Gníomhaireacht Bainistíochta an Chisteáin Náisiúnta
National Treasury Management Agency

An Ghníomhaireacht um Éilimh ar an Stát
State Claims Agency

Catastrophic Claims relating to Babies in Maternity Services

Claims Review Report

The State Claims Agency has completed a five-year review of concluded claims arising from catastrophic injuries to babies in maternity services. The aim of this report is to present the key findings of that review, its key learnings and our advice for maternity units and frontline health and social care staff to help mitigate the risk of similar claims occurring.

What are catastrophic birth injury claims?

A catastrophic birth injury claim, as defined by the SCA*, is one where a birth injury arises that results in serious disability/permanent incapacity to a baby (for example, cerebral palsy), or where the estimated liability is over €4 million. Catastrophic birth injuries exact a high toll physically, emotionally, and financially on both the people affected and their family members or caregivers, in addition to the financial cost to the State.

This report discusses 80 catastrophic claims concluded between 2015 and 2019 arising from injuries to infants before or during labour, or up to 28 days postnatally; 74 claims related to incidents that occurred before or during birth and six related to incidents that occurred in the neonatal period.

Review of Claims- A Snapshot

Key findings related to incidents that occurred before or during labour:

- **66%** of the women were nulliparous
- **76%** of the women were ≤ 34 years old, with almost half under age 30
- **28%** of the women had a BMI ≥ 25.0, **14%** had a BMI of 18.5–24.9, **1%** had a BMI of <18.5 (Data not available in **57%**)
- **53%** of the women presented to hospital in spontaneous labour, **39%** of women had a planned induction, **6%** of women presented to hospital with concerns (i.e., reduced fetal movement)
- **24%** of the labours involved an acute obstetric emergency**
- **43%** of the women had labour accelerated by oxytocin, artificial rupture of membranes or both
- **47%** of the babies were delivered by emergency caesarean section (national CS rates ranges between 28–43%)
- **59%** of the babies were male, **41%** of the babies were female
- **82%** of the babies weighed 2.5–4.5kg, **1%** weighed >4.5kg, **9%** weighed 1.6–2.5kg and **7%** weighed <1.6kg

* This definition is applied to the categories of claims described, recognising, however, that there are other claims, not included in the definition, which involve catastrophic injury, ordinarily understood.

** For the purposes of this review, obstetric emergencies included: cord prolapse, arm prolapse, uterine rupture, placental abruption, shoulder dystocia, eclamptic seizure, ruptured vasa praevia and cardiac/respiratory arrest.

Review of Claims – A Snapshot

Gestational age of delivery

78% of the babies were born at 37–<42 weeks gestation
15% of the babies were born preterm (<37 weeks)
7% of the babies were born ≥42 weeks gestation

26% of the babies would be considered small for gestational age if their metrics were plotted on a standardised fetal growth chart

No home births, water births or elective caesarean sections featured

Learning from Claims

Antenatal/intrapartum issues identified

Issues related to the 74 claims that involved incidents that occurred before or during labour:

Delay in delivery

- In **77%** (n=57) of claims related to injuries sustained before or during labour, there was evidence of a delay in delivery.
- There was a delay of 30 minutes or greater in **41%** (n=30) of claims.

Other prominent issues identified

- Absent or poor documentation – **64%** (n=47)
- Failure to interpret or recognise an abnormal CTG – **61%** (n=45)
- Failure to monitor fetal heart / uterine contractions appropriately – **51%** (n=38)
- Delay in escalation – **50%** (n=37)
- Inappropriate use of oxytocin – **36%** (n=27)
- Inadequate assessment – **31%** (n=23)

Vaginal birth after caesarean section (VBAC)

- **11%** (n=8) of claims involved women who trialled labour having had a previous caesarean section.
- Six of these claims featured lack of consent or counselling on the risks of VBAC or lack of documentation of these processes.

Postnatal issues identified

Six claims related to incidents that occurred in the postnatal period. Issues identified in these claims included failure to adequately monitor the neonate, failure to adequately diagnose or treat neonatal infections and inadequacies related to pharmacological therapeutic interventions.

Advice for Maternity Units

Based on our analysis of the claims in this review, we advise that all maternity units should consider implementing:

- A standardised approach to fetal monitoring and documentation of findings, e.g., intermittent auscultation of the fetal heart / CTG proforma sticker.
- A standardised approach to monthly reviews of perinatal clinical incidents, which have given rise to suboptimal outcomes. This is an opportunity to identify and learn from issues that may have contributed to adverse outcomes.
- Regular audit of clinical documentation (at least annually) on a random selection of births. Substandard documentation should be highlighted directly to the staff involved and as a regular part of ongoing competency and training.
- A process to ensure mandatory multidisciplinary training for all relevant staff in relation to fetal monitoring and management of obstetric emergencies and neonatal resuscitation, in addition to regular skills and drills.
- A mechanism to capture data on cases of impacted fetal head/difficulty delivering the head during caesarean section.

