# Care provided during labour to patient with large baby (09HDC01592, 31 January 2012)

*Obstetric registrar ~ Midwife ~ District health board ~ Maternity Care ~ Monitoring ~ Care and skill ~ Professional standards ~ Rights 4(1), 4(2)*

At 37 weeks gestation, a growth scan revealed that a woman's unborn baby was large for gestational dates. The lead maternity carer (LMC) consulted a specialist and delivery at hospital was recommended. The woman went into spontaneous labour and was assessed by the locum midwife because her LMC was on leave. Following assessment, the midwife recommended transfer to hospital.

A CTG was commenced when the woman arrived at the hospital. The midwife noted concerning features on the CTG and called the obstetric registrar for review at 2.40am, 4.10am, 4.20am, and 6am. Following the 4.20am review the obstetric registrar noted a "suspicious but not pathological pattern" on the CTG which he considered to be due to maternal dehydration. The obstetric registrar identified no other concerns and was satisfied that everything was progressing normally.

The hospital midwife was aware that meconium had been present after the woman's membranes were ruptured. She remained concerned about the CTG readings. Despite not being reassured by the registrar's assessment and feeling "fearful of the outcome of the delivery", the midwife did not contact the on-call consultant.

At 7.05am, the baby's head was delivered but the delivery was obstructed by shoulder dystocia. An emergency call was made and after approximately five minutes the baby was born. Resuscitation was commenced but the baby's response was not favourable. The baby was transferred to a specialist neonatal unit but died a short time later.

It was held that the hospital midwife acted appropriately in consulting with the duty obstetric registrar when she was concerned about the CTG trace. However, the hospital midwife failed to escalate matters further when she remained concerned. In not doing so, the midwife failed to provide the expected standard of services to the mother and her unborn child, and was held to have breached Right 4(1).

The obstetric registrar was also held to have breached Right 4(1) because he misread the CTG trace and failed to take appropriate clinical action. In addition, he breached Right 4(2) by failing to follow the relevant policies on CTG recordings.

Adverse comment was made about a breakdown in the DHB's booking system and the existence of a hierarchy at the DHB which may have got in the way of good team work and the best interests of the mother and baby.

The antenatal care provided by the LMC and locum midwife was held to be appropriate.