Monitoring of woman in labour; resuscitation of infant
16HDC00977, 25 June 2019

District health board ~ Lead maternity carer ~ Midwife ~ Assessment ~ Monitoring ~Fetal heart rate ~ Right 4(1)

A woman went into labour and was advised by her lead maternity carer (LMC) to meet her at the public hospital. When the woman arrived at 2.20pm she was examined by a core midwife. The LMC arrived at 2.58pm. However, neither midwife carried out an initial assessment of the woman's vital signs, and they were recorded only once during her labour.

The LMC had previously established that the woman was positive for Group B Streptococcus (GBS), and the appropriate prophylactic antibiotics were administered at 6.10pm.

The fetal heart rate (FHR) was recorded from 3.13pm to 9.06pm. At 9.06pm, the LMC recorded that she was having difficulty hearing the FHR. She pressed the "staff assist" button, and two core midwives responded. The first core midwife examined the woman and listened to the FHR. A CTG was not used to assess the FHR. At 9.20pm, the first core midwife called the on-call obstetrician, who recommended that labour continue.

The labour progressed, and the midwives continued to have difficulty hearing the FHR. At 9.49pm, the first core midwife attached a CTG, but none of the midwives present in the room monitored the results. At 10.07pm, the second core midwife noticed the lack of variability in the FHR on the CTG. The obstetrician was called, but the on-call paediatrican was not asked to attend. At 10.10pm, the baby was born with the obstetrician's assistance. The baby was white and floppy, and was making no respiratory effort.

The core midwives commenced emergency resuscitation using a Neopuff. However, the device did not function, owing to a displaced tube, and resuscitation continued using an Ambu-bag. An instruction was given to activate the emergency bell, but instead the staff assist button was pressed. Hospital staff responded, and at 10.16pm the emergency bell was pressed. There were further delays in contacting the on-call paediatrician. The paediatrician arrived at the delivery suite at 10.42pm, and assisted with resuscitation and transferred the baby to the specialist care baby unit (SCBU) at 11pm.

Intensive care continued in SCBU. The baby was transferred to a ventilation machine, but it was not set properly. The neonatal intensive care unit team at a main centre hospital was called, and arrived at 2.15am. The ventilator was adjusted to the correct setting, and the baby was transferred to the main centre hospital. However, subsequently the baby's life support was withdrawn, and the baby died.

Findings

The Deputy Commissioner was critical that the LMC did not undertake the following:

- Assess the woman at home when labour commenced, in view of her GBS status;
- Administer antibiotics within the appropriate timeframe;
- Check that initial maternal observations had been undertaken, and carry out further appropriate maternal monitoring, including over the period when the woman was in the birthing pool;
- Auscultate and record the FHR adequately between 3pm and 9.50pm;

- Recognise that a CTG was necessary when she was having difficulty auscultating the FHR;
- Observe the CTG and call for obstetric support before 10.07pm;
- Take responsibility for ensuring that a paediatrician was present at the birth;
- Communicate clearly with the core midwives, and take responsibility for communicating with the obstetric and paediatric teams; and
- Ensure that full and accurate clinical records were kept.

It was held that the LMC failed to provide the woman with services with reasonable skill and care and, as a result, breached Right 4(1).

The first core midwife had a responsibility to advocate for adequate monitoring of the FHR, and after commencing the CTG she should have recognised and responded to the fetal distress. It was considered that by failing to do so, the midwife did not provide the woman with services with reasonable care and skill and, as a result, breached Right 4(1).

The second core midwife was not found in breach of the Code.

A number of concerning features were noted about how the woman and the baby were cared for by multiple DHB staff:

- The core midwives failed to advocate for the adequate monitoring of the FHR and, after commencing a CTG, failed to recognise and respond to the fetal distress;
- Staff failed to call the paediatrician prior to the baby's delivery and, when they did attempt to call the paediatrician, they called the wrong number;
- The staff assist bell was pushed instead of the emergency bell when emergency assistance was required;
- The switchboard failed to make contact with the paediatrician or to leave him a message, which resulted in an additional delay in the arrival of the paediatrician;
- The equipment required for an emergency resuscitation in the delivery room was not fit for immediate use; and
- The ventilator was set up incorrectly.

These failures in the care, communication systems, and emergency equipment at the DHB resulted in delays in providing care to the woman and the baby. Accordingly, the DHB failed to provide services with reasonable skill and care, and breached Right 4(1).

Recommendations

It was recommended: (a) that the Midwifery Council of New Zealand consider whether any further review of the LMC's competence was required; (b) that should the first core midwife apply to return to midwifery practice, the Midwifery Council of New Zealand consider whether a competence review is warranted; (c) that both the LMC and the first core midwife provide a written apology to the woman and her family; and (d) that the DHB report on its communication systems for maternity emergencies, and the frequency of the fetal surveillance education being providing to its staff and to LMCs.