical Lecturer in obstetrics and gynaecology at the Wellington School of Medicine and the University of Otago from 1975 until recent retirement. He is a Fellow of the Royal College of Obstetricians and Gynaecologists and a Fellow of the Australian and New Zealand College of Obstetricians and Gynaecologists (since its amalgamation in 1982).

207. With regard to particular (i), Dr Dukes stated that even if there were no abdominal examination he would not see this as a significant problem and explained why. In particular, he referred to the fact that Dr Harrild had examined Mrs Birchall two days previously and it was unlikely that the general abdominal findings would have been in any way different at that stage and that the information he required was going to be best obtained by bimanual vaginal examination. He stated that such an examination might be reasonably rapid. In his opinion he would not see the lack of formal abdominal examination in this situation as being a deficiency, as the information required was going to be more readily obtained once the patient was anaesthetised and in lithotomy position.

208. With regard to particular (ii), Dr Dukes noted that Dr Harrild had thought that baby Samuel was in the mid cavity although he noted that he thought the station was -1 and elected to deliver the baby in the delivery suite of the maternity unit. Although this delivery was ultimately described as difficult it was successful and the baby was delivered apart from facial bruising in good condition with APGAR scores of 9 and 10. While there was some suggestion of irritability post partum as far as baby Samuel was concerned and he was referred briefly to Wellington because of the possibility of seizures, a CT scan in

Wellington did not demonstrate any bony or intracranial abnormality, nor any surface collections.

209. Dr Dukes stated that it was therefore a matter of judgment on the practitioner's part as to whether he thought that delivery could be achieved vaginally with safety for both mother and baby. In 1995 (when this event occurred), the decision to undertake a trial delivery would have been made less frequently than in current practice.

210. Dr Dukes observed that in the present instance, while Dr Harrild recorded the indications as being direct occipito-posterior and a posterior rim of cervix, it was difficult at this distance (in time) from the procedure to assess what other influences, if any, were present in the decision to proceed to vaginal delivery forthwith.

211. Dr Dukes was cross-examined about the wisdom of performing an operative vaginal delivery in a theatre with caesarean facilities available should the need arise. Dr Dukes replied that he did not think that a practitioner would necessarily think this on every occasion in this situation. He said that whenever a practitioner did an operative vaginal delivery, there was going to be a possibility that failure might occur and it was up to the operator at the time to decide whether he thought he was likely to be successful. While he accepted the wisdom of undertaking a trial of vaginal delivery in a theatre with caesarean section facilities, he could not honestly say whether he would have delivered in a caesarean theatre in this situation and at that time.

212. When asked further questions in cross-examination about this issue, Dr Dukes said that in most situations if there was going to be a likelihood that a caesarean section was going to be required, then it would be appropriate to do the delivery in a caesarean theatre with caesarean section facilities but again that would be a matter for the judgment of the operator at the particular time.

213. With regard to particular (iii), Dr Dukes stated that the manner and mode of operative delivery used by individual practitioners is generally that which is established in the training years as a Registrar prior to registration as a specialist. He stated that one would be

expected to be competent in the assessment of obstetric patients in labour and in operative delivery at the time of registration as a specialist.

214. Dr Dukes set out a history of the use of the vacuum extractor (ventouse). He stated that following its introduction in 1956 by Dr Malestrom it was not taken up widely by British obstetricians. However, there were a few enclaves in Britain where vacuum extraction was considered to be appropriate management, even in the second stage of labour.

215. He explained that the use of the vacuum extractor in the first stage of labour has always been somewhat contentious in British obstetrics although more widely considered in Scandinavia where vacuum extraction is almost universally used for operative delivery in second stage. He stated it is recognised that application of the vacuum extractor cup to the presenting part of the head, appropriately placed, according to the position of the head and the degree of deflection would, with traction, bring the cervix to full dilatation from 7 to 8cm quite rapidly but that it was already at 9.5cm in Mrs Birchall's case.

216. Dr Dukes then referred to the medical literature regarding the use of the vacuum extractor in the first stage of labour and provided extracts from the relevant authorities.

217. Having summarised the literature, Dr Dukes concluded that there was therefore increasing and significant support for the use of the vacuum extractor in the first stage of labour.

