Assessment and management of a woman during labour (12HDC01031, 6 June 2014)

Community-based midwife ~ Primary care unit ~ Ambulance transfer ~ Preterm labour ~ Footling breech ~ Cord prolapse ~ Assessment and management ~ Rights 4(1), 4(2)

A woman complained about the care she received during the labour of her second child. The woman went into labour when she was 35 weeks' pregnant. She advised that she called her Lead Maternity Carer (LMC) back-up midwife twice and told her she was experiencing regular painful contractions. The midwife understood that the woman was experiencing back pain and mild tightenings that were no different from those she had been experiencing throughout her pregnancy. She arranged to assess the woman at the maternity unit (a primary care unit).

On arrival at the maternity unit it was apparent that the woman was in labour. The woman's uterine membranes ruptured and an ambulance was called to transfer her to hospital. A copious amount of straw-coloured liquor (amniotic fluid) was noted. The midwife inserted an IV line but did not do an abdominal palpation or vaginal examination to establish the presentation of the baby and the stage of labour.

The woman was transferred into the ambulance, accompanied by the midwife. Shortly after leaving the primary care unit the woman felt she needed to push and said that she told the midwife that she had felt something "fall out". The midwife decided to return to the maternity unit. Upon arrival back at the maternity unit the baby was identified to be in a footling breech position. Another midwife boarded the ambulance and ordered it to continue to the hospital.

A vaginal examination was then carried out and a cord prolapse identified. The woman was assisted onto her hands and knees. On arrival at the hospital the woman was immediately transferred to theatre, where a Caesarean section was performed under general anaesthetic. The baby was admitted to the neonatal unit, where brain cooling was commenced to try to minimise any damage caused by hypoxia.

The baby continues to be followed up by the developmental team at the hospital. Her fine and gross motor skills have been assessed as being "largely age appropriate" but she has demonstrated delayed communication and social skills.

It was held that the midwife failed to provide services to the woman with reasonable care and skill and breached Right 4(1) for failing to communicate adequately with the patient and to elicit an accurate clinical picture when she initially called her by telephone, inappropriately instructing the patient to go to the primary care unit for assessment, failing to assess the patient adequately at the primary care unit, and then inappropriately returning to the primary care unit in the ambulance when the woman started to push.

It was also held that the midwife breached Right 4(2) for failing to adequately document her telephone calls with the woman.

The midwife was referred to the Director of Proceedings. The Director decided not to issue proceedings as appropriate resolution had been obtained.