Assessment of woman during pregnancy and labour (14HDC01440, 27 May 2016)

Midwife ~ Antenatal assessments ~ Labour ~ Stillbirth ~ Rights 4(1), 4(2), 6(2)

A 32-year-old woman, pregnant with her first child, engaged a community-based midwife, as her lead maternity carer. The scan at 21 weeks' gestation revealed a low-lying placenta, and the radiologist advised that a further scan should take place at 32 weeks' gestation. The midwife discussed the low-lying placenta with the woman at a later appointment.

The next appointment took place at 32+5 weeks' gestation. At that appointment, the midwife recorded in the clinical notes the "need to follow-up" the 32-week scan. The midwife told HDC that the woman told her she had had the scan done and it was "all normal". The midwife did not follow up on the 32-week scan, which had not taken place. Further midwifery appointments took place and normal antenatal clinical assessments were recorded.

The woman's husband telephoned the midwife at 4.22am and again at 7.30am when his wife was 39 weeks' pregnant, and advised her that his wife had unbearable lower abdominal pain. The midwife suggested comfort measures, advised that labour appeared to be starting and what to expect, and said she would visit later in the day.

The woman's husband telephoned the midwife at 3.30pm and requested an urgent home visit. The midwife arrived at approximately 4.30pm. The woman consented to the midwife performing some assessment by touching her stomach, but then withdrew her consent for further examination. The midwife recorded in the clinical notes that the woman was not in established labour, and advised the woman's husband to contact her if contractions became closer together and stronger.

The husband telephoned the midwife at 9.37pm and said that his wife was experiencing stronger labour pain. The midwife listened to the woman over the telephone, suggested further comfort measures, and advised that it was not yet time to go to hospital. At 11.34pm the husband told the midwife that his wife was experiencing more frequent pain and that they were going to the hospital. The woman arrived at the public hospital at 12.22am. She was met there by the midwife, who assessed her and could not find a fetal heartbeat. At 12.44am the woman delivered a stillborn baby girl. The cause of death was moderately severe chorioamnionitis with chronic vessel vasculitis and associated thrombosis.

It was held that the midwife failed to provide services to the woman with reasonable care and skill by failing to follow up the advice from the radiologist and ascertain whether a 32-week ultrasound scan had been performed. Additionally, the midwife failed to arrange a full assessment, either in her home or at hospital, at 9.37pm. For these reasons, the midwife breached Right 4(1).

At the home visit at 4.30pm, when the midwife interpreted the woman's comments and actions as declining further assessment, the midwife did not explain the reasons for performing a further examination, what the examination would involve, and the consequences of not doing an examination. This was information that a reasonable

consumer in those circumstances required before making the choice to refuse consent. Accordingly, the midwife also breached Right 6(2).

By failing to document significant events, discussions and decisions, the midwife did not meet professional standards and, accordingly, she breached Right 4(2).