Abnormalities missed during labour
(07HDC15908, 5 December 2008)

Midwife ~ District health board ~ Maternity care ~ Labour ~ Cardiotocograph ~ Fetal distress ~ Delivery ~ Communication ~ Rights 4(2), 4(5)

A man complained about the care his wife received during labour. The woman did not progress into natural labour on her estimated delivery date. A date for induction was subsequently made, but the woman chose to delay this for a few days. The independent LMC midwife identified no concerns during this period.

The labour started naturally, but progressed slowly, and the woman was transferred to the delivery unit at the hospital because she was becoming distressed. The midwife and clinical staff agreed that the woman should be managed as a high-risk patient because she was post-mature. An epidural and Syntocinon were subsequently commenced on agreement by the clinical team, but the care was not handed over to the clinical team.

Throughout the day the midwife noted some decelerations on the cardiotocograph (CTG), used to measure the fetal heart rate, but considered that these were normal. The obstetric registrar later reviewed the CTG and noted some abnormalities. An emergency delivery was subsequently performed but the baby was born unresponsive and was declared dead.

It was held that the midwife failed to provide services in accordance with professional standards by not carrying out a continuous CTG trace prior to inserting an epidural, by failing to appropriately interpret the CTG, and by failing to adequately document her discussions with the obstetric team. In all these circumstances, the midwife breached Right 4(2). She also breached Right 4(5) by failing to refer the woman's care to the secondary care team.

It was also held that the obstetric team was not adequately informed of any abnormalities in the woman's labour, and therefore had no obligation to initiate a three-way discussion under the referral guidelines. Accordingly, the district health board did not breach the Code.