Midwifery care provided to young mother
(12HDC00460, 21 May 2014)

Midwife ~ Lead maternity carer ~ Back-up midwives ~ Primagravida ~ Care plan ~ Growth chart ~ Episiotomy ~ Oxygen cylinder ~ Intrapartum asphyxia ~ Professional standards ~ Rights 4(1), 4(2), 6(2)

A young woman, pregnant with her first baby, engaged the services of a registered community midwife as her lead maternity carer (LMC). The LMC started a customised fetal growth chart, and both she and a back-up midwife charted the fundal height measurements in completed weeks of gestation, rather than by the more specific measure of weeks and days. The woman wished to have a water birth at home.

At 39 weeks and 5 days' gestation, the back-up midwife saw the woman, who reported a reduction in her baby's movements. The LMC also saw the woman later that day and noted on the Antenatal Record that the fetal movements were "fine".

The following day, at 1.50am, the woman's partner contacted the LMC and said that the woman was having contractions every 2–3 minutes. At 3.15am the LMC arrived at the woman's house. During the labour, the midwife did not monitor the maternal temperature or blood pressure, and did not auscultate the fetal heart rate adequately. Towards the end of the labour the LMC suggested to the woman that she perform an episiotomy in order to progress the birth, which the woman declined as she believed there was no local anaesthetic available.

At 7.31am the baby was born with the umbilical cord wrapped around her neck several times. She had poor muscle tone and was blue. The LMC was not carrying an oxygen cylinder, and the second back-up midwife did not remember to place her home birth equipment in the car.

Resuscitation was commenced but there was little improvement. An ambulance was called, and paramedics performed advanced resuscitation. A helicopter conveyed the baby to hospital, and the second back-up midwife drove the parents to hospital. Following assessment by the neonatal intensive care unit, a decision was made to withdraw ventilation from the baby and, sadly, she died. A post mortem reported a final diagnosis of intrapartum asphyxia.

It was held that the LMC failed to monitor the woman during labour with reasonable care and skill and breached Right 4(1) of the Code. The LMC did not advise the woman of the risk to her baby if she decided not to have an episiotomy, nor did the LMC advise that local anaesthetic was available. Accordingly, the LMC breached Right 6(2). It was the responsibility of the LMC to ensure the provision and availability of all home birth equipment, including oxygen. For failing to do so, she breached Right 4(1).

The LMC's actions following the birth were concerning and unprofessional. The LMC discussed with the woman her interactions with the Police, and the preparation of a statement for the Coroner. The LMC sent her statement to the baby's grandmother, and distributed it to a number of other local health professionals. The

LMC failed to comply with professional and ethical standards and, accordingly, breached Right 4(2).

Adverse comments were made about the back-up midwife's actions in failing to complete the customised antenatal growth chart accurately, and regarding her limited assistance to the woman when she assessed her at 39 weeks and 5 days' gestation. Adverse comments were also made about the second back-up midwife needing to be adequately prepared when attending a home birth, and the maintenance of full and complete records.