Provision of information and care during stillbirth
15HDC00550, 15 December 2017

Midwife ~ Stillbirth ~ Referral Guidelines ~ Rights 4(1), 4(2), 6(1), 7(1)

A woman became pregnant with her third child and intended to have a home birth. The woman engaged a self-employed community-based registered midwife as her Lead Maternity Carer (LMC).

At approximately 6.30am, at 22 weeks' gestation, the woman contacted her LMC reporting vaginal bleeding and contraction-type pains. The woman and the LMC met at a hospital at 8am. The LMC assessed the woman and, with support from a hospital midwife, was unable to detect a fetal heartbeat. The LMC scheduled the woman for an ultrasound scan to "determine fetal viability". The ultrasound scan appointment was booked for 2.30pm.

The LMC documented in her retrospective notes that she informed the woman that "the current need was to finish the assessments then discuss with a doctor the options of 'wait and see' or referral to the gynaecology ward at a different hospital once she had her ultrasound scan". The LMC also recorded that the woman did not want to go to the second hospital. Prior to her attendance at hospital, the LMC attempted to telephone the on-call obstetrician, but dialled the incorrect number. The LMC did not attempt to make any further contact with an obstetrician. The LMC told HDC that she was under the impression that the woman needed to have her ultrasound scan prior to consultation with an obstetrician. The LMC said that as the woman appeared clinically stable and wanted to go home, and had agreed to return for her ultrasound scan at 2.30pm, she felt that this was an acceptable plan.

The woman said that the LMC made no mention of needing to talk to, or consult with, any other medical professional, or of transferring to any other department.

Following the ultrasound scan at 2.30pm, intrauterine death was confirmed, and the LMC drove the woman and her husband home. At 3.05pm, the LMC left them at their home and documented that the woman was "[h]ome having increasing pains", and that they would "call [her] if needed". The LMC provided the woman with information leaflets relating to both miscarriages and stillbirths. The LMC told HDC: "[U]nfortunately I did not find or make a time to review these materials with [the woman] and address any of her subsequent concerns."

The woman told HDC that her labour went on like a normal labour, and she delivered what she believed to be the placenta. She asked her husband to telephone the LMC and ask her to return to their home. At 4.15pm, the LMC returned to their home.

There is some discrepancy between the woman's husband and the LMC's account about the discussion that took place once the LMC arrived. The woman's husband stated that he told the LMC that the tissue delivered was in the basin. The LMC stated that she has no recollection of the woman's husband informing her of this, and she believed that the piece of placenta she located on the bathroom floor was the only tissue that had been delivered.

At 4.42pm, the LMC left the woman and her husband because she decided to drive to her home to seek collegial advice, as she "did not feel comfortable having a conversation in front of [the woman] and [her husband] that may have woken [the woman] and been distressing for them".

The LMC returned to the woman and her husband's home at approximately 5.50pm and offered to take them to hospital. Prior to leaving, the woman asked the LMC whether they should take the placenta, which was located in a towel outside on the porch. The LMC collected the container in which she had placed the piece of placenta she had found earlier, and showed it to the woman, but the woman told her that that was not it. The LMC said that when she went out to the porch, she "found the baby and most of the placenta complete in its sac" in a container.

Findings

By not providing the woman with adequate information about her stillbirth, and not advising her of the recommendations in the Referral Guidelines, the LMC failed to provide essential information that a reasonable consumer in the 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 her care. Accordingly, the LMC also breached Right 7(1).

The Commissioner was critical that the LMC did not consult with an obstetrician when she was outside her scope of knowledge and experience in relation to stillbirths, and that the LMC failed to identify the need to request emergency services for the woman when she believed that a piece of the placenta had been delivered prior to the fetus. This amounted to a severe departure from an accepted standard of care. Accordingly, the LMC failed to provide services to the woman with reasonable care and skill and breached Right 4(1).

By failing to record accurate and timely written progress notes, and by failing to document evidence of all decisions made and the midwifery care offered and provided, the LMC did not meet professional standards. Accordingly, she was found to have breached Right 4(2).

Recommendations

It was recommended that the LMC apologise to the woman and arrange further training on record-keeping and documentation, and provide HDC with confirmation of her attendance at the appropriate workshops, should she return to midwifery practice in New Zealand.

It was recommended that should the LMC return to midwifery practice, the Midwifery Council of New Zealand conduct a review of the LMC's competence. The LMC was referred to the Director of Proceedings, who decided not to take formal proceedings.