218. Dr Dukes referred to Chamberlain, in the text book "Obstetrics" by Turnbull and Chamberlain published in 1989. Chamberlain noted in the chapter on the vacuum extractor that "Many indications for operative vaginal delivery are not for acute foetal distress but relate to slow progress at the end of the first stage or in the second stage of labour. For these the vacuum extractor is ideal". Specifically for the first stage Chamberlain noted "Hence in the first stage of labour the major indication for the vacuum extractor is the lack of advance and delay at the end of the first stage. There should be no obvious disproportion and the Operator should reasonably expect to deliver the baby per vaginam. Occasionally there may be a place for trial vacuum extraction performed in the operating theatre with all facilities ready for Caesarean Section."

219. Dr Dukes stated that in 1989 when the above text was published it was one of, if not the, pre-eminent textbook on Obstetrics.

220. He stated that while some earlier authors restricted the indications for the use of the vacuum extractor in the first stage to acute foetal distress, it could be seen that Chamberlain placed no such restriction and indicated that its prime use was for delay in the first stage, as was noted with Mrs Birchall.

221. Dr Dukes observed that in situations where the vacuum extractor was applied in the first stage one would not necessarily expect the head to be at the level of the spine as often descent does not take place until full dilatation occurs.

222. In cross-examination, Dr Dukes agreed that an operator should not use the ventouse if the baby's head was more than two fifths palpable.

223. Dr Dukes was asked by a member of the Tribunal how many fifths palpable he would expect to feel with the station of –1. Dr Dukes replied one fifth depending on the degree of moulding. One might feel two fifths if the head was very moulded.

224. He was asked whether he considered a station of –1 to be acceptable in terms of attempting a vaginal delivery.

225. Dr Dukes replied that one of the difficulties about being station –1 was that the estimate of –1 in a pelvis and with a head that has recently had a vacuum extraction performed was quite difficult. He stated that even although station –1 was written in Mrs Birchall's medical records he thought it was very difficult to know exactly what –1 represented. He said that one really needed to have an overall picture of what was going on in the pelvis at the time. He said one needed to know whether there was two or three fifths of head above the brim or whether there was plenty of room in the pelvis, whether, in fact, the head appeared as though it was engaging in the pelvis. He said that one was talking about using the vacuum extractor in the first stage of labour, not in the second stage of labour, and one might not necessarily expect the head to have engaged in that situation. Once the forceps were started, then the –1 was still recorded but Dr Dukes thought one would need

to take the whole picture into account at that time. He said that just relying simply on –1 as an indicator of whether or not one should proceed with a vaginal delivery was not really the whole picture.

226. Dr Dukes was asked whether, in summary, he was suggesting station –1 was not that meaningful on its own but needed to be considered amongst other things, Dr Dukes replied it was a very difficult assessment. He said he "had the pleasure of teaching the trainee interns over the last 20 years about the difficulties of a labour and assessment of station as one of the most variable assessments individual operators can make and reproduce ability is very poor".

227. With regard to particular (iv), Dr Dukes observed that there was no information within the file which would allow any opinion to be formed on the matter of consent. He observed that in 1995 it would have been his practice, in most situations if forceps delivery was being undertaken, for this consent to be verbal unless a specific trial of operative delivery was being undertaken.

The Decision

228. **Particular (i):**

Prior to attempting delivery of baby Samuel, failed to perform an abdominal examination on Mrs Birchall to assess the amount of head palpable abdominally and thereby failed to assess adequately the percent of the presenting part.

229. At the conclusion of the evidence for the Complaints Assessment Committee, Mr Hodson submitted that there was no case to answer regarding this particular as well as particulars (ii) and (iii). Following this submission, the Tribunal retired to consider his submissions.

230. The Tribunal found that with regard to particular (i) there was no case to answer.

231. The medical records established that Mrs Birchall was given an epidural on the day of delivery, Sunday 8 October 1995, which was effective at 11.35am. Shortly after 5pm the anaesthetist further reviewed the epidural and increased the infusion to improve pain relief.

232. In cross-examination, Mr Hodson put to Mrs Birchall that there was nothing in the first statement about this matter which she prepared in November 2000 which Dr Harrild did or did not do, and asked her when she first turned her mind as to whether or not he had done an abdominal examination.

233. While Mrs Birchall had written out a statement in November 2000 it was not forwarded to the Health & Disabilities Commissioner until 23 July 2001. She said it was only after that "some time late in 2001" when it was being discussed that somebody asked her whether there had been an abdominal examination to which she answered no. In re-examination, Mrs Birchall said that nobody had asked her before 2001 whether an abdominal examination had been done.

