Death of baby after delay in Caesarean section (04HDC04652, 17 January 2006)

Midwife ~ LMC ~ Obstetrician ~ Fetal distress ~ Deceleration ~ Caesarean section ~ CTG trace ~ Induction ~ Labour ~ Syntocinon ~ Prostaglandin ~ Documentation ~ Retrospective records ~ Access agreement ~ Speed of labour ~ ACC ~ Medical error ~ Vicarious liability ~ Rights 4(1), 4(2)

A couple complained about the services provided during the labour and delivery of their first child. The woman had an uneventful pregnancy, and at 41 weeks + 4 days' gestation she saw an obstetric registrar to discuss induction. The plan was to induce the woman the following day under her midwife's (her lead maternity carer) care. The consultant obstetrician warned of the risk of shoulder dystocia as the baby was large. The woman was to be continuously monitored during labour with active management of the third stage; the registrar was to attend the birth; and a paediatrician was to assess the baby following birth.

During labour, following some non-reassuring CTG traces, the obstetric registrar ordered hourly CTG recordings. The woman became very distressed with pain and asked for an epidural. The baby was born by Caesarean section at the hospital birthing unit. He was described as "flat" following birth and, following resuscitation, he was transferred to a neonatal intensive care unit, where he died several days later. The autopsy report indicated that he was a large baby who appeared anatomically normal. The cause of death was "hypoxic ischaemic encephalopathy grade 3" precipitated by fetal distress.

It was held that the midwife did not have the skills to provide appropriate services in this situation and should have passed the woman's care to the secondary care team. The midwife's care did not meet professional standards, and she did not provide midwifery services of an appropriate standard, breaching Rights 4(1) and 4(2).

The obstetric registrar was sufficiently qualified and experienced to handle the situation. However, she did not comment at all on uterine activity, did not correct the midwife's interpretation of events, misread a CTG tracing and failed to indicate clearly the urgency of the Caesarean section. She failed to provide maternity care of the standard expected of an obstetric registrar with four years' experience, and breached Right 4(1).

The DHB was not held vicariously liable for the actions of the midwife (an independent contractor) or the registrar. Although the registrar was an employee, she had not followed the relevant DHB guidelines and had not called for on-call consultant support, and thus the DHB was not liable for her breach of the Code.

This case highlights potential problems in the co-ordination and quality of care where LMC midwives access public hospital maternity facilities, and the need for review of the national maternity services access agreement.