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Court medical matters: It started with a headache

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Abstract

The symptom of headache is one of the most ubiquitous in daily life. Its reference ranges from the wifely nightly excuse to the most deadly of underlying causes. In 1999, the UK witnessed an obstetric case which also started with a headache, but tragically ended up with the death of a 31-year-old woman following childbirth.

The case exhibited several unusual features both at clinical management level as well as in the legal response it generated. In such a case, one would have expected the subsequent core medico-legal issue to be one of legal redress sought by the husband of the deceased, for alleged negligence of care of his wife. In fact, the ensuing medico-legal Court battle was between the coroner and the husband, for, while the coroner declared the death to be natural and refused to demand an inquest, the patient's husband, sanely enough, demanded such an inquest.

In *R v HM Coroner for Inner North London District ex parte Touche* [1] the Court ruled for Mr Touche, the husband of the deceased. The Coroner appealed and in *R (on the application of Touche) v Inner London North Coroner* [2] the Court once again ruled against the Coroner.

The case exhibits extremely fascinating features, mostly in a negative light and in a number of spheres including the medical management, the response of the Coroner and the doctors who filled in the pre-cremation forms. Another aspect, worthy of comment, is that the deceased's husband, who, stuck to his principle in demanding an inquest, does not seem to have sued for damages (as far as this author can find out) in a case with clear evidence of practice below the expected normal standard of care. Maybe his point was to seek justice for his dear wife rather than gain any pecuniary profit.

This case discussed may have started with a headache but it was one type of headache which, sadly, led to the crematorium.

The Case

31-year-old Mrs Lara Touche, delivered twins by Caesarean Section on 6 February 1999 at 10.25 pm and upon transfer back to her room, she was complaining of headache. This was a severe type of headache which was progressively worsening. Previously recorded as normotensive, her BP shot up to 190/100 at 1.35 am. The patient later developed neurological symptoms and was transferred to a more neurologically specialised hospital but, tragically died on 15 February, "the cause of death being intra-cerebral haemorrhage". At this point, the reader should be asking a million and one clinical questions. I did too. But, even at the end of the two Court cases, which are referred to, I was not much wiser. An abysmal lack both of checking of vital signs as well as of recording them, seems to plague this case.

The post-mortem result of 18 February 1999 confirmed the diagnosis of a sub-acute intra cerebral haemorrhage in the right basal ganglia, consistent with the clinical history of eight days' duration. The area of haemorrhage was typical of hypertensive brain haemorrhages and a mild degenerative vascular pathology in the same region was noticed and "may have predisposed to hypertensive haemorrhage following delivery." There was no histological evidence of eclampsia. As a cause of death, the pathologist affirmed:

1a. Brain swelling and tonsillar herniation.

1b. Intra cerebral haemorrhage.

2. Recent pregnancy.

Without questioning neither the pathologist's ability nor his upstanding in the least, the comment on eclampsia comes as a surprise. As will be discussed, one Court expert stated categorically that this was a case of pre-eclampsia/eclampsia. The limited clinical information, the timing (immediately post-delivery), the circumstances and the pre-disposition of multiple pregnancy to pre-eclampsia, makes this assumption a most valid one.

A medico-legal battle ensued between Mr Touche and the Coroner.

The Coroner, after consideration of the facts and a post mortem report, concluded that the death was not unnatural and therefore it was unnecessary to hold an inquest. The husband sought judicial review of that decision [1].

The direction of the Law as to when an inquest must be held (s 8(1) of the Coroners Act 1988) essentially states that:

"Where a coroner is informed that the body of a person ("the deceased") is lying within his district and there is reasonable cause to suspect that the deceased –

(a) has died a violent or an unnatural death;

(b) has died a sudden death of which the cause is unknown; or

(c) has died in prison or in such a place or in such circumstances as to require an inquest under any other Act, then, whether the cause of death arose within his district or not, the coroner shall as soon as practicable hold an inquest into the death of the deceased . . ."

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On September 20, 1999 the coroner replied, indicating his lack of any general discretion and saying he was satisfied that the deceased died consequent to natural causes

Maternal mortality

A maternal death is one which occurs when a woman is pregnant, or within 42 days of delivery, miscarriage, or termination of pregnancy, and resulting from any cause which may be related to or aggravated by the pregnancy itself or its medical management. This definition excludes accidental or incidental causes [3].

Maternal deaths are classified [3] as:

- Direct (deaths resulting from obstetric complications of the pregnant state (pregnancy, labour, and puerperium), from interventions, omissions, incorrect treatment, or from a chain of events resulting from any of the above).
- Indirect (deaths resulting from previous existing disease or diseases that developed during the pregnancy and not due to direct obstetric causes but aggravated by the physiological effect of pregnancy).
- Late (deaths occurring between 42 days and one year after termination of pregnancy, miscarriage, or delivery that are due to Direct or Indirect maternal causes.
- Coincidental (previously known as Fortuitous) deaths (those due to unrelated causes which happen to occur in pregnancy or the puerperium).