234. There then followed an exchange of questions and answers between a member of the Tribunal (Dr Fenwicke) and Mrs Birchall. It became apparent that the pain relief would have been most effective lower down, particularly with the top-up of the epidural before the delivery. Mrs Birchall conceded it might have been more difficult for her to feel pressure lower down as opposed to feeling it higher up. To another member of the Tribunal, Mrs Birchall confirmed that the epidural gave her good pain relief and that following the top-up she felt quite comfortable prior to the delivery.

235. Mr Birchall stated that when Dr Harrild arrived he remembered him "having a quick look at Tracey and checking her out to see whether or not she was fully dilated. Everything happened very quickly."

236. Later in his written brief of evidence he stated that Dr Harrild did not do an abdominal examination.

237. When questioned about this by Mr Hodson, Mr Birchall established that his wife was lying on a bed on an angle with the bed partly hoisted up so that she was partly in a sitting position. Her legs were covered by a sheet. He was standing at the right hand side of the bed by his wife at the level of her head. He was not looking "at the other end". It was put to him that he was not looking at what Dr Harrild was doing under the sheet to which he

replied that he did not "poke [his] head down, no, but [he] could see the sheet up on her legs, it was obvious what he was looking at".

238. When challenged about his assertion that Dr Harrild did not do an abdominal examination it was put to him that is not what he saw or did not see himself. Mr Birchall replied that he did not see Dr Harrild push on the stomach because "the sheet was to here and nothing got pushed up this way, it was looking from the bottom".

239. In cross examination, Dr Tait agreed that there were only two ways in which Mrs Birchall could know whether she had had an abdominal examination – she could either see it or feel it.

240. Dr Tait agreed that as she was in bed in a sitting position with her feet on something but not stirrups and with a sheet draped over her she would not necessarily have been able to see what Dr Harrild was doing with his hands.

241. When asked to comment on Mrs Birchall's ability to feel an examination of the lower abdomen, Dr Tait said that if she had had a very effective epidural she may certainly not have noticed an abdominal hand at the time of the vaginal examination pushing down on the head.

242. Dr Tait said he normally did an abdominal examination with the patient lying flat.

243. The evidence established that Mrs Birchall was in a semi-recumbent position. Dr Tait was asked whether it was reasonable to perform the bimanual vaginal examination rather than an abdominal examination. Dr Tait replied that if the practitioner could get the amount of information wanted and could actually feel the baby's head in that way then, while it may not be optimal, it was probably not unreasonable.

244. The Tribunal was satisfied at that juncture that Mrs Birchall had not addressed her mind as to whether or not there had been an abdominal examination until late in 2001, some six years after the event, when she was asked this during an investigation, following her complaint.

245. The Tribunal was also satisfied on the evidence that Mrs Birchall was not able to see or feel whether or not there had been an abdominal examination.

246. Mr Birchall's evidence regarding this particular issue was somewhat confusing.

247. Dr Tait's evidence was of assistance to the Tribunal and put the issue in a fair context.

248. While the threshold of establishing a prima facie case is lower than the threshold required to prove the charge (or elements of it), the Tribunal was not satisfied on the evidence before it that a prima facie case had been made out.

249. In reaching that conclusion when it did, the Tribunal did not have regard to any of the evidence provided in advance by or on behalf of Dr Harrild.

250. However, the Tribunal, having heard all of the evidence (even if a prima facie case had been made out) would not have found this charge to have been proved. Having regard to all the evidence, the Tribunal has concluded that Dr Harrild had, in all probability, performed a bi-manual vaginal examination. According to Dr Dukes such an examination was appropriate in the circumstances. Dr Tait also stated that this type of examination was an acceptable alternative to an abdominal examination. Accordingly, the Tribunal would have dismissed this particular in any event.

251. **Particular (ii):**

When performing a forceps delivery of baby Samuel failed to observe and/or adequately observe the usual procedures consistent with a trial of operative vaginal delivery including failure to perform the delivery in a theatre in which caesarean section facilities were available; and/or

252. It was not in contention that in 1995 there were three theatres at Masterton Hospital with caesarean section facilities, that is, two main operating theatres and an endoscopy theatre. The delivery suite in the Maternity Annexe where baby Samuel was delivered did not contain caesarean section facilities. Further, on the evening in question, one team of theatre staff would have been on call rather than on duty. It was also not in contention that the main theatre was four to five minutes walking distance from the Maternity Annexe.

