Death of a baby born with severe cerebral insult (02HDC01476, 30 September 2003)

Independent midwife ~ Hospital midwife ~ Obstetrician ~ Paediatrician ~ Public hospital ~ Standard of maternity care ~ Co-ordination of providers ~ Right 4(1), 4(5)

A complaint was made by a woman and her husband about the services provided to the woman and her baby by a hospital midwife, an obstetrician and a paediatrician. The baby was severely compromised at birth and subsequently died. The complaint was that: (1) the midwife did not contact the obstetrician on call as requested by the lead maternity carer (LMC); (2) the obstetrician was not familiar with the fetal scalp monitor, did not take immediate steps to deliver the baby following rupture of the woman's membranes revealing blood-stained liquor, and unnecessarily delayed performing a Caesarean section; and (3) the paediatrician did not immediately provide oxygen to the baby and delayed intubating him despite the baby's obvious breathing difficulties, and displayed no sense of urgency in taking the baby to ICU.

The Commissioner held that:

1 the obstetrician did not breach Right 4(1) because:
   (a) even though it appeared to the woman that his actions in taking steps to obtain a CTG tracing contributed to a delay in his decision to perform a Caesarean section, the obstetrician had sound clinical reasons for attempting to obtain a reliable reading;
   (b) the presence of blood-stained liquor alone did not warrant emergency management; and
   (c) his assessment and management of the delivery, including performing an abdominal and vaginal examination and artificial rupture of membranes before making a decision regarding a Caesarean section, was appropriate and swift;
2 the paediatrician did not breach Right 4(1) because even though he could have instigated more aggressive and earlier respiratory support for the woman's baby, this would not have affected the baby's prognosis (given the severe degree of cerebral insult already present), and he acted with reasonable care and skill both in his initial and subsequent resuscitation of the baby;
3 the hospital midwife breached Rights 4(1) and 4(5) because:
   (a) she failed to call the obstetrician when requested by the LMC;
   (b) her decision to "take over" to check the observations of the LMC led to a delay in contacting the obstetrician; and
4 the public hospital was vicariously liable for the midwife's breach of the Code, as it did not have in place a clear policy that clarified the responsibilities of hospital midwives, and so had not taken reasonable steps to prevent the interface problem that occurred.