Communication during labour
16HDC01786 & 18HDC01259, 11 October 2019

District health board ~ Obstetric registrar ~ Ventouse ~ Haemorrhage ~ Consent ~Consultant support ~Right 4(1)

A woman in her twenties was pregnant with her first baby. The pregnancy proceeded normally until her lead maternity carer, a registered midwife, referred her to the public hospital because of decreased fetal movement.

The woman was admitted for an induction of labour. At 2.30am an oxytocin infusion was commenced. At 1.30pm, the midwife conducted a vaginal examination (VE) and recorded that the woman was fully dilated. The woman commenced pushing at 1.40pm. At 2.10pm, the woman was moved to the lithotomy position to assist effective pushing. However, there was no further descent of the baby's head, and the senior obstetric registrar was informed of the lack of progress. The CTG was normal.

No fetal head was palpable abdominally, and a VE found that the woman was fully dilated and the baby's position was right occipito-transverse/right occipito-posterior (ROT/ROP), central caput and mild moulding were present, and the station was +1.

The obstetric registrar discussed the findings with the woman and her husband, and explained the options of an attempted rotation of the fetal head and continued pushing, or of an instrumental delivery. The woman verbally consented to manual rotation of the fetal head, but that was unsuccessful.

The obstetric registrar decided to deliver the baby by ventouse, and the woman verbally consented to that. The couple said that the alternatives and risks were not discussed with them prior to the obstetric registrar deciding the delivery method.

At 3.15pm, the obstetric registrar applied a posterior ventouse cup and began the instrumental delivery. Following the first pull, the baby began to descend. During the fourth contraction, the obstetric registrar cut an episiotomy. The head had descended and rotated to an occipito-anterior position. The obstetric registrar considered that delivery was imminent, so she did not call the consultant. Following the episiotomy, two further pulls were required, and a total of six pulls were needed to deliver the baby's head. Firm traction was required to deliver the shoulders. The baby was born at 3.37pm, extremely white and floppy.

The placenta showed no signs of separating after birth and, after 30 minutes, the obstetric registrar transferred the woman to theatre for further analgesia and manual removal of the placenta with repair of the episiotomy.

The baby was noted to have a heart rate greater that 100bpm, a superficial scalp laceration approximately 6cm in length, and a soft swelling of her scalp approximately 1.5cm in height under the location where the cup had been applied. A subgaleal haemorrhage was queried.

The baby had no spontaneous respiration, and was resuscitated in the Delivery Suite. After five minutes she was breathing spontaneously, but rapidly with increased effort. A venous cord blood gas showed a baseline haemoglobin of 145g/L and mild acidosis, with an elevated lactate level.

The baby was transferred to the Neonatal Intensive Care Unit at 4pm, and was seen by a paediatric consultant at around 4.30pm. The consultant said that when he carried out his assessment, a subgaleal bleed was apparent immediately.

Following a difficult catheterisation, the baby was resuscitated with normal saline. Blood gas tests showed severe metabolic acidosis, secondary to hypovolaemia. The baby was administered blood and blood products during the evening, but continued to bleed, and required more than three and half times her total blood volume before she was stabilised.

The baby showed evidence of renal impairment, which was likely to be an ongoing issue. The baby's weight gain and blood pressure control improved, and she was discharged two months later.

Findings

It was found that the district health board did not provide adequate guidance to staff in relation to seeking consultant support when undertaking potentially difficult deliveries, and that a number of staff did not respond sufficiently promptly and effectively to the baby's subgaleal haemorrhage. Accordingly, the district health board failed to provide services to the woman and the baby with reasonable care and skill, and breached Right 4(1).

Adverse comment is made that the obstetric registrar did not fully discuss with the woman the risks of an instrumental delivery, and the option of a Caesarean delivery. Although there was no reason to recommend a Caesarean section, it was important that the woman understood the reasons for recommending a vaginal delivery with ventouse as the preferred option.

Recommendations

It was recommended that the obstetric registrar undertake refresher training on informed consent.

The district health board agreed to undertake the following recommendations:

a) Review the "Practice Recommendation on the Management of Neonatal Subgaleal Haemorrhage" with a view to adopting the guideline or preparing a guideline specific to the district health board.
b) Review the implementation of the protocol "When to call the SMO", to ascertain whether registrars call for support from consultants for all instrumental rotational deliveries.
c) Include in the policy "Responsibilities and the limits of delegation of responsibilities to RMOs" a statement about what to do if any concerns arise while undertaking procedures.

It was also recommended that the DHB provide an apology, and review the effectiveness of its "Speaking up for Safety" programme and the pathway to follow in serious events with adverse patient outcomes.