Death of baby several hours after home birth (06HDC08238, 28 June 2007)

Independent midwives ~ Back-up support ~ Home birth ~ Prolonged labour ~ Shoulder dystocia ~ Standard of care ~ Rights 4(1), 4(2), 6(1)

A woman and her partner complained about the maternity care provided by their lead maternity carer (LMC) and two back-up midwives. The woman's first child was born at home, and was transferred to hospital, where he died several hours later.

The 40-year-old woman and her partner opted for a home birth, and chose an independent midwife whose interest in natural health and alternative therapies fitted the way they wanted maternity care to be provided.

There were no complications during the antenatal period. Towards the end of the pregnancy, they discussed back-up midwifery support. The LMC recommended both a first-year midwifery graduate with whom the LMC had worked, and another independent midwife. The woman was agreeable to the former midwife providing back-up support but did not want the latter. However, the LMC misunderstood her decision not to involve the latter in her delivery, and did not document this in her notes. She also did not inform the back-up midwife that the latter was not to be contacted for back-up midwifery support.

The back-up midwife and student midwife attended to the woman as the LMC was away on the weekend that the woman was due to deliver. The midwife whom the woman did not want present also attended as a back-up midwife. The woman had a prolonged second stage of labour and the birth was complicated by a shoulder dystocia. The baby was born flat and toneless, and had a low fetal heart rate of 60bpm. Resuscitation procedures were commenced and an ambulance called. Following admission to hospital, the baby was intubated and manually ventilated, and was then transferred to the neonatal unit for review. In light of his poor prognosis, the parents decided to withdraw active treatment. His death was reported to the Coroner, and an inquest was held a year later.

It was held that although aspects of the LMC's care were less than optimal, in particular, that she failed to document the woman's decision not to involve a particular back-up midwife, these deficiencies did not amount to a breach of the Code.

It was held that the midwife who attended the delivery breached Rights 4(1) and 4(2) for failing to provide the mother and baby with services of reasonable care and skill, and that complied with professional standards. In addition, she also breached Right 4(2) for failing to adequately document the progress of the labour, and Right 6(1) for failing to provide vital information regarding the slow progress of the woman's labour, which prevented her from being involved in the important decisions regarding her care.

It was also held that although the back-up midwife generally provided an appropriate standard of clinical care, her documentation was brief and did not comply with the professional standards expected of a midwife, and breached Right 4(2).

This case highlights the importance of adopting a low threshold and seeking extra assistance promptly when there are concerns regarding prolonged labour. This is especially important for home births and where the attending midwife is relatively

inexperienced. The case also highlights the importance of keeping comprehensive records, and the need for good communication between the LMC and the woman, and between different midwifery staff involved in a woman's care.