Advice for the Health and Social Care Staff

Based on our analysis of the claims in this review, we advise that all staff should:

- Recognise deviations from normal and ensure appropriate and timely intervention/decision–making when clinical concerns are present.
- Escalate concerns regarding fetal and maternal wellbeing to the senior midwife and obstetrician without delay; clear lines of escalation should be communicated at each shift.
- Anticipate the need for multidisciplinary assistance (e.g., neonatal paediatrician, microbiologist) and communicate this as soon as possible to the relevant team members.
- Check equipment at the start of every shift and before accepting each woman into the delivery suite/labour ward.
- Maintain situational awareness and be aware of the importance of room layout and storage.
- Follow the Start Smart and Then Focus approach for antimicrobial therapy[1].

Documentation

- Maintain legible, complete, and contemporaneous clinical documentation.
- Document all clinical examinations/reviews, rationale for decisions, reasons for delays, personnel involved and all timings of events.
- Use retrospective notes only when necessary and clearly identify the record as retrospective.
- Assign a nominated staff member, where possible, during emergencies to record timing of medication administration, interventions, personnel present, additional assistance summoned etc.

Communication

- Use communication tools such as ISBAR/ISBAR$_3$ to impart relevant clinical information during handover[2].
- Ensure clear verbal communication when highlighting the urgency of a situation; in an emergency, where possible, assign one team member to coordinate phone calls to theatre, laboratory, and other clinical personnel.

Staff caring for women in the antenatal and intrapartum period should:

- Ensure the woman is assigned to the correct pregnancy care pathway in accordance with her determined risk group[3].
- Perform adequate assessment of any presenting complaints, taking all relevant history into account at each antenatal interaction.
- For women planning a VBAC: obtain and document informed consent which should include the communication of risks, benefits and alternative modes of delivery.
- Perform fetal assessment to include regular ultrasound scans when deemed appropriate and in line with local and national policy. Additional surveillance ultrasound scans may be required in certain circumstances e.g., when intrauterine growth restriction (IUGR) is suspected.
- Be aware of the risk factors for neonatal encephalopathy[4].

Fetal monitoring

- Recognise that CTG interpretation should not occur in isolation and should be undertaken as part of a holistic assessment of fetal and maternal wellbeing[5].
- Ensure appropriate and timely intervention/decision–making when abnormalities are present.
- Ensure the fetal heart rate is confirmed by a pinard stethoscope before and during electronic fetal monitoring, in addition to taking the mother's pulse manually.
- Ensure the CTG recording is complete and that it includes the fetal heart rate, tocograph, accurate date and time, and maternal pulse. The midwife should document the CTG findings on a regular basis, and should document more frequently with a suspicious or pathological CTG.
- Ensure the correct placement of the tocograph transducer for accurate detection of uterine activity in conjunction with manual palpation of uterine contractions.
- Ensure alarms are enabled, audible and maintained on all CTG machines.
- Consider a "fresh eyes and ears" approach to fetal monitoring; have a colleague perform a fresh review of the fetal heart rate during intermittent or continuous fetal monitoring which is documented with time and signature[6].

Intrapartum care

- Know when oxytocin is indicated/contraindicated and the appropriate dose and method of administration for the different clinical scenarios in which is it used.
- For women undergoing a VBAC or trial of labour after caesarean section:
    - Augmentation of labour should be in consultation with senior clinical input throughout.
    - Be alert to potential complications such as uterine rupture or dehiscence.
- Undertake fetal blood samples where indicated and repeat within the appropriate timeframe, where necessary.
- Be aware of and able to recognise the signs of an obstructed labour.
- In the case of an instrumental delivery, document the assessment prior to the delivery including the station and presentation of the fetal head, the presence or absence of caput, formation of moulding, abdominal examination etc.
- Ensure timely transfer to theatre when a decision is made for a caesarean section, based on the assigned emergency category, and ensure that all relevant members of the multidisciplinary team are available.

Staff caring for women and babies in the postpartum period should:

- Be aware of the potential for sudden unexpected postnatal collapse (SUPC) of the newborn.
- Know when passive cooling and Therapeutic Hypothermia (TH) is indicated/appropriate and ensure prompt referral to a specialist centre where indicated.
- Ensure adequate information is provided to mothers to detect early onset of jaundice and what action to take if it occurs.

If you require further information, or references, please get in touch with us via stateclaims@ntma.ie

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