

## **Monitoring and recording of progress of labour by midwife (05HDC12098, 30 October 2006)**

*Midwife ~ Standards of care ~ Disposal of placenta ~ Right 4(2)*

A 19-year-old woman was admitted to a rural maternity unit at 2am. Her midwife examined her and noted that the fetal heart rate was 160bpm. Over the next three hours the woman walked about outside the unit and had a bath. The records show that the midwife recorded the fetal heart rate at 3.20am and that another midwife assessed her and recorded her observations at 5am, 5.20am and 6.20am. At 7.40am her midwife examined her and assessed that she was fully dilated, the membranes were bulging, but the head was still high. The fetal heart rate was 135 bpm. At 8.30am she had concerns about the progress of the labour as she found meconium when she examined her vaginally. She advised the woman that she needed to transfer to the public hospital.

She was assessed at the hospital by an obstetric registrar and an obstetric consultant. The consultant determined that she needed a Caesarean section and arranged for a scheduled orthopaedic procedure to be postponed so that an operating theatre was available. She was taken to theatre 53 minutes after her admission to the hospital. At 11.51am, she was delivered of a stillborn baby boy, who did not respond to resuscitation attempts. The placenta was disposed of in error. The post-mortem report did not reveal any cause for the death of the baby.

The woman's aunt complained about the care provided to her niece by the midwife.

The midwife acknowledged that the fetal heart rate was "not checked as frequently as it could have been" and said that this was in part because the woman, who was a heavy smoker, spent a lot of time outside the unit.

It was held that she did not monitor progress regularly during labour, and that she should have referred the woman to hospital earlier. In addition, her documentation was inadequate. Accordingly she breached Right 4(2) of the Code.

The investigation was extended to include the care provided by the District Health Board. It was held that the time taken between the woman's admission and the delivery of her baby was reasonable in the circumstances, and that the DHB did not breach the Code. The hospital discussed future protocols with the maternity department and advised all staff that in future, where there is a fetal death, the placenta is to be sent for histological examination.