Midwives, Ms B and Ms C

A Public Hospital

A Report by the

Health and Disability Commissioner

(Case 01HDC10714)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Ms A	Consumer / Complainant
Mr A	Consumer's partner / Complainant
Ms B	Provider / Independent Midwife
Ms C	Provider / The public hospital's Charge Midwife
Dr D	Obstetric Registrar
Dr E	Anaesthetist
Ms F	Corporate Solicitor for the public hospital

Complaint

On 24 September 2001 Accident Compensation Corporation (ACC) forwarded to the Commissioner a complaint made by Ms and Mr A, at their request. The complaint concerned the standard of service Ms A received from Ms B, an independent midwife, and Ms C, charge midwife at a public hospital. The complaint was summarised as follows:

Ms C

- *On 18 September 2000 at the hospital's Delivery Suite, charge midwife Ms C did not recognise signs that Ms A's labour appeared not to be progressing or that the unborn baby was in foetal distress.*
- *There was uncertainty as to who had primary responsibility for the care of Ms A and her unborn baby during labour.*
- *Charge midwife Ms C did not obtain assistance from other available providers or ensure that the urgency the situation required was communicated to those providers.*

Ms B

- *On 18 September 2000 at the hospital's Delivery Suite, independent midwife Ms B did not recognise signs that Ms A's labour appeared not to be progressing or that the unborn baby was in foetal distress.*
- *There was uncertainty as to who had primary responsibility for the care of Ms A and her unborn baby during labour.*
- *Independent midwife Ms B did not obtain assistance from other available providers or ensure that the urgency the situation required was communicated to those providers.*

An investigation was commenced on 14 December 2001.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Information reviewed

- Ms A's clinical records from the public hospital
- Accident Compensation Corporation (ACC) records relating to Ms A's baby
- Transitional Health Authority Guidelines for Referral to Obstetric and Related Specialist Medical Services (1997)
- The public hospital's Access Agreement for Maternity Facilities (1998)
- The public hospital's Position Description for the Clinical Midwifery Leader (1998)
- The public hospital's nursing certification and performance review and assessment documentation for Ms C
- The public hospital's nursing career path manual
- Ms C's curriculum vitae and education certificate
- Ms C's midwife workbook
- New Zealand College of Midwives' *Code of Ethics* (1993)
- Independent expert midwifery advice from Ms Chris Stanbridge

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Information gathered during investigation

Overview

In March 2000 Ms A, a 26-year-old woman in her first pregnancy, booked independent midwife Ms B as her Lead Maternity Carer (LMC). The Lead Maternity Carer is the general practitioner, midwife or obstetric specialist who has been selected by the woman to provide comprehensive maternity care including the management of labour and birth.

Ms B provided care for Ms A throughout her pregnancy. Ms B ordered an ultrasound examination for Ms A on 13 April 2000, when Ms A was in the 19th week of her pregnancy. The report stated that no obvious foetal abnormality was seen and estimated the delivery date as 12 September 2000. Ms A noted reduced foetal movement on two occasions during the 30th and 36th week of her pregnancy. In response to these reports Ms B conducted a cardiotocograph (CTG) tracing to monitor the foetal heartbeat. The tracings were normal.

Ms A went into labour in the early hours of 18 September 2000 and was admitted to a Maternity Unit at 8am by Ms B. At midday Ms B became concerned about the lack of progress of Ms A's labour and the rapid foetal heart rate. Following discussion with Ms A about the management of her labour, Ms B arranged for Ms A to be transferred to the public hospital for the insertion of an epidural.

When Ms A and Ms B arrived at the hospital's Delivery Unit at 1.30pm, Ms B spoke with Dr D, the registrar on duty, to inform him that Ms A had been admitted.

During the course of the afternoon, Ms B recorded the slow progress of the labour and abnormalities in the foetal heart rate. Shortly after the epidural was inserted at 3pm, Ms B

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notified Ms C, the Clinical Midwifery Leader, of her concerns about the foetal heart rate. Ms B requested medical review again at 3.30pm when there was a further dip in the foetal heart rate. The timing of these interactions is disputed.

When Dr D assessed Ms A at about 4pm, the foetal heart monitor was showing severe abnormalities. Ms A was transferred to theatre and her baby was delivered by Caesarean section at 4.44pm. The baby was in a very poor state. She had suffered an acute hypoxic event at or prior to delivery, which caused neurological damage from which she will not recover. As a result, the baby is severely disabled.

Definitions

In the course of outlining the background facts relating to Ms A's labour a number of medical terms are referred to and are defined as follows:

Clinical Midwifery Leader role
The role of Clinical Midwifery Leader (CML) (the position held by Ms Ms C) is described by the hospital as being "to provide expertise and support for operational, clinical and professional related issues" within maternity services. One of the key responsibilities of the CML is the area of service delivery, where the CML is charged with ensuring that services are delivered "through clinical leadership, provision of expert advice, education and the promotion of safe and best practices".