253. What was in contention was whether a theatre with caesarean section facilities was available on the night of Mrs Birchall's delivery. Dr Harrild said that he could not say whether a theatre was available or not as it was not recorded in the notes although counsel for the CAC submitted that there was nothing in the notes which suggested that any attempt was made to ascertain theatre availability or that there were problems with theatre availability or that a theatre was not available and had this been so then one would have expected that to be recorded.

254. Dr Harrild stated that an unsuccessful search for the 1995 theatre records had been made. His recollection was that there was only one theatre available at nights (which is still the position) and it may have been that there was an emergency using the theatre at the time. He stated he could not be certain. Another possibility was that he may have felt that the baby could be delivered vaginally without incident and without the need to be in theatre.

255. Dr Harrild added that at that time in 1995 there was no fixed practice (at Masterton Hospital) about where an operative vaginal delivery took place.

256. Dr Prior confirmed there was no fixed practice. Dr Prior stated that at the time (in 1995) the maternity unit was in the old wing of the hospital. He said today their practice is always to take such patients to the main theatre in case they need to proceed to a caesarean but in those days that was not the practice unless there were some indications for urgency.

257. Dr Prior added that in this case baby Samuel's CTG trace was not of concern.

258. While Dr Prior also had no particular memory of this case he stated that his lack of memory was consistent with him not having a concern about Dr Harrild's decision.

259. When cross-examined by Mr Hodson, Dr Tait agreed that where cases are not clear cut, the self confidence of the operator in his own skills and reliance on his own judgment was a factor.

260. He agreed that from what he had read of Dr Harrild's brief of evidence, Dr Harrild was by New Zealand standards unusually well trained and conversant with the ventouse extractor.

261. Ms McDonald put to Dr Dukes in cross-examination a section from an article by Baker ("The place of midforceps deliveries in obstetric practice") which was published in 1995 and which stated that the capability to perform a caesarean section was also imperative and that if there was any doubt regarding the mode of the delivery then the procedure should be performed as a trial in the operating theatre with everything ready for an emergency caesarean.

262. Dr Dukes said that in most situations if there was going to be a likelihood that a caesarean section was going to be required then it would be appropriate to do the delivery in a caesarean theatre with caesarean section facilities but added that this was a decision for the operator at the particular time.

263. He said he thought that if a caesarean section was more likely than a vaginal delivery then he would certainly have taken the patient to the operating theatre but if he thought that a vaginal delivery was very likely then he may well make an attempt in the delivery suite at that stage, at that time.

264. In answer to a question from a member of the Tribunal, about how long it would have taken to prepare a theatre if he had decided (in the delivery suite) to undertake a caesarean section, Dr Harrild replied it would depend on how urgent he said it was going to be and it would depend upon which members of staff were on call but he would have been very unhappy if it had been longer than half an hour from the moment the decision was made to the moment the knife started to cut the skin.

265. Dr Dukes was asked by another Tribunal member how soon after a decision to abandon an operative vaginal decision would an operator like to be able to do the caesarean section, in a situation such as this. Dr Dukes said that one would like to do it as quickly as one could and one would not want any delay but he would not consider a delay of 30 minutes too long in organising the theatre and setting everything up if there were no foetal distress.

266. Dr Tait stated that it would be prudent practice, if it was considered that the operative vaginal delivery was going to be difficult, to do the delivery in a caesarean section theatre

and that it would have been wise for Dr Harrild to have performed the forceps delivery of baby Samuel in the main theatre where caesarean section facilities were available when it became clear that an operative vaginal delivery was likely to be problematic.

267. Taking into account the evidence of Drs Tait and Dukes, but having regard to the common practice at the time in a provincial hospital with secondary facilities, the uncertainty that a theatre in which facilities for a caesarean section were available was in fact available to Dr Harrild at the time and Dr Harrild's own experience and capabilities, the Tribunal is not satisfied the CAC has proved Dr Harrild failed to observe usual procedures as alleged in this particular.

268. The Tribunal therefore finds particular (ii) was not proved.

269. **Particular (iii):**

performed an operative vaginal delivery of baby Samuel prior to full dilatation of Mrs Birchall's cervix and when the presenting part was at the level of station –1; and/or

270. Counsel for the CAC submitted that the baby's head was at station –1 all along. However, on the balance of probabilities the evidence did not establish that. Once Dr Harrild took off the Kiellands forceps no-one can say with certainty what the baby's descent was after that.

