Death of baby following obstructed home labour and delayed referral to specialist care
(00HDC08628, 30 July 2002)

Independent midwife ~ Home birth ~ Obstructed labour ~ Response to fetal distress ~ Referral to specialist care ~ Information about treatment options ~ Disclosure of lack of access agreement ~ Rights 4(1), 4(2), 4(5), 6(1)(a), 6(1)(b)

An obstetrician complained about the standard of care a patient received from an independent midwife. The complaint was that the midwife did not respond appropriately to an anterior lip presentation, or to the slow descent of the head during labour and lack of progress in second stage, and that she did not document appropriately throughout the labour and did not transfer the patient to hospital in a timely manner. The complaint also alleged that the midwife failed to inform the patient of the deceleration of the fetal heartbeat, the presence of caput, and the slow progress of second-stage labour, or to explain why she did not have an access agreement with the hospital.

The Commissioner held that the midwife breached Right 4(1) in that she failed to provide midwifery services of an appropriate standard. The death of the baby was directly linked to the prolonged obstruction, and was a direct result of the midwife not acting soon enough on her assessments. The midwife failed to realise that this was an abnormal labour and that the baby's progress was obstructed. The midwife also breached Right 4(2) because she failed to further investigate the deceleration of the fetal heart and thus failed to comply with professional standards. She breached Right 4(5) because she did not recognise that she had reached the limits of her expertise, and did not promptly transfer the patient to secondary specialist services.

The midwife also breached Right 6(1)(a) and 6(1)(b) because she failed to adequately explain the status of the labour, the factors that she had observed that posed a risk to the labour, and the management options available. The patient was entitled to be told, without asking, about the progress of her labour, the abnormalities detected, the expected risks, and the options available (in particular, the option of immediate transfer to specialist care in hospital) and the reasons for the midwife not having an access agreement with the hospital.

Although there were significant omissions, the midwife did not breach Right 4(2) because overall her recording of the patient's labour was adequate.

The Commissioner referred the matter to the Director of Proceedings, who laid a charge of professional misconduct before the Nursing Council. The charge in relation to not ensuring adequate communication was upheld by the Council and it imposed a penalty of censure and ordered payment of 30% of the costs of the hearing. The midwife was given permanent name suppression, as since the events she had undertaken further professional development and demonstrated a willingness to learn from her mistakes.