CORONERS INQUEST - DEATH DUE TO HYPOXIC BRAIN DAMAGE FOLLOWING OBSTRUCTED LABOUR - RECOMMENDATIONS FOR NEW HOSPITAL PROCEDURES.

By David Hirsch, Cashman & Partners

On 12 January 1994 a Newcastle coroner handed down his decision from an inquest into the death of a child following an obstructed labour at a large public hospital.

The mother was a small women of Thai origin who had previously given birth to a large (3.77kg) baby. Her second child was expected to be larger. In fact the baby weighed 4.22 kg, in the 97th percentile gestational age. No ultrasound had been done which would have estimated foetal size and weight. The delivery staff included two midwives and an inexperienced intern.

The labour progressed uneventfully until the baby's head presented spontaneously with the umbilical cord wrapped once loosely around the neck. The cord could not be slipped over the baby's head so it was clamped and cut. Due to the disproportion between the size of the baby and the mother's pelvis the anterior shoulder did not deliver with the next contraction. A textbook shoulder dystocia emergency had arisen.

The delivery staff followed the hospital's guidelines for the management of shoulder dystocia. After nine minutes during which time a number of recommended positions and manoeuvres were tried without success, help was finally called.

A senior registrar arrived a minute or so later. He performed the McRoberts manoeuvre (hyperflexion of the maternal legs with knees to the chest) and directed that fundal pressure cease and suprapubic pressure be applied. The baby was delivered about a minute later in very poor condition. She died a month later after life support was removed.

The coroner found that on balance, had McRoberts manoeuvre been applied earlier the baby would have lived.

The coroner accepted that the hospital's guidelines were followed strictly. Still, the delivery staff waited too long before calling for help. He found that the staff wrongly applied the guidelines as if they were predetermined protocol permitting or requiring certain things to be done before emergency help was summoned. He said: "An emergency is an emergency regardless of any protocol."

Recommendations made by counsel on behalf of the family and accepted by the coroner included better training of staff in anticipating and managing obstructed labour and a recommendation that the McRoberts manoeuvre be used as a priority in cases of shoulder dystocia.

These recommendations were ordered to be sent to the NSW Minister of Health for circulation and implementation in all hospitals where babies may be delivered.

Solicitors who are consulted about cases involving injury or death following obstructed labour ought to be aware of these recommendations as they may be evidence of a new standard of reasonable care.

Those interested in a copy of the decision and the recommendations should contact David Hirsch, Cashman and Partners Solicitors, PO Box A266 Sydney South 2000.