Care of woman in labour with abnormal CTG
17HDC00384, 10 December 2018

Obstetrician ~ District health board ~ Midwife ~
Abnormal CTG ~ Caesarean section ~ Right 4(1)

In 2015, a woman pregnant with her second baby was admitted to a public hospital for a maternal and fetal post-dates check, which included cardiotocography (CTG) monitoring. Two years previously, the woman had delivered her first baby by emergency lower segment Caesarean section owing to a failed forceps delivery.

When the CTG was commenced, the woman's lead maternity carer (LMC), a registered midwife, noted a variable fetal heart rate (FHR), no accelerations, and three late decelerations. She contacted an obstetrician, and the woman was reviewed by the obstetrician throughout the course of the day. He offered the woman a Caesarean section, which he recommended, or an induction of labour.

The obstetrician accepts that he did not advise the woman that a Caesarean section was the only appropriate course of action. He stated that he needed to consider the woman's "very strong preferences".

CTG monitoring continued into the evening, and the obstetrician reviewed the woman one more time. Although the fetal heart rate showed decelerations, the obstetrician carried out a Cook's catheter induction. His plan was to stop CTG monitoring to allow the woman to mobilise, and for another CTG to be commenced at 10pm. The obstetrician went home after this, and said that he asked to be called back at 10pm. This was not documented and he was not called. At handover, all four hospital-employed core midwives working on the shift viewed the CTG and made a decision to discontinue the trace. The decision was made because the CTG had not deteriorated and was no different from previous CTGs.

In the early hours of the next morning, the core midwife recommenced CTG monitoring and documented that it was non-reassuring. After turning the woman onto her left side to try to improve the CTG, the obstetrician was called in to review her. He arrived at 4am, and at 4.40am documented that there had been a prolonged period of reduced variability and that he had ruptured the woman's membranes and found meconium-stained liquor present. The obstetrician noted his plan to continue the CTG monitoring and to review the trace again in 15 to 30 minutes.

At 5.20am, the obstetrician decided to proceed to an emergency Caesarean section. The baby was delivered at 6.55am in poor condition, with no heartbeat and no respiratory effort, and immediate resuscitation was carried out. Later, the baby was diagnosed with multiple co-morbidities and hypoxic ischaemic encephalopathy, and subsequently passed away.

Findings

The obstetrician failed to provide the woman services with reasonable care and skill, including incorrectly interpreting the CTG when the woman was admitted, and not

recommending a Caesarean section as the only appropriate course of action. When the obstetrician reviewed the woman again, the CTG continued to be abnormal, but he decided to proceed with an induction of labour. Overall, there was a concerning delay in delivery of the baby, and the obstetrician was found to have breached Right 4(1).

The woman's care by DHB staff is concerning for a number of reasons. Over an extended period of time, four midwives failed to comply with the RANZCOG *Intrapartum Fetal Surveillance Clinical Guideline* adopted by the DHB as its policy. In addition, at no point during the woman's admission did midwifery staff think critically about the abnormal CTG or challenge the obstetrician's management plan and advocate for the woman. The DHB should have had in place a system to ensure that staff were aware of, and complied with, its policies and procedures, and a culture that supported staff to voice concerns and ask questions.

Ultimately, the DHB is responsible for the failings of multiple staff and, as such, it did not provide services to the woman with reasonable care and skill. Accordingly, the DHB breached Right 4(1).

Recommendations

It was recommended that the obstetrician provide the woman with a formal written letter of apology for his breach of the Code.

It was recommended that the DHB:

a) Provide the woman with a formal written letter of apology for its breach of the Code.

b) Update HDC on the progress made in relation to increasing the number of employed obstetricians based at the public hospital.

c) Consider developing local policies around intrapartum fetal surveillance in accordance with RANZCOG guidelines; implementing an updated CTG interpretation sticker and providing training on the use of that sticker; and introducing mandatory fetal surveillance updating for all staff who work in maternity services.

d) Use this investigation (anonymously) as a case study to provide training for obstetric and midwifery staff.