CTG
A cardiotocograph or CTG is the external electronic monitoring of the foetal heart rate. A CTG can indicate any abnormalities in foetal heart rhythm, which may indicate foetal distress. The Doppler unit converts foetal heart movements into audible beeping sounds and records this on graph paper.

Bradycardia
Foetal bradycardia occurs when the foetal heart rate is below 120 beats per minute (bpm) for 10 minutes. A moderate bradycardia of 100 to 119 bpm is not considered serious and is probably due to the foetal head being compressed during labour. Marked bradycardia (under 100 bpm) is a sign of hypoxia (oxygen deficiency) and is considered dangerous.

Foetal heart variability
Foetal heart rate variability is considered to be one of the most reliable indicators of foetal well-being. Baseline variability (the normal variation of the foetal heart rate within the normal range) increases when the foetus is stimulated, and slows when the foetus sleeps. If no variability is present, it indicates that the natural pacemaker activity of the foetal heart has been affected. The cause may be a response to narcotics or barbiturates administered to the woman in labour, but the possibility of foetal hypoxia and acidosis must be investigated. Decreasing variability indicates the development of foetal distress. Absent variability is considered a severe sign, indicating foetal compromise.

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Foetal tachycardia
A normal foetal heart rate is between 105 and 155 bpm. The rate fluctuates slightly (5 to 15 bpm) when the foetus moves or sleeps. Foetal tachycardia occurs when the rate is 160 beats or more a minute (for a 10-minute period). Moderate tachycardia is 161 to 180 bpm. Marked tachycardia is more that 180 bpm. Marked foetal tachycardia may be due to foetal hypoxia (lack of oxygen), maternal fever, drugs, or abnormal foetal heart rhythm.

'Dips' or decelerations
Early decelerations are periodic decreases in the foetal heart rate resulting from pressure on the foetal head during contractions. The deceleration follows the pattern of the contraction, beginning when the contraction begins and ending when the contraction ends. The tracing of the deceleration wave shows the lowest point of the deceleration occurring at the peak of the contraction. The rate rarely falls below 100 bpm and returns quickly to between 120 and 160 bpm at the end of the contraction.

Late decelerations are those that are delayed until 30 to 40 seconds after the onset of the contraction and continue beyond the end of the contraction. This is an ominous pattern in labour because it suggests placental insufficiency or decreased blood flow through the uterus during contractions. The lowest point of the deceleration occurs near the end of the contraction (instead of at the peak). This pattern may occur with abnormal uterine tone caused by the administration of oxytocin (a drug used to stimulate labour). If oxytocin is being used, the rate of administration should be stopped or slowed when this pattern occurs.

Foetal acidosis
Cord blood pH gives information about the foetal metabolic state. A pH of 7.4 is considered normal. When blood analyses are made of the foetus during labour by use of a scalp capillary technique, a finding of acidosis (blood pH below 7.2) is a certain sign that foetal well-being is compromised.

Meconium
Meconium is the first faecal material evacuated from the foetus' or newborn's rectum, and appears green to very dark green. It is normal for meconium to be expelled within the first one to two days of birth. Meconium can be present in the amniotic fluid as a green staining. Although not always a sign of foetal distress, meconium in the amniotic fluid is highly correlated with its occurrence. Meconium in the amniotic fluid reveals that the foetus has had an episode of loss of sphincter control.

Station
'Station' refers to the relationship of the presenting part of the foetus to the level of the ischial spines (outlet) of the mother's pelvis. When the presenting part is at the level of the ischial spines, it is at an O station (synonymous with engagement). If the presenting part is above the spines, the distance is measured and described as minus stations, which range from -1cm to -4cm. If the presenting part is below the ischial spines, the distance is stated as plus stations (+1cm to +4cm). At a +3 or +4 station, the presenting part is at the perineum (synonymous with crowning).

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18 September 2000

At 3.15am on 18 September 2000 Ms A's labour started spontaneously with mild but regular contractions. Her uterine membranes ruptured (ie, her waters broke) at 6am. Ms A, accompanied by her mother and her partner, Mr A, arrived at the Maternity Unit at 7.45am.

The Maternity Unit – 8am to 1pm
Ms B examined Ms A at 8am, found that she was in active labour (she was experiencing contractions every 1½ to 2 minutes), the cervix was 4cm dilated, and the foetal heart rate was within normal limits at 148 bpm.

Ms A had a deep bath at 9.10am to relieve the painful contractions. Ms B noted that Ms A was feeling "a little warm" in the bath and gave her "ice water and flannels for her face" for her comfort. When Ms A got out of the bath 20 minutes later, Ms B observed that the foetal heart rate was elevated to between 150 to 172 bpm.