In view of the medical management, which left much to be desired, as we shall find documented in Court, one reaches the conclusion that the death of Lara Touche would fall under the first category. It is strange how the Coroner would consider a maternal death to be natural when besides the clinical circumstances which unfurl, was of the order of incidence of 11.4 deaths per 100 000 maternities [3] in the UK for 11.4 per 100,000 maternities, in 1999.

Headache in the peri-partum period

Every medical student knows, or ought to, if wants to pass his under-graduate. Obstetrics exam, that peri-partum headache is due to rising blood pressure unless proven otherwise, and this, in turn, is due to pregnancy induced hypertension or preeclampsia, unless proved otherwise. Judging from the case file as discussed in. In *R v HM Coroner for Inner North London District ex parte Touche* [1] headache, apparently was the only symptom experienced by Mrs Touche, in the immediate post-caesarean section, recovery period. In the normal UK Obstetric unit of 1999, this would have set off alarm bells, and probably, these alarm bells would have likely gone off, even before the symptom was experienced. We have no mention of the presence or otherwise of oedema (admittedly non- significant in most cases), of any sign of a rise in blood pressure over the previous weeks, days or hours (no records of observations or evidence of being taken, period), no mention of a platelet county or serum uric acid levels….Yet, even if we assume, that there had not been the least sign and pre-eclampsia struck like lightning from blue skies, the management once the tell-tale severe and worsening headache set in, is difficult to comprehend, even by basic late 20th century obstetric management.

Dr Bogod, an experienced consultant anaesthetist with a particular interest in obstetric anaesthesia, described *the level of neglect as "starkly apparent"* and also criticised strongly the lack of per and post-operative note keeping. Apparently there is no mention of enquiry of other symptoms accompanying the headache such as visual disturbances, abdominal (hepatic) discomfort or pain… He also found a profound failure of monitoring and recording of vital signs including blood pressure while the post-operative patient *was also receiving analgesia* (my italics).

It is mystifying to find a British Obstetric Unit in the year 1999, where, in the immediate post-partum period, acute headache subsequently found to be associated with a blood pressure reading of 190/100, did not immediately launch an ITU management of acute pre-eclampsia potentially veering towards eclampsia. Little wonder, that the Court stressed that *the issue central to the applicant's case, (was) namely the relevance of the apparent failure properly to monitor and treat the patient during the immediate post-operative phase.*

In spite of the autopsy concluding that pre-eclampsia was not present, Dr H Williams, who ran the high-risk obstetrics service at the Chelsea and Westminster Hospital concluded that *her severe hypertension was responsible for her cerebral haemorrhage, and the hypertension was secondary to pre-eclampsia/eclampsia. …if she had not been hypertensive he does not think she would have had a cerebral haemorrhage,*

He also stated that

"When her hypertension was eventually treated, she responded with a significant fall in BP within 15 minutes. It is likely that more prompt identification and treatment of her hypertension would have prevented her cerebral haemorrhage".

This is a crucial comment for the management of fulminant pre-eclampsia is not the same as simply lowering the blood pressure. The impression given is that once action was eventually taken, and this was too slow and too late in response to the increasingly severe headache, it simply consisted in lowering the blood pressure [7]. The impression given is that. once action was eventually taken, and this was too slow and too late, it simply consisted in lowering the blood pressure. If we justifiably assume pre-eclampsia/eclampsia, the correct management is not simply that of a hypertensive crisis. This point, should also have been brought out in Court, for this management took place in an obstetric unit and not in a general cottage hospital. In spite of an occurrence of 1/2000 deliveries in the West [8], the condition and its management have been well described, at least, for the last 50 years. Also well established is the 44% occurrence of eclampsia post-natally [8] and management protocols are freely available and should be known by all practising obstetricians [9].

Furthermore, high dependency care should have been immediately instituted and maintained for 24 hours [10]. Another great shortcoming concerns documentation. All management steps should have been fully documented, dated and clearly timed[11].

Re-entering the legal Arena

In 2001, the Coroner appealed the Court's decision in *R (on the application of Touche) v Inner London North Coroner* [2]. In this session, a few more clinical details emerge – and they paint an even worse picture of management. Thus, we know that *Mrs Touche had spinal anaesthesia for her caesarean section* – a fact which, if anything, requires much stricter post-operative vigilance in monitoring. It is a well established fact that spinal anaesthesia may be associated with hypotension [12]. hence intensive blood pressure monitoring before and during such anaesthesia, is a basic requirement. This time we also learn that Mrs Touche's blood pressure was 120/60 during the operation at

about 10.25 pm. At this stage, one asks whether there was a record of the blood pressure in pregnancy, especially the first trimester and whether the blood pressure was even checked and recorded on admission to hospital, *before* the administration of the spinal anaesthetic. One gets the impression that these facts were not deemed important or at least not important to record. We are only told that the antenatal course of events was normal. Antenatal blood pressure is extremely important, and excluding the mid-trimester physiological drop, offers a precious guide to any *relative* rise in blood pressure. If Mrs Touche's normal ante-natal blood pressure was 100/ 50, even the 120/60 per-operative blood pressure (under spinal anaesthesia) could have been a warning light.

