Supervision of registrar during a labour and delivery (13HDC00093, 17 December 2014)

Obstetrics registrar ~ Obstetrics consultant ~ Lead maternity carer ~ Public hospital ~ District health board ~ Communication ~ Supervision ~ Training and orientation ~ Policies and procedures ~ Right 4(1)

A woman was admitted to a public hospital for Prostin priming at 40 weeks plus 9 days' gestation. An induction of labour (IOL) was planned for the following day, but that evening the woman went into labour.

At 11.17pm cardiotocography monitoring showed deep fetal heartbeat decelerations, and at 11.55pm the woman was reviewed by the obstetrics registrar. The obstetrics registrar rang the on-call obstetrics consultant. The doctors have different recollections of the telephone conversation, but both recall that the plan was to attempt a trial of forceps and, if unsuccessful, proceed to a Caesarean section. The obstetrics registrar understood that she was to carry out the procedures unsupervised, while the obstetrics consultant understood that he was to attend the trial of forceps and, if necessary, the Caesarean section.

At 12.40am the obstetrics registrar commenced a trial of forceps unsupervised, which was unsuccessful. The obstetrics registrar then proceeded with the Caesarean section unsupervised, but was unable to deliver the baby, whose head was impacted in the pelvis.

The obstetrics consultant had arrived in the delivery suite when the obstetrics registrar commenced the above procedures, but was intercepted on his way to the woman by another obstetrics emergency.

At approximately 1am the obstetrics consultant attended the woman, and was able to flex and deliver the baby's head. At 1.02am the baby was born, white and floppy, with the umbilical cord wrapped around her neck and shoulder. It took the neonatal resuscitation team five and a half minutes to resuscitate the baby, who was then transferred to the Neonatal Intensive Care Unit. The baby was taken off life support and, sadly, passed away, having sustained hypoxic ischaemic encephalopathy secondary to perinatal hypoxic ischaemic insult.

It was held that the hospital policy for obstetric surgery and procedures triage and the hospital senior medical officer cascade process were not followed. Furthermore, the orientation and induction of the obstetrics registrar was not appropriate, in that the obstetrics registrar was unaware of the level of supervision she required. For not ensuring that its obstetric policies and procedures were followed, and for failing to provide appropriate orientation, induction and supervision for the obstetrics registrar, the DHB breached Right 4(1).

The obstetrics consultant was responsible for supervising the obstetrics registrar. For inappropriate supervision of the obstetrics registrar, the obstetrics consultant was found in breach of Right 4(1).

The obstetrics registrar inappropriately attempted an unsupervised trial of forceps and a Caesarean section. However, as the obstetrics registrar was guided by the advice of her consultant, her actions were not found to be in breach of the Code.

Adverse comment was made about the lead maternity carer, who should not have proceeded with the woman's IOL until the plan had been discussed with an obstetrics consultant.