Care of pregnant woman with high risk factors
16HDC00144, 19 December 2018

District health board ~ Registered midwife ~ Senior medical officer ~ Obstetric registrar ~ Risk factors ~ Information ~ Rights 4(1), 6(1)

During the antenatal care of a woman, her lead maternity carer, a registered midwife, did not recommend that the woman attend a consultation with an obstetrician owing to risk factors of a high body mass index and an inconclusive Hepatitis C status. The woman's waters broke when she was at 39 weeks and two days' gestation. She was admitted to the birthing suite of a public hospital and cared for initially by a back-up midwife, then overnight by an obstetrics registrar and the hospital core midwives.

The woman's risk factors were not handed over to the on-call registrar or the on-call senior medical officer at the morning handover. The registrar and the senior medical officer agreed that syntocinon could be commenced for poor progress if required.

The midwife commenced syntocinon at 10.20am after consulting with the registrar. At 11.10am, the midwife noted an increase in the fetal heart rate, so attempted to contact the registrar. There were issues in getting hold of the registrar to review the woman. The registrar attended the woman at 12pm and planned for a category 2 Caesarean section owing to fetal distress. The registrar discussed this plan with the senior medical officer, and the senior medical officer agreed with it. At the time, the senior medical officer was conducting a clinic elsewhere in the hospital.

Attempts were made to insert a spinal anaesthetic for the Caesarean section, but these were unsuccessful. The registrar contacted the senior medical officer at 1.20pm to advise that a general anaesthetic was required, and the senior medical officer agreed with this decision. The Caesarean section proceeded under general anaesthetic. Tragically, the baby was stillborn.

Findings
It was held that the midwife failed to advise the woman of the recommendations in the Ministry of Health's Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines) in relation to her obesity and inconclusive Hepatitis C status. This was information that a reasonable consumer would expect to receive in the woman's circumstances. Accordingly, the midwife breached Right 6(1). The district health board (DHB) had a responsibility to provide services to the woman with reasonable care and skill. It failed to do so, because it did not create an environment that ensured that resident medical officers were supervised appropriately; its handover practice was suboptimal; there were deficiencies in internal communication; and its policy relating to syntocinon was inappropriate. For these reasons, it was held that the care provided to the woman was seriously compromised, and the DHB breached Right 4(1).

The Commissioner was very concerned that the registrar was left to manage the woman's case without direct senior medical officer oversight. However, the

Commissioner also considered that the registrar was by all accounts a competent second-year registrar, and therefore should have been able to identify the extent of fetal compromise and correctly assess the level of urgency required for delivery, particularly given the woman's presenting risk factors.

It was held that as the specialist responsible for supervising the registrar, the senior medical officer must bear some responsibility for the deficiencies in the care provided to the woman. The senior medical officer should have done more to satisfy himself that the registrar was not continuing to manage a situation where he was potentially out of his depth.

It was recommended that the midwife undertake training on informed consent and the Referral Guidelines, and provide a written apology to the woman.

It was recommended that the DHB review its handover process, implement daily consultant-led ward rounds, take steps to ensure that staff are aware of the on-call registrar mobile phone, and confirm that the following implemented changes remain in place: the associate clinical midwifery manager role, cardiotocograph (CTG) interpretation cards, and weekly CTG meetings. These recommendations were met.

It was also recommended that the DHB provide a written apology to the woman and that the registrar undertake training on fetal surveillance.