271. Station –1 was recorded at the start of the application of the Kiellands forceps but there was no recording of the station afterwards.

272. The evidence did not establish that Dr Harrild performed an operative vaginal delivery of baby Samuel prior to full dilatation of Mrs Birchall's cervix.

273. The Abnormal Delivery Summary document produced in evidence recorded that following application of the ventouse there was "full dilatation". The baby's head would have descended so that there was progress. However, Dr Harrild recorded it as station –1 but

the Tribunal accepts his explanation and understanding of what station –1 meant. Other practitioners may have recorded that as station 0.

274. In this regard, the Tribunal also refers to the evidence of both the experts. As Dr Tait agreed, station –1 for one practitioner could be station 0 or station –2 for another practitioner.

275. The Tribunal is of the view that in all the circumstances Dr Harrild was entitled to form the judgment that the baby was deliverable vaginally.

276. In this regard we refer also to the evidence of Mr Birchall when asked about the time it took for the actual delivery. Mr Birchall stated he could not say how long but it did not seem long to him (as a lay person) and that "it just happened – everything happened so fast".

277. The delivery would not have proceeded at the pace Mr Birchall recalls without full dilatation and descent at the end of the ventouse procedure.

278. The other piece of compelling evidence is that Dr Harrild turned the baby to occipito-posterior (accidentally) with the Kiellands and delivery was effected quite quickly thereafter. This suggests that there must have been considerable room in the pelvis to do the delivery.

279. It is common obstetric practice to use the Kiellands forceps for the rotation and then change to Andersons for the lift out which would not have been possible without adequate descent.

280. There is no evidence the delivery was prolonged.

281. Taking into account Dr Harrild's experience and training, particularly in the use of the ventouse, it could not be said that he had commenced the operative vaginal delivery prior to full dilatation and was thereby guilty of professional misconduct. The Tribunal is satisfied the use of the ventouse effected full dilatation, as is recorded in Mrs Birchall's medical records.

282. The Tribunal records that the part of the charge which refers to the presenting part being at the level of station –1, on its own, could not be said to amount to professional misconduct because of the variation in clinical assessment of what is meant by station –1.

283. The Tribunal finds that particular (iii) was not proved.

284. **Particular (iv):**

at the time of delivery, failed to keep Mrs Birchall informed and/or adequately informed of the options for delivery and/or failed to obtain her informed consent to the forceps delivery he performed.

285. At the conclusion of the hearing, the Tribunal was not satisfied there had been a failure of informed consent. The Tribunal was not satisfied that this particular had been proved to the requisite standard.

286. Dr Harrild was at a distinct disadvantage in that he was being asked to recall what had occurred almost nine years earlier. In the absence of any precise documentation, the most that he could do was to explain to the Tribunal what his practice was at that time and what he believed he would have done.

287. Dr Prior had similar difficulties, as did the midwives, Ms Baird and Ms Collins.

288. All of them stated in their evidence that if there had been something untoward about this particular delivery they would have expected it to stick in their minds. None of them had any memory whatsoever of the birth which all said was consistent with their having no concerns.

289. Dr Harrild did report to Dr Prior in writing on 6 October 1995 following the antenatal consultation with Mrs Birchall two days previously. In that letter he specifically referred to the possibility of a caesarean. A fair reading of the words "I have discussed the possible means of delivery" would imply more than one means of delivery was discussed and that may well have included the use of forceps (since that was his practice).

290. Just as Dr Harrild could not be precise nine years later about what was said or not said on either 6 or 8 October 1995, nor could the Tribunal have any degree of certainty. At the end of the evidence, all members of the Tribunal were left in considerable doubt as to the position. Accordingly the Tribunal cannot make adverse findings of fact against Dr Harrild on the evidence presented.

291. The Tribunal does not in any way wish to minimise the concerns of Mr and Mrs Birchall and it recognises that the delivery was a difficult one and traumatic for Mrs Birchall. However, it is not prepared on the evidence before it to find there was a failure of informed consent to the standard required in 1995.

Orders and Conclusion

292. The Tribunal therefore makes the following orders:

(a) The charge of professional misconduct laid against Dr Harrild is dismissed.

(b) As a consequence there are no issues as to penalty or costs.

DATED at Wellington this 27th day of October 2004

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S M Moran

Deputy Chair

Medical Practitioners Disciplinary Tribunal