Failure to recommend to a woman in labour that a specialist consultation was warranted
15HDC00924, 20 June 2017

Midwife ~ Lead maternity carer ~ Labour ~ Referral guidelines ~ Fetal monitoring ~ Transfer ~ Information ~ Informed consent ~ Rights 4(1), 6(1), 7(1)

A woman pregnant with her second baby booked a self-employed community based registered midwife as her lead maternity carer (LMC). The woman planned to give birth at a local hospital without obstetric services, approximately two and a half hours' travel by road from the nearest base hospital.

Antenatally, the LMC used palpation alone to assess the fetal size. There is no written care/birth plan in the woman's records, nor is there a record of a discussion about pain relief or the circumstances in which a transfer to a larger hospital would take place.

At term, the woman went into labour and met her LMC at the local hospital. The LMC undertook an assessment and monitored the woman and her baby. At 10.30am the woman's cervix was 6–7cm dilated. At 1.20pm, the LMC recorded that the contractions were less frequent. Shortly after 2.15pm a repeat vaginal examination showed that the cervix had not dilated further. The woman returned home where she said that her contractions continued to be irregular but very strong.

Following contact by the woman at 4.50pm, the LMC met her back at the hospital and at 6.30pm, cervical dilation was 8–9cm dilated. The LMC told HDC that she would have discussed with the woman that she had made some progress, but would not have discussed the options of either transferring or consulting with a specialist at that time, as she was "quite happy with [woman's] progress at that stage".

At 8.10pm, the woman was 9cm dilated. At 9.40pm, the LMC pushed the remaining cervix over the baby's head, and the woman experienced a spontaneous rupture of membranes at that time. The baby's heart rate was recorded at a normal rate at 9.45pm but there was no further record of the heart rate after that time. At 9.55pm, the woman was pushing spontaneously with contractions. Following delivery of the baby's head at 10.15pm, one of the baby's shoulders became stuck, and the delivery of the body was delayed by five minutes., The baby weighed 4.87kg and was delivered in a very poor condition, resuscitation was required, and the baby was transferred to a main centre hospital by helicopter for further treatment.

The woman suffered a fourth degree perineal tear during the delivery, and was transferred by ambulance accompanied only by a friend and the ambulance driver.

Findings
The LMC failed to provide services to the woman with reasonable care and skill, in breach of Right 4(1), in the following ways:

a) Antenatally, the LMC failed to measure the fundal height and, instead, used palpation alone to assess the fetal size.
b) The LMC failed to comply with the Ministry of Health Referral Guidelines for Consultation with Obstetric and Medical Related Services (Referral Guidelines) by failing to recommend to the woman that due to slow progress in labour a consultation with a specialist was warranted at 2.15pm and, instead, sent the woman home. The LMC also

failed to comply with the Referral Guidelines at 6.30pm by not recommending to the woman that due to slow progress in labour a consultation with a specialist was warranted at that time.

c) The LMC failed to recognise that the woman's labour was not progressing normally.
d) During the delivery, the LMC did not try recommended manoeuvres to facilitate the delivery of the shoulders, other than repositioning and traction, and did not provide appropriate instructions to the hospital midwife or communicate effectively with her.
e) The LMC did not follow the *RANZCOG Guideline*, and did not monitor the fetal heart rate (FHR) every 15 to 30 minutes in the active phase of the first stage of labour, and did not auscultate the FHR after each contraction or every five minutes during the active second stage of labour. In addition, the LMC sent the woman home for a four-hour period without midwifery support at 2.15pm, knowing that the FHR would not be monitored during that period.
f) The LMC did not comply with the DHB's "Maternity Inter-hospital Transfers" guideline, and did not make arrangements for the woman to be escorted in the ambulance by an appropriate practitioner.

In addition, by not providing the woman with adequate information about transfer to the larger hospital should problems arise during labour, and not advising her of the recommendation in the Referral Guidelines that a specialist consultation was warranted at 2.15pm and 6.30pm, the LMC failed to provide the woman with essential information that a reasonable consumer in the woman's circumstances would expect to receive, and breached Right 6(1). It follows that the woman was not in a position to make informed choices about the delivery of her baby and, accordingly, the LMC also breached Right 7(1).

Recommendations

It was recommended that the Midwifery Council of New Zealand undertake a review of the LMC's competence should the LMC make an application to return to midwifery practice, and that the LMC provide a written apology to the woman. V

The LMC was referred to the Director of Proceedings. The Director filed proceedings by consent against the LMC in the Human Rights Review Tribunal. The Tribunal issued a declaration that the LMC breached Rights 4(1), 6(1), and 7(1) of the Code in relation to the care she provided.