Care provided during labour to a woman with diabetes (12HDC00932, 21 February 2014)

Obstetric registrar ~ Public hospital ~ District health board ~ Labour and delivery ~ Instrumental delivery ~ Support for junior staff ~ Rights 4(1), 4(4)

A man complained about care provided to his partner, a 34-year-old woman, during the labour and birth of her first child. The woman had a medical history of type 1 diabetes. When the woman was 36+6 weeks' gestation she went into labour and presented to the delivery suite at the hospital.

Because of slow progress the woman was started on Syntocinon to help speed up her labour. The woman also had an epidural for pain.

Because of changes on the CTG trace the on-call registrar was called. The registrar noted the changes on the CTG which he considered were indicative of fetal compromise. The registrar discussed the options with the woman and her partner, and the decision was subsequently made to deliver the baby by instrumental delivery.

The registrar commenced the delivery using a ventouse on the ward. After five traction attempts the head was noted to be crowning, and the ventouse detached. The registrar subsequently converted to a forceps delivery, and the baby was delivered with one traction.

The baby initially required respiratory resuscitation, but she responded well. However, approximately two hours later, the baby was noted to be displaying unusual movements and was transferred to the Neonatal Intensive Care Unit. The baby continues to be followed up by the paediatric team at the hospital, and still has some weakness down her left side. It is too early to accurately assess the extent of any developmental delay.

It was held that the registrar failed to recognise the complexity of the woman's presentation, including that she had type 1 diabetes, was small in stature, the baby was large, and the baby's head was positioned in a high transverse position, and the registrar made a series of poor clinical decisions.

The registrar failed to provide services with reasonable care and skill and breached Right 4(1) for: failing to assess the situation adequately; proceeding with an instrumental delivery without recognising the complexity of the woman's presentation; and for continuing with an instrumental delivery rather than converting to a Caesarean section when delivery was not imminent. For failing to contact the on-call consultant and making the decision to proceed with an instrumental delivery on the ward rather than in the operating theatre, the registrar breached Right 4(4).

While the registrar had an individual responsibility to provide the woman with an adequate standard of care, the DHB did not have a culture that sufficiently supported the registrar, and essentially placed the responsibility on more junior staff to recognise the extent of their own expertise. Accordingly, the DHB breached Right 4(1) for failing to provide services with reasonable care and skill.