

## **Monitoring of maternal and fetal well-being during labour (10HDC00996, 11 January 2013)**

*Midwife ~ District health board ~ Maternity Care ~ CTG ~ Appropriateness of care ~ Professional standards ~ Communication ~ Rights 4(1), 4(2), 4(5)*

A woman was admitted to hospital for induction of labour. Her care was initially managed by the hospital's core midwifery staff and she was provided with routine care and monitoring in accordance with the district health board's (DHB) induction of labour guidelines.

The morning after labour was induced, the fetal heart rate increased and a cardiotocogram (CTG) was commenced. The on-call consultant obstetrician reviewed the CTG trace shortly after, and considered it showed normal fetal activity. That evening, the woman's waters broke and her lead maternity carer (LMC) was called to attend. The LMC assessed that woman was in early labour and the woman was given sedation to help her rest overnight.

The following morning, the woman requested an epidural. The LMC was not certified to administer epidurals and stated that she handed over the woman's care to the hospital midwives. The LMC left the hospital at 6am. The hospital midwife caring for the woman monitored the fetal heart rate by CTG, assessing it as "overall reassuring".

Around two hours later, a senior midwife noted that the CTG was monitoring the maternal heart rate and alerted the hospital midwife. However, when the senior midwife returned to the room approximately an hour later, she saw that the CTG was still monitoring the maternal heart rate. The senior midwife repositioned the CTG and saw that the fetal heart rate was abnormal. The woman's labour was expedited however, sadly, the baby died soon after birth.

It was held that the LMC failed to appropriately monitor maternal and fetal well-being and breached Right 4(1). She also failed to take appropriate steps to arrange for an epidural or hand the woman's care over to the secondary care team, and breached Right 4(5).

The hospital midwife failed to use appropriate equipment, correctly read the CTG and request assistance when necessary and breached Right 4(1). Her failure to seek assistance impaired the woman's continuity of care and, accordingly, she breached Right 4(5).

The senior midwife failed to provide adequate supervision to the hospital midwife, and failed to take adequate steps to monitor the maternal and fetal well-being when she became aware that the CTG was monitoring the maternal heart rate instead of the fetal heart rate. The senior midwife breached Right 4(1). She also failed to call for assistance when she became aware that the baby was at risk and an emergency delivery was required, and breached Right 4(2).

The DHB failed to take reasonable steps to ensure that services of an appropriate standard were provided to the woman and breached Right 4(1). For failing to have systems in place to ensure that services of an appropriate quality and continuity were provided, the DHB also breached Right 4(5).