Antenatal and intrapartum care provided by midwife (11HDC00596, 21 February 2013)

Midwife ~ Fetal movements ~ Fetal heart rate ~ Support ~ Communication ~ Right 4(1)

This case is about the care provided to a 24-year-old woman in the third trimester of her first pregnancy. At 38 weeks' gestation, the woman's Lead Maternity Carer handed over the woman's care to another midwife (the midwife).

A week before the woman's due date, she sent the midwife a text message, indicating concerns about a lack of fetal movement and increased vaginal discharge with black spots. This was the woman's first contact with the midwife. The midwife replied to the woman by text message, advising her to drink ice-cold water and sit quietly on the couch to feel the baby move. Although the woman received the message, it confused her and she therefore did not follow the advice. The midwife did not follow up on the woman's concerns that day or ensure that she was reassured and/or had felt fetal movement.

A day or two later, the woman met the midwife and a student midwife for the first time at a clinic visit. The midwives assessed the woman. After a discussion about what fetal movement could be expected, the woman became unsure and decided she may have felt some small movements. The student midwife recorded that the movements were not as hard as they had been previously. Both midwives had difficulty detecting the fetal heart rate (FHR), but the midwife said that she eventually heard it "in the background".

At 3.20am the next day, the woman began having contractions. At 2.20pm the midwife and student midwife visited and assessed her at her home. She was in established labour. Again, the midwives had difficulty finding the FHR. The midwives left the woman, advising her to call them when she felt bowel pressure. At 7.35pm, after being advised that the woman was feeling bowel pressure, the midwives returned to the woman's home and conducted a further assessment. The woman was driven to the hospital by her mother when she was close to delivery, while the midwives drove separately. The woman gave birth to her baby minutes after arriving at the delivery suite. Sadly, the baby was born with no heartbeat or respiratory effort, and resuscitation was unsuccessful.

It was held that the midwife should not have responded to the woman's concerns via text message without also calling her to clarify and follow up her concerns. The midwife failed to respond appropriately to the history of reduced fetal movement by not checking the maternal pulse and not arranging a CTG. She also did not remain with the woman to monitor the maternal and fetal well-being when the FHR was still difficult to find and the woman was in established labour. Furthermore, the midwife left the woman unsupported in travelling to the hospital when she was about to give birth. The midwife therefore did not provide services with reasonable care and skill and breached Right 4(1).

The midwife was referred to the Director of Proceedings. The Director of Proceedings filed a statement of claim in the Human Rights Review Tribunal against

the midwife. The claim was able to proceed by agreement and compensation for the woman was resolved between the parties by negotiated agreement.

The Tribunal's decision can be found at:

http://www.nzlii.org/nz/cases/NZHRRT/2013/40.html