Consultant obstetrician's failure to recognise CTG abnormalities and to take appropriate action (15HDC01415, 13 October 2017)

Consultant obstetrician ~ District health board ~ Public hospital ~ Twin pregnancy ~ CTG monitoring ~ Right 4(1)

A woman pregnant with twins went into labour at 35 weeks and three days' gestation, and was admitted to the birthing unit at a public hospital.

Continuous CTG monitoring of the twin fetal heart rates (FHRs) was commenced and continued throughout the labour. Between 4pm and 5.30pm the twins were showing some variable decelerations of their FHRs. Syntocinon (a hormone that may be used to induce or to augment labour) was increased on several occasions.

At 5.54pm, Twin 1 was born by forceps delivery. The consultant obstetrician told HDC that because Twin 2's head was high, she decided to increase the Syntocinon infusion again to increase the frequency of contractions. At 6.03pm, the membranes of Twin 2 were ruptured. At 6.05pm, a deceleration of Twin 2's FHR was noted as being down to 66, with recovery to 105bpm. The FHR was then noted to be between 100 and 144bpm until the last recording of 110bpm at 6.31pm.

Twin 2 was born 38 minutes after Twin 1 had been delivered. There was no respiratory effort and no audible heartbeat. Notwithstanding clinicians' and midwives' resuscitation efforts, at 7pm Twin 2 died.

The consultant obstetrician told HDC that although the FHRs were monitored continuously, there were occasions, especially during pushing, on which there was loss of contact with the monitor. As such, this meant that she was unsure of the accuracy of the CTG trace, but they used a fetal Doppler monitor (an ultrasound monitor used to listen to the babies' heart rates).The consultant obstetrician noted in retrospect, the following day: "CTG reassuring throughout labour", and "2nd Stage — No fetal heart concerns".

It was found, however, that there was a failure to recognise CTG abnormalities and to take appropriate action during the second stage of the woman's labour. Accordingly, the Commissioner found that the consultant obstetrician breached Right 4(1) of the Code. Criticism was also made of her limited documentation in this case.

Adverse comment was made regarding the DHB failing to respond appropriately to the adverse events that occurred.

The consultant obstetrician has since retired from practice. It was recommended that, should she return to practice, the Medical Council of New Zealand consider whether a review of her competence is warranted, and report back to HDC. It was also recommended that the consultant obstetrician provide a written apology to the family.

In accordance with the recommendations, the consultant obstetrician provided confirmation of completion of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists Fetal Surveillance course, and the DHB provided an update on the changes it had made.