Maternity triage: did negligent assessment lead to cerebral palsy?

Andrew Symon reports on the recent case of PXW v Kingston Hospital, which examined a midwife's conduct in relation to assessing a woman in the latent phase of labour

A recent court case in London (PXW v Kingston Hospital) heard that a baby was born with cerebral palsy, allegedly because of a midwife's negligence when assessing the mother in the maternity assessment unit—referred to in court as 'triage'.

The multiparous mother (RXF, who was 39 weeks' pregnant) attended triage at 17:55 on the day in question, having walked more than half a mile to the unit. The midwife who assessed her concluded that she was in early but not established labour, and, following the unit protocol, advised the woman to return home. RXF and her husband left the unit at 18:20.

According to the defence, when RXF returned to the unit at 20:41, she gave:

> ***'A history of more intense contractions since 19:30, good fetal movement, no vaginal loss and no rectal pressure, suggesting that she was still in the active first stage of labour and without any complications.' (McKenna at paragraph 10).***

Having gone to the bathroom to provide a urine sample, RXF quickly called the midwife because her membranes had ruptured; clear liquor was noted. On returning to the assessment room, the midwife attempted unsuccessfully to auscultate the fetal heart. The vertex was first seen at 20:50, the head was born at 20:55, with the body following at 20:57.

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The baby (PXW) was asphyxiated at birth, and two midwives commenced immediate resuscitation. Apgar scores were recorded as two at 1 minute, and four at 5 minutes, when PXW showed 'some respiratory effort and improved perfusion' McKenna at paragraph 13).

On reviewing all the evidence, the obstetric and neonatal experts concluded that established labour had commenced at 19:30 (some 70 minutes before RXF attended the unit for the second time), and that an acute, near total cord occlusion had occurred in the minutes immediately before the baby's birth.

PXW's parents sued on two grounds: firstly that the triage midwife should not have sent RXF home, because then effective monitoring would have begun as soon as labour was fully established and this would have identified fetal heart rate abnormalities. Secondly, the second midwife should have performed fetal heart auscultation as soon as RXF was admitted, and should have performed an episiotomy, requesting obstetric and paediatric help.

Clearly, events moved quickly following RXF's second attendance at the unit, with the fetal head apparently descending rapidly following the membrane rupture. During the court proceedings, the claimant's lawyers dropped the claim against the second midwife, focusing instead on what they asserted should have happened when RXF was seen earlier in triage.

Having concluded that labour was not established, the triage midwife advised RXF to go home and await events. This reflected the unit guideline, which was based on recommendations from the National Institute for Health and Care Excellence (NICE):

> **'[When]** ***a woman … is not in established labour … encourage her to remain at or return home, unless doing so leads to a significant risk that she could give birth without a midwife present or become distressed.'' (NICE, 2014: 20)***

While this appears to exonerate the midwife, an internal root cause analysis investigation cited in court found, among other things, that:

> ***'A full history of assessment of a multiparous woman was not undertaken by the midwife in triage prior to sending the woman home. The woman's transport arrangements were not considered … The communication skills and the advice of the midwife in triage may have influenced the decision of the couple to delay returning to the Maternity Unit.' (McKenna at paragraphs 31–32)***

There appeared to be more to it than this simple chronological account of events. Had the midwife's attitude discouraged early re-attendance at the unit? Had she performed an adequate assessment in triage? The midwife's witness statement noted that she would normally take 25-35 minutes to do this, but as RXF's total time in the unit was 25 minutes, was the assessment adequate? The court heard that it was the adequacy of the assessment, and not just its length, that was crucial. The argument that the midwife's assessment was inadequate included a claim that the midwife had not properly ascertained RXF's transport arrangements, although it was conceded that neither RXF nor her husband had raised this issue. When RXF and her husband left the unit, they

'Decided to walk to* [the] *station, which is about half a mile away from the hospital. On the way, they had to stop several times because of continuing contractions, many of which were intense.' (McKenna at paragraph 40)

RXF's father came by car to collect her and she did go home for a while, suggesting that she did not consider herself to be in advanced labour. The issue of whether the midwife's attitude may have been a dissuading factor in re-attending the unit was left unresolved by the court.

In the event, the judge concluded that the claimant was misguided to rely on the criticism made by the root cause analysis investigation, as:

'It was prepared without any account from* [the first midwife]. *No interviews were carried out and no hearing and the purposes of the report were very different, namely to identify any shortcomings in practice and to improve standards of best practice. It does not apply the legal test for negligence and of course does not consider either the local or national guidance.' (McKenna at paragraph 59)

Although the root cause analysis report stated that the triage midwife's performance could have been better, it appears that neither midwife had acted in a way that could be deemed negligent, and so the claim failed. A near total cord occlusion was not foreseeable, nor could it have been managed in a way that would have made the outcome any different for the baby.

One legal commentator analysed the case and noted that had RXF:

'Been admitted to the Hospital's Maternity Unit at or about 18:20 the eventual outcome would have been the same. Intermittent auscultation would not have identified any abnormalities as early as 20:00 and there would therefore have been no cause to commence a CTG.' (Medical Negligence Team, 2019)

This is another example of a tragic set of events that does not entitle the damaged parties to any compensation. For midwives, there are still lessons to be learned, however. The root cause analysis, for all that it was criticised by the judge, did suggest that:

'Multiparous women in early labour should be given the option to mobilise for an hour in the Maternity Unit and be clinically reassessed prior to discharge home. When midwives are taking a clinical history they should also consider any social factors such as transport which may have an impact on their ability to access the service.' (McKenna at paragraph 33)

In this particular case, neither of these would have made a difference to the outcome, but practitioners must always be alert to possible improvements in care. Was the triage assessment adequate? The root cause analysis investigation did not think so, but as the judge pointed out, its method of enquiry (in particular in not interviewing the midwife in question) made its evidence

effectively worthless in court. Since it was later determined that labour was not established until 19:30—after RXF was advised to return home — it can be seen that the midwife did follow the unit guideline, but could things have been done differently? Allowing RXF to stay in the unit for a while longer would not have changed the clinical outcome in this case, but it might have met RXF's needs better at the time. A guideline is not a tramline, and individual circumstances can mean that an alternative, perhaps more woman-centred, course of action might be taken instead. **BJM**

Medical Negligence Team. PXW V Kingston Hospital NHS Foundation Trust [2019] EWHC 840 (QB) (05 APRIL 2019). 2019. https://medicalnegligenceteam.com/post/pxw-v-kingston-hospital-nhs-foundation-trust-2019-ewhc-840-qb-05-april-2019 (accessed 1 May 2019)

National Institute for Health and Care Excellence. Intrapartum care for healthy women and babies [CG190]. London: NICE; 2014

PXW v Kingston Hospital NHS Foundation Trust [2019] EWHC 840 (QB) (05 April 2019)