Provision of care to pregnant woman with high risk factors (15HDC00540, 30 June 2016)

Midwife ~ Lead Maternity Carer ~ Community midwifery ~ Antenatal care ~ Labour ~ Postnatal care ~Obstetric risk factors ~ Fetal monitoring ~ CTG ~ Information ~ Referral Guidelines ~ Rights 4(1), 6(1)

A 27-year-old woman, pregnant with her first baby, booked a registered midwife as her Lead Maternity Carer (LMC). The woman's body mass index (BMI) was noted to be high at 44.6. The Ministry of Health (2012) Guidelines for Consultation with Obstetric and Related Medical Services (the Referral Guidelines) require that if the mother's BMI is above 40, the LMC must recommend to the woman that the responsibility for her care be transferred to a specialist. The LMC did not discuss this recommendation with the woman during her pregnancy, or refer the woman to the obstetric team for specialist review.

The woman began experiencing back pain, and then regular contraction pains. She sent two text messages and had two telephone conversations with her LMC that afternoon about the pains, and one telephone conversation with the back-up midwife overnight, during which the woman was advised to stay at home. The woman's membranes ruptured spontaneously at 7am and she was told to go to the hospital. On arrival the woman was assessed as being 8cm dilated and CTG monitoring was carried out for about 30 minutes. The CTG was non-reassuring. The LMC discontinued the CTG monitoring so that the woman could go to the toilet, and did not recommence it.

When the LMC next tried to listen to the fetal heart rate (FHR) about 90 minutes later, she was unable to detect it and the baby was subsequently stillborn. A post mortem showed that the baby died as a result of infection with Group B Streptococcus.

It was held that the LMC failed to provide adequate care to the woman in a number of regards as follows:

- The woman had clear risk factors. The LMC should have recommended to the woman that the responsibility for her care be transferred to a specialist at an early stage of her pregnancy, as required by the Referral Guidelines.
- The LMC did not document telephone assessments, including whether or not the baby was active, and the advice given.
- The LMC did not follow the RANZCOG Intrapartum Fetal Surveillance Clinical Guideline and the district health board policy, which both recommend continuous FHR monitoring in labour when a woman has a high BMI. In addition, even if the LMC did not consider that a CTG was warranted, she failed to auscultate the FHR every 15 to 30 minutes, which the RANZCOG Guideline recommends as the minimum fetal assessment required for any woman at this stage of labour.

Overall, the LMC failed to provide services to the woman with reasonable care and skill, and, accordingly, breached Right 4(1). By not recommending to the woman that the responsibility for her care be transferred to a specialist, the LMC failed to provide the woman with essential information that a reasonable consumer in the woman's circumstances would expect to receive, also breaching Right 6(1).

The Commissioner referred the LMC to the Director of Proceedings for the purpose of deciding whether any proceedings should be taken, and recommended that the LMC provide a written apology to the woman. The Director of Proceedings did not institute proceedings. The matter was resolved by way of a negotiated agreement.

The Commissioner recommended that the district health board provide an update to HDC on the implementation of the recommendations made in its root cause analysis report.

The Commissioner noted that, should the LMC wish to return to midwifery practice, the Midwifery Council of New Zealand would decline to issue a practising certificate prior to undertaking a review of the LMC's competence. The Commissioner supported this approach.