Provision of antenatal and labour care
(05HDC01760, 22 November 2006)

Midwife ~ Lead maternity carer ~ Birthing unit ~ Midwifery service provision ~ National guidelines ~ Antenatal and intrapartum care ~ Neonatal resuscitation ~ Rights 4(1), 4(2), 4(4), 6(1)

A woman complained about the antenatal and labour care provided by her LMC. She complained that the LMC did not attend her appointments regularly, and did not attend to her when she reported reduced fetal movements. The LMC was called for the labour but missed the delivery, leaving an inexperienced midwife to deliver on her own. The baby was stillborn.

It was held that the LMC failed to provide services of an appropriate standard in the provision of antenatal care in that she did not provide services with reasonable care and skill; did not act in accordance with relevant standards and legislative requirements; did not appropriately ascertain and respond to risk issues; and did not provide care consistent with the woman's needs. She was not available to the woman at all times and did not provide an alternative back-up midwife in her absence. The LMC was found to have breached Rights 4(1) and 6(1).

It was also held that the birthing unit did not have adequate midwifery cover for labour and births, and did not have adequate emergency systems in place, in breach of Right 4(2). It also did not provide adequate access for the administration of emergency drugs in a resuscitation situation, in breach of Right 4(4).

The delivering midwife was alone and delivered the baby unexpectedly. Her actions were held to be reasonable in the circumstances, and she was not found to have breached the Code.

The LMC was referred to the Director of Proceedings, who laid a charge before the Health Practitioners Disciplinary Tribunal. The Tribunal concluded that given a reported lack of fetal movements, the LMC failed to respond appropriately by ensuring a kick chart was commenced, or a CTG undertaken and interpreted. She also failed to attend in a timely manner, failed to notify of an anticipated delay, and failed to provide adequate information or handover to the maternity facility. The Tribunal found that these actions amounted to such a significant departure from the accepted standards that discipline was warranted, and it upheld the charge of professional misconduct.

Penalties included supervision/monitoring of the midwife for a period of two years; a limit of no more than four midwifery cases per month for a year; a recertification audit by the Midwifery Council; a New Zealand College of Midwives Midwifery Standards review; a fine of $2,080, and a penalty of censure.The Director decided not to issue proceedings before the Human Rights Review Tribunal.

Link to Health Practitioners Disciplinary Tribunal decision:
http://www.hpdt.org.nz/portals/0/mid0763dfindings.pdf