Fetal and maternal assessment in labour
(15HDC00189, 29 June 2016)

Obstetrician ~ Midwife ~ Birthing clinic ~ Uterine hyperstimulation ~ Right 4(1)

A woman engaged a private birthing clinic to provide her maternity care. The woman went into spontaneous labour when she was 39+3 weeks' gestation and went into hospital where she was met by the duty midwife who worked for the clinic. The duty obstetrician arrived shortly afterwards and carried out a full assessment, noting that the cervix was fully effaced, 1cm dilated and central, and the fetal head was at station –3. The obstetrician planned to review the woman again in two hours.

Two hours later the obstetrician reviewed the woman as planned. At that time she noted that the fotus was in a potentially undesirable position for delivery and the contractions varied between two and three every 10 minutes. The obstetrician made the decision to commence Syntocinon in an attempt to try and regulate contractions, achieve descent of fetal head, and encourage rotation of the fetal head into a better position for delivery.

The Syntocinon infusion was subsequently commenced at 2.04pm. The midwife noted changes in the fetal heart rate (FHR) variability and then a deceleration down to 70bpm and turned off the Syntocinon infusion. At that time she noted the woman's contractions continued to be "slightly irregular".

After a discussion with the obstetrician the midwife turned the Syntocinon back on at a reduced infusion rate. The woman then began feeling rectal pressure, and the midwife performed a vaginal examination, noting that the cervix was 6–7cm dilated and the fetal head was at station –1. The FHR was 151bpm and contractions were documented to be six every 10 minutes. The midwife turned down the Syntocinon infusion.

A short time later the obstetrician reviewed the CTG, noting that the contractions were still irregular with four to five every 10 minutes. 45 minutes later the obstetrician noted that the CTG was showing decreased FHR variability. She performed a vaginal assessment, noting that the woman was almost fully dilated and that the fetal head was in a better position. The obstetrician then made the decision to proceed with an instrumental delivery owing to the deterioration in the FHR pattern.

The obstetrician commenced a ventouse delivery. The fetal head was delivered after three tractions. Shoulder dystocia was then noted and the obstetrician performed various manipulations to deliver the shoulders, and, subsequently, the baby was delivered with good Apgars. Approximately two hours later the baby's condition deteriorated and he was transferred to the neonatal intensive care unit. He was later diagnosed with severe dystonic cerebral palsy disease.

The obstetrician was found to have breached Right 4(1) for continuing the Syntocinon infusion in the presence of a hyperstimulated uterus, and for her failure to recognise that this was the likely cause of the FHR abnormalities.

The midwife was found to have breached Right 4(1) for failing to comply with the DHB's policies and guidelines in relation to the Syntocinon infusion, and by failing to

recognise the clinical concerns and request the obstetrician's assessment in person. Criticism was also made of the failure by the midwife to document her discussions with the obstetrician, including the rationale for the decision to recommence the Syntocinon.

The birthing clinic was not found to have breached the Code.

Both the obstetrician and midwife have undertaken, or agreed to undertake, further training relating to fetal and maternal assessment in labour. The midwife has also undertaken further training on clinical documentation. Both the midwife and obstetrician agreed to provide a letter of apology.