Care provided to pregnant woman with cardiac problems (05HDC13401, 29 June 2007)

Public hospital ~ District health board ~ General practitioner ~ Midwife ~ Obstetrician ~ Cardiologist ~ Maternity services ~ Death of mother and baby ~ Informed consent ~ Communication between subspecialties ~ Communication of treatment options ~ Documentation and formulation of management/treatment plans ~ Rights 4(4), 4(5)

A woman who had congenital aortic stenosis and had had an aortic valve replacement in 1997 had her first baby without complications in 1999. In 2004, she became pregnant with her second child. Her first cardiac assessment during the pregnancy was not until 15 weeks' gestation, and at 21 weeks she was found to have significant redevelopment of aortic stenosis. At her further cardiac assessment, at 25 weeks, she was found to have signs of cardiac failure and was admitted to the antenatal ward at a hospital in a main centre.

On admission, early delivery was considered. The woman's condition stabilised after admission, and the plan was to deliver the baby and possibly perform valve replacement surgery, depending on her condition. During her admission, she was seen frequently by the cardiology team, maternal fetal medicine team, and cardiothoracic team, but no formal management plan was documented, and no plan apart from "expectant management" was considered.

The woman's condition deteriorated suddenly and, despite an emergency Caesarean section and heart surgery, tragically, both she and her baby died.

It was held that the public hospital did not have an effective system to ensure a co-ordinated approach to the woman's care. There were three options available to the woman when the significance of her cardiac condition became known. She was not adequately informed about two options — termination of pregnancy or earlier surgery. The third, most risky option of expectant management appears to be the only option that was meaningfully discussed, and that was the path that was ultimately taken.

It was held that the woman's care was jeopardised by the failure of the clinical teams to plan and coordinate her treatment. Corporate responsibility for this failure lay with the DHB. Accordingly, it was found to have breached Rights 4(4) and 4(5).