Delay in requesting assistance when fetal heart rate inadequate (11HDC00521, 10 June 2013)

Midwife ~ Monitoring ~ Fetal heart rate ~ Communication ~ Documentation ~ Right 4(1)

This case concerns the adequacy of care provided to a woman during the labour and delivery of her first child. In the evening, the woman, accompanied by her husband, was admitted to the public hospital as she had started having contractions. A registered midwife was assigned to her care, and undertook an assessment at 11.20pm. The fetal heart rate (FHR) was adequate. The woman was assessed to be in latent labour, and the midwife suggested that the couple might wish to return home. They decided to stay in hospital.

At 12.45pm, the midwife documented that the woman's contractions were approximately four minutes apart. The midwife left the delivery room at 1.30pm, instructing another midwife to respond if the couple rung the call bell.

Sometime between 1.30am and 2am, the man rang the call bell as his wife was unable to cope with the pain. Another midwife responded initially and began to run a bath for the woman. The woman's assigned midwife returned to the room and listened for the FHR using a Sonicaid. The notes record that the FHR was 102bpm at 2.10am. The midwife then decided to commence a cardiotocogram (CTG) and a trace at 2.15am showed a potential heart rate between 60 and 105bpm. One of the transducers was not working, so the midwife left the room to retrieve a second transducer and to seek assistance from the assistant charge midwife (ACM).

The midwife and ACM returned to the room. The ACM first attempted to listen to the fetal heartbeat while the woman was standing, but could not hear one. The ACM then asked the woman to lie down and palpated her abdomen. The ACM then attempted to find a fetal heartbeat with the CTG machine but could not. She left the room, and paged the obstetric registrar at 2.31am.

The obstetric registrar arrived between 2.35 and 2.44am. He ruptured the membranes and applied a fetal scalp electrode but no fetal heartbeat was detected. He also confirmed the absence of a fetal heartbeat with an ultrasound scanner. The obstetric registrar expedited delivery with forceps and the baby was born at 2.50am with no audible heartbeat. Sadly, immediate resuscitation was unsuccessful.

It was held that the midwife failed to take appropriate action as soon as she suspected that the FHR was inadequate. In addition, she communicated poorly with the couple, did not carry out adequate reviews in accordance with an individual assessment of the woman's needs, and did not complete documentation to an acceptable standard. The combination of these factors pointed to a pattern of inadequate care. By failing to provide services with reasonable care and skill, the midwife breached Right 4(1).

It was also held that the ACM failed to request medical assistance sufficiently promptly. Her documentation was brief and did not describe her examinations. By delaying contacting the obstetric registrar for at least nine minutes and not completing documentation to an acceptable standard, she did not provide services with reasonable care and skill and, accordingly, breached Right 4(1).

The midwives' failures to take the appropriate action in response to a situation of possible fetal distress are fundamental clinical failures which cannot be attributed to any alleged systemic deficiencies at the DHB. Accordingly, the DHB was not liable for the failings of the midwives.