Care during labour of post-dates woman who had risk factors (13HDC00843, 10 March 2015)

Obstetric registrar ~ Obstetrician ~ Midwife ~ Public hospital ~ District health board ~ Intrapartum care ~ Syntocinon ~ Fetal heart rate ~ Rights 6(1)(b), 4(1)

A woman, who was pregnant with her third child, was scheduled for an induction of labour (IOL) because she was post-dates. This was booked for 10 days after her due date.

On the day of the IOL the woman was assessed by the on-call registrar who performed an artificial rupture of membranes. The baby was noted to be in a face presentation. Later that day Syntocinon augmentation was commenced. A short time later the LMC midwife was unable to locate a fetal heart rate (FHR). The Syntocinon was turned off and the registrar was called. The registrar noted FHR decelerations and that the baby was now in a brow presentation. The decision was made to perform a Caesarean section.

Prior to transfer to theatre the hospital midwives assisting in preparing the woman again had difficulty detecting and recording the FHR. The woman arrived in theatre and the anaesthetist inserted a spinal block. During this time the FHR was not monitored. A midwife then attempted to locate the FHR by auscultation with a hand-held Doppler but was unable to locate it. The registrar performed an ultrasound scan and confirmed that no fetal heartbeat was present.

After discussion with the parents, the registrar made the decision to perform a Caesarean section. Sadly, the baby was stillborn.

It was held that for failing to provide the woman with information about the option of performing a Caesarean section and the risks of Syntocinon before it was commenced, the registrar breached Right 6(1)(b). The registrar breached Right 4(1) by not consulting with the on-call consultant after her second assessment, by making the decision to commence Syntocinon, and by failing to reassess the woman's uterine activity adequately and to ensure monitoring of the FHR in the perioperative area.

The registrar was criticised for her failure to proceed with a crash Caesarean section when no fetal heartbeat was detected initially, but this failure did not warrant a finding that she breached the Code.

It was held that the DHB failed to have a system in place that ensured policies and procedures were followed. Staff failed to think critically, and important information was not communicated effectively. Furthermore, the DHB must take some responsibility for the registrar's decision-making in this case. The DHB failed to provide services to the woman with reasonable care and skill and, accordingly, breached Right 4(1).

The LMC midwife's recommendation to commence Syntocinon was criticised. However, this was ultimately an obstetric decision, and the midwife's involvement in the decision did not warrant a finding that she breached the Code.