Monitoring and care during labour
(12HDC00481, 11 June 2014)

Midwife ~ Obstetrician ~ District health board ~ Risk factors ~ Labour ~ CTG monitoring ~ Information ~ Informed consent ~ Resuscitation ~ Delayed call to NNU ~ Professional standards ~ Rights 4(1), 4(2), 4(5), 6(1)(b), 7(1)

A woman was pregnant with her first child and her antenatal care was shared between her general practitioner and her Lead Maternity Carer (LMC), an obstetrician and gynaecologist. The nature of the shared care arrangement was somewhat unclear, and the woman saw her LMC only three times during her pregnancy.

The woman was admitted to hospital at midday, and was assessed and monitored with a CTG, the results of which were reassuring. At 5.30pm the woman's waters were artificially ruptured with the liquor stained with old meconium. As the evening progressed, the woman laboured in a birthing pool and continued to be monitored, but no further CTG monitoring occurred.

At 11pm the midwife (employed by the DHB) came on duty and took over the woman's care. At that time the woman had a raised temperature and had started to feel unwell. The midwife instituted cooling measures, and the woman's temperature returned to normal by 11.30pm. However, the woman had a raised pulse that was within the same range as the fetal heart rate (FHR), and had begun to feel tired and thirsty.

Between 12am and 1am, the woman's condition deteriorated. In the context of the woman having had a raised temperature and a pulse that was significantly above normal limits (and within the same range as the FHR), there was a raised FHR and copious amounts of meconium stained liquor was draining. The midwife called the Neonatal Unit (NNU) at 1.10am to advise of the possibility of being called for resuscitation following delivery, but did not contact the LMC obstetrician or institute CTG monitoring. At 2.20am the woman's temperature was again raised. At 2.37am, following further assessment, the midwife contacted the LMC obstetrician.

At 2.50am the LMC obstetrician arrived. He considered an instrumental or forceps delivery but discounted those options, partially because of an unfounded assumption that the woman did not want obstetric input into her care. At 3.20am a Syntocinon infusion was commenced in the continued absence of CTG monitoring and, at 3.50am, the baby was born — pale, floppy, and covered in meconium. At 3.55am the LMC obstetrician consented to the midwife's third request to call the NNU, once his own attempts to resuscitate the baby had failed. The baby was transferred by air ambulance to another hospital, where she was treated for hypoxic ischaemic encephalopathy, seizures and suspected sepsis, and has since experienced significant health difficulties and developmental delay.

It was held that the LMC obstetrician did not provide services to the woman or the baby with reasonable care and skill, failed to adhere to professional standards, did not provide the woman with information that a reasonable consumer in her circumstances would have expected to receive, and failed to obtain informed consent. The LMC obstetrician was found in breach of Rights 4(1), 4(2), 6(1)(b) and 7(1).

The midwife did not provide services to the woman with reasonable care and skill and failed to adhere to professional standards, and was found in breach of Rights 4(1) and 4(2).

The LMC obstetrician and the midwife were referred to the Director of Proceedings. The Director decided to institute proceedings in both cases.

Multiple individual failures at the hospital suggested that there were inadequate systems in place to ensure that women received safe care. Some of the guidelines in place at the hospital's labour ward were suboptimal and/or not routinely complied with, and a culture existed that compromised the standard of care provided in this instance. Overall, the DHB did not provide services to the woman and the baby with reasonable care and skill, and did not ensure quality and continuity of services. The DHB was found in breach of Rights 4(1) and 4(5).