Death of baby following prolonged pregnancy (06HDC18721, 14 May 2008)

Midwife ~ Health trust ~ Pregnancy ~ Overdue ~ Standard of care ~ Information provided ~ Documentation ~ Stillbirth ~ Rights 4(1), 4(2), 6(1)(a), 6(1)(b)

A woman in her early thirties was expecting her first baby, and engaged the services of an independent midwife, employed by a health trust. The midwife provided a minimal antenatal service to the woman, did not offer any of the usual routine testing, and did not adequately document any of the consultations, making scant diary notes only. She claims that this was because the woman preferred a natural approach, specified no clinical intervention, and did not want any records kept.

The midwife went on leave the week that the woman's baby was due, and arranged for another midwife to check on the woman. When the midwife returned from leave, the woman was three weeks past her delivery date. The midwife visited the woman the next day. Induction of labour was discussed in general terms, but the midwife did not inform the woman of the potential risk to the baby of being so far overdue or that she should see an obstetrician.

That evening the baby stopped moving, and the midwife admitted the woman to a small provincial hospital for an assessment. The midwife examined the woman but was unable to locate a fetal heartbeat. The woman was transferred to a larger public hospital, where an ultrasound scan three hours later confirmed that the baby had died. The woman's labour was induced and, after a long and difficult labour, the baby was delivered.

It was held that there was no evidence that the midwife recommended that the woman see an obstetrician to further discuss induction and the risks of continuing with the pregnancy. Accordingly, the midwife did not provide services that complied with professional standards, breaching Right 4(2). She failed to provide a service with reasonable care and skill, breaching Rights 4(1) and 4(2). Additionally, she did not provide information that a reasonable consumer would expect to receive, breaching Rights 6(1)(a) and 6(1)(b).

It was held that the health trust did not breach the Code and was not vicariously liable for the midwife's breaches of the Code. The Trust clearly outlines roles and responsibilities towards clients, and that their staff are expected to comply with professional standards. Policies are in place to guide staff in relation to referral to related medical services.

The midwife was referred to the Director of Proceedings, who decided to take a disciplinary proceeding against her. On 22 June 2009 the Health Practitioners Disciplinary Tribunal found the midwife guilty of professional misconduct. It held that her conduct amounted to malpractice and negligence and, in many instances, her conduct amounted to acts or omissions that would bring discredit to the midwifery profession.

In its penalty decision the Tribunal cancelled the midwife's registration. She was ordered to pay $10,000 in costs. The Tribunal also imposed a condition that in the event that she seeks re-registration, she undergo a specified course of education set by

the Midwifery Council of New Zealand in order to satisfy the Council that she meets the competencies for entry to the Register. The Tribunal also recommended that in the event that she seeks re-registration, consideration be given to her practising under supervision for 18 months, following re-registration.

The Tribunal's full decision can be found at:

http://www.hpdt.org.nz/Default.aspx?tabid=218