SUMMARY of the Decision of the Inquiries, Complaints and Reports Committee (the Committee)
(Information is available about the complaints process here and about the Committee here)

Dr. Peter Douglas Watt (CPSO #56891)
(the Respondent)

INTRODUCTION

In July 2018, the Respondent delivered the Complainant's baby by Caesarean section. Tragically, the baby died hours after birth. The Coroner identified that death was likely due to multiple pathologies and subgaleal and intracerebral hemorrhages, in the context of arrested second stage of labour and instrumentation.

The Complainant contacted the College of Physicians and Surgeons of Ontario (the College) to express concerns about the Respondent's care.

COMPLAINANT'S CONCERNS

The Complainant is concerned about the intrapartum care the Respondent provided to her during her labour and delivery admission in July 2018, which resulted in the death of her son.

COMMITTEE'S DECISION

An Obstetrical Panel of the Committee considered this matter at its meeting of August 16, 2019. The Committee required the Respondent to attend at the College to be cautioned in person with respect to the management of the second stage of labour, including the assessment and documentation of fetal heart rate (FHR) patterns, performance of an operative vaginal delivery, and awareness of anesthesia availability. The Committee also directed staff to negotiate an undertaking with the Respondent. The College subsequently received the Respondent's signed undertaking and it is posted on the College's public register.

COMMITTEE'S ANALYSIS

The Committee found the Respondent's management of the second stage of labour to be concerning. There was a delay of more than one hour between the appearance of late deceleration in the FHR and the Respondent's intervention. Delivery of the baby did not occur until approximately two hours after the late deceleration began. The Committee felt strongly that the Respondent should have intervened earlier upon the appearance of late deceleration.

The Committee had a number of specific concerns with the Respondent's care, including:

- Failure to recognize and document the seriousness of the deterioration in the FHR pattern
- The decision to proceed with an operative vaginal delivery rather than Caesarean section under general anesthesia
- Inadequate performance and documentation of the operative vaginal delivery
- Failure to ensure immediate resources to perform an urgent Caesarean section if attempts at operative vaginal delivery failed
- Lack of direction to anesthesia that general anesthesia, not a top-up of the epidural, was required.

As a result of this investigation, the Committee had concerns about the Respondent's obstetrical care and decided to seek an undertaking from the Respondent and require him to attend for a caution regarding the management of the second stage of labour including: assessment and documentation of FHR patterns, performance of an operative vaginal delivery, and awareness of anesthesia availability. The Respondent's undertaking includes a requirement that he engage in review of the guidelines in fetal health surveillance and operative vaginal delivery.