Death of baby as a result of birth asphyxia after abnormal labour (01HDC05155, 12 February 2003)

Obstetrician ~ Midwife ~ Public hospital ~ Standard of care ~ Prolonged rupture of membranes ~ Fetal distress ~ Co-ordination of providers ~ Excessive workload ~ Rights 4(1), 4(2)

A 25-year-old woman complained about the services she received from an obstetrician and an independent midwife at a public hospital. Her baby died from complications associated with cerebral palsy as a result of birth asphyxia.

The Commissioner held that the midwife breached Right 4(1) and 4(2) in failing to recognise and respond to the significance of abnormalities of the fetal heart rate combined with signs of uterine infection. She also failed to plan, effectively communicate and formally hand over care. There was a failure in communication during labour when the signs of fetal distress were evident. The midwife's monitoring of the abnormal labour was also inadequate and her maternal observations fell below expected standards.

However, the midwife did not breach Right 4(1) when she encouraged the woman to push with her contractions without first checking with the obstetrician, because she had reason to believe this was in line with the obstetrician's plan to expedite delivery.

The obstetrician breached Rights 4(1) and 4(2) in: (1) failing to recognise and respond to the abnormal fetal heart rate pattern; (2) his management of the premature uterine rupture of membranes and failing to recognise the signs of uterine infection; (3) not responding appropriately to the worsening situation by progressing to a Caesarean section; (4) his inappropriate direction to administer oxytocin in the presence of fetal tachycardia and maternal pyrexia; and (5) failing to communicate effectively and plan the management of the woman's labour, and not clarifying with the midwife his understanding of his responsibilities. It would have been good practice to consider fetal scalp blood sampling to assess fetal well-being.

The public hospital was not vicariously liable for the obstetrician's breaches of the Code because it had taken reasonable steps to prevent his shortcomings with mechanisms of ongoing peer review and support.

However, the hospital breached Right 4(1) in failing to ensure that the woman received obstetric services of an appropriate standard, as its protocol to manage pre-labour rupture of membranes was inadequate. It also breached its organisational duty of care and skill, as the obstetrician's excessive workload contributed to his failure to effectively perform his duties.

The Medical Council was asked to consider a review of the obstetrician's competence and the matter was referred to the Director of Proceedings. On behalf of the complainants, the Director of Proceedings issued proceedings before the HRRT against the obstetrician. These were discontinued following agreement by all parties.