Clarity of roles during labour,
and failure to recognise developing fetal distress
15HDC01534, 21 June 2018

Registered midwife ~ Lead maternity carer ~ Transfer of care ~ Support person ~ Monitoring ~ Fetal distress ~ Right 4(1)

A woman engaged a registered midwife as her LMC because she had attended the births of her previous children. However, because the midwife had had elective surgery, she handed over care to another midwife, when the woman was at 37 weeks' gestation. The first midwife told the second midwife that at the woman's request she would be attending the birth as a support person only, although she hoped to be able to undertake postnatal visits. The second midwife saw the woman twice antenatally following the handover of care.

The woman was admitted to a public hospital. Hospital records indicate that the second midwife arrived at 8.20pm. There is no record of the first midwife's arrival, which she says was at approximately 9.20pm. However, the second midwife said that the first midwife was already at the hospital when she arrived, and that the first midwife had provided initial midwifery care.

The second midwife had another client in labour during the woman's delivery, and was absent from the woman's room for periods of time. The hospital staff were busy that night and unable to assist. Despite this, the second midwife did not arrange for a back-up midwife.

Throughout the woman's labour, both the second midwife and the first midwife were involved in providing midwifery care to the woman, although they disagree as to which midwife provided some aspects of the care, including the administration of drugs and vaginal examinations. Both midwives undertook observations, monitoring, and limited documentation throughout the labour.

CTG monitoring during the woman's labour was inadequate, with no abdominal tocograph recorded to assist with assessment of fetal decelerations. When thin meconium-stained liquor was observed, the second midwife wanted to apply a fetal scalp electrode, but said that she was over-ruled by the first midwife. The second midwife considered that she was "not listened to" by either the first midwife or the woman, because of their close personal relationship. The first midwife denied this and said that she was in a difficult situation owing to the woman's increasing distress and the second midwife's absences from the room. The first midwife said that she was "forced to step in … and provide some limited midwifery care".

The first midwife suggested that the woman be given a small dose of pethidine to assist with her distress. However, the second midwife disagreed and refused to administer it, saying that it was inappropriate because of the earlier presence of meconium in the liquor. The first midwife administered 25mg IV pethidine while the second midwife held the woman still.

The second midwife documented that because the CTG monitoring was difficult to interpret, she made the decision to call for an obstetric review, but she did not document any reference to meconium or any concerns about the CTG, and there was no indication that the registrar was advised that there was any urgency or concern for the baby's well-being, and there was no paediatrician at the birth.

The baby was born in poor condition, with meconium aspiration and hypoxic ischaemic encephalopathy. His Apgar scores were 2 at one minute, 5 at five minutes and 6 at ten minutes. He was transferred to a neonatal unit and then to another hospital before being discharged home.

Findings

The second midwife accepted the responsibility as LMC from the first midwife, and therefore held overall responsibility for the midwifery care provided to the woman. It was held that the second midwife should have been more conscientious in her discussions with the woman and the first midwife about her role as LMC, and should have ensured that both her role and the first midwife's role were clearly defined and documented appropriately. The second midwife failed to ensure adequate monitoring of the woman and the fetal heart rate (FHR), and failed to recognise developing symptoms of fetal distress over a period of almost two hours. This failure resulted in the second midwife not requesting an earlier obstetric review or ensuring that there was paediatric support at the birth. Accordingly, the second midwife failed to provide services with reasonable care and skill, in breach of Right 4(1).

The first midwife handed over responsibility as LMC to the second midwife. It was held that aspects of the transfer of care were not managed appropriately or, if they were, they were not documented clearly. The first midwife provided midwifery care to the woman during labour and, as a midwife, had a responsibility to advocate for adequate monitoring of the FHR and to recognise and respond to the developing symptoms of fetal distress. The failure to do so resulted in neither midwife requesting an earlier obstetric review or ensuring that there was paediatric support at the birth. Accordingly, the first midwife failed to provide services with reasonable care and skill, in breach of Right 4(1).

Recommendations

It was recommended that both midwives provide a written apology and complete a course in fetal surveillance.

It was recommended that the Midwifery Council of New Zealand (MCNZ) consider using this case to develop guidelines for midwives who wish to act as a support person for a woman in labour.