At about 11 pm the patient was transferred to the post-natal ward, complaining of headache, which did not seem to elicit sufficient concern, neither to check the blood pressure and record it, nor to alert the anaesthetist in view of the spinal anaesthesia.

The next blood pressure note was when the headache was extremely severe and Mrs Touche was "*clearly unwell*" and this was at 1.35 am when the blood pressure was noted as190/100. Again, "clearly unwell" is an unacceptable term in medical parlance – it could range from a simple faint to a full convulsion. Be that as it may, treatment (presumably anti-hypertensive but what was it? How was it administered? And at what dose?..) was started only then, but by 5.15 am she suffered a left – sided hemiplegia. At 6.15 am she was transferred Middlesex Hospital and from there to the National Hospital for Neurology and Neurosurgery at Queen Square where eight days later, on 15 February, she died.

On 28 July 1999 Mr Touche, hardly surprisingly. wrote to the coroner stressing the lack of blood pressure monitoring for a 2.5 hour period between 11 pm and 1.30 am. This was the tip of the iceberg he could have fairly and squarely complained of. His complaint, was also taken up by Touche's solicitors who on 28 July 1999 refer to *"a basic, fundamental failure to record blood pressure readings . . . vitiated any opportunity to avoid the catastrophic events which lead to Mrs Touche's death."*

On 15 September 199, the same solicitors would put the lack of Mrs Touche's blood pressure monitoring on a more solid legal footing:

"The Portland Hospital have already confirmed in writing to our client that a protocol does not exist to reflect the level of monitoring that should be given following a caesarean section. We have expert evidence to the effect that every NHS hospital in the country has a protocol in place for the care of patients in the post-operative phase in order to maintain standards within the hospital and ensure an appropriate level of patient care. It is disturbing that a private hospital with this reputation chooses not to adopt such a protocol."

Another strange twist to the tale – a misled Coroner

On 16 February 1999, the day following Mrs Tuche's death, the Coroner was informed by his officer of the presence of a body within his district. But, even here, we find an odd twist to the story. A doctor at the National Hospital at Queens Square, the following information was supplied::

"Gave birth to twins by caesarean on 6.2.99 at Portland Hospital. Collapsed three hours later. Admitted to National Hospital on 7.2.99. Exam indicated spontaneous brain haemorrhage unconnected with surgical procedure . . . No evidence of neglect nor complaint by family. No PM required."

The doctor, could have been partly excused in stating that there was no evidence of neglect in the sense that the surgery was not contributory or in stating that no neglect occurred in the hospital where Mrs Touche died. But, knowing all the facts, it is a misleading statement, however, well intentioned.

Hence, from the information emanating from Queen Square, the coroner was led to believe that an inquest was not necessary. Mrs Touche was cremated on 22 February after the requisite forms as required by the Cremation Regulations of 1930 were filled in by two doctors who certified amongst other things that they had no reasonable cause to suspect that the deceased died an unnatural death or from "privation or neglect", and that there was no reason for any further inquiry or examination. It was not until after the Divisional Court's judgment that the coroner became aware of Mrs Touche's cremation! Fate seemed to be ganging up against the Touches obtaining an inquest. However, the Appeal by the coroner in *R (on the application of Touche) v Inner London North Coroner* was dismissed by the Court, which *was* fully aware of the global situation. For the second time, Court vindicated

Mr Touche's demand for an inquest – small recompense for the loss of his dear wife and his motherless twins.

Final reflections

If one reflects on the case of Mrs Lara Touche, the adjective *strange* or *unusual* looms paramount. We must not forget the wounded humanity aspect of a situation where a woman enters hospital, celebrating double life-to-be, and exits the rosy picture as ashes from a crematorium. We speak of 1999 in the UK, not the jungles of bonga bonga Island. It *is* strange that a serious hypertensive/pre-eclmpsia - eclampsia crisis did not set off immediate correct management. It *is* strange that, whether a headache was present or not, close observations and chartings were not held in a woman who has just had

- A childbirth.
- A childbirth involving multiple pregnancy.
- A childbirth involving major surgery, namely a caesarean section.
- The administration of spinal anaesthesia.
- Evidence of a hypertensive crisis.
- Manifestations of a potentially extremely serious symptom, namely worsening headache, even if other signs and symptoms were not elicited or if so, recorded and acted upon.

It should not be that lessons are learnt, at the cost of a patient's life, when the principles of management of the involved pathology have been well established for decades previously.

The expert witness H Williams' assumption that this was a case of preeclampsia/eclampsia is difficult to challenge irrespective of anything else stated. The story, as described retrospectively, *may* have started with a headache. Yet, an obstetric unit is admirably poised to unleash an ITU type of management when a serious and worsening headache strikes immediately post-partum. Omitting all other signs and symptoms and seeking comfort in mentioning such a simple, every day symptom provides little medico-legal camouflage or sympathy, in the circumstances of fact and even more so, in view of the final terrible aftermath.

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