Ms B checked the foetal heart rate again at 9.45am and found that it was 140-158 bpm. At 10.12am the foetal heart rate had increased to 152-178 bpm.

Ms A asked for pain relief and was given nitrous oxide and oxygen at 10.35am. Ms B monitored the foetal heart rate over the next half hour and found that it ranged between 148 and 176 bpm.

At 11.15am Ms B performed a vaginal examination on Ms A to assess the progress of her labour, and found that the cervix was 6-7cm dilated and the foetus was at station -1 to -2.

Ms A informed me:

> "By midday I was tired and given oxygen … I said to [Ms B], 'I think I need an epidural.' I felt I wasn't getting anywhere in the labour.
>
> [Ms B] replied, 'If that's what you want, I'll call an ambulance.' I asked [Ms B] what she thought and she said OK. [Ms B] seemed fairly 'laid back'. I don't know if this was to keep my anxiety down."

At midday Ms B noted that the foetal heart rate was accelerating to 180 bpm (foetal tachycardia) and detected an audible deceleration to 120 bpm during a contraction. Her notes record "quick pick up to baseline". Ms B listened to the foetal heart for the next 20 minutes.

At 12.15pm Ms B performed a further vaginal examination and found that Ms A's cervix was still 6cm dilated. She recorded that Ms A was "having very strong urges to bear down with most contractions". There was a small amount of greenish-brown mucus on Ms B's glove following this examination, which indicated that meconium was present.

In response to these factors, Ms B telephoned the hospital and spoke to Dr D, an obstetric registrar. Ms B outlined the progress of the labour, and that there had been no progress in cervical dilation in the previous hour, and said that Ms A was troubled by painful

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contractions. Ms B arranged for Ms A to be transferred to the hospital's Delivery Suite, and recorded that Ms A was "transferred from [the Maternity Unit] for pain relief".

The hospital's Delivery Suite – 1.30pm to 4.44pm
Ms A was admitted to the hospital's Delivery Suite at 1.30pm. When she and Ms B arrived in Delivery Suite, Dr D was in the operating theatre. Ms B went to the doorway of the theatre to inform him that she had arrived with Ms A and, through one of the theatre staff, asked his permission to arrange an epidural anaesthetic for Ms A. Dr D acknowledged Ms B and gave his permission for the anaesthetic.

Ms B informed ACC:

> "I referred to the medical team and they ordered an epidural. [Dr E], the anaesthetist, was consulted and she gained consent for this procedure … I considered that once I had referred to secondary care, transfer had occurred and I continued to provide midwifery care.
>
> If the doctor to whom the woman is referred is busy then that doctor will give a verbal consent for the midwife to arrange the epidural and will then come to meet and review the woman at the earliest opportunity."

Dr D told ACC that Ms B and Ms A arrived at the hospital at 1.50pm and that he was busy in theatre and gave his verbal consent to an epidural anaesthetic being inserted. Dr D told ACC "she [Ms B] had no other concerns".

While waiting for the on-call anaesthetist, Dr E, to arrive, Ms B prepared Ms A for the epidural. She applied an abdominal monitor for external foetal monitoring, took blood for testing and cross match (in the event that a blood transfusion was required), and inserted a cannula for intravenous fluids. The monitor showed a foetal heart rate baseline of 110-130 bpm, which was lower than it had been previously, but the machine was not receiving a strong signal because Ms A was in the sitting position. Ms B told Ms A that she would examine her to assess the dilatation of her cervix and possibly apply a foetal scalp clip to monitor the heart rate more efficiently.

Ms B performed a vaginal examination at 2.15pm. The dilation of the cervix had not progressed from the 6cm it had been when assessed two hours earlier. Ms B applied the foetal scalp clip. The foetal heart rate was recorded between 145 and 175 bpm.

Some time after 2.20pm Dr E administered an epidural anaesthetic to Ms A. (Ms B's records (which were written retrospectively) note that the epidural was inserted by Dr E at 3pm. However, she later stated that the epidural was inserted between 2.20pm to 2.40pm.) The CTG trace records that the epidural was inserted at 2.35pm and Dr E recorded that the analgesia commenced at 3pm.

First discussion between Ms C and Ms B
At approximately 2.50pm Ms B noted that there was a further deceleration of the foetal heartbeat, dipping to 100 bpm. She recorded retrospectively:

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> "Advised CML, [Ms C], as Registrar, [Dr D], back in OT (Operating Theatre). Lying on left side … Baseline dropping to 95-110 bpm. Maternal pulse 112 bpm. Asked CML [Ms C] to view – occurring with sensation of bowel pressure – Type I (early) decelerations. Toco [cardiotocograph] not picking up contractions on graph."

Ms B informed ACC:

> "[Dr D] was in the operating theatre upon our arrival … and in the theatre again at 1455 hours when the first request was made for a medical review of the CTG tracing.
>
> …
>
> I was asking for a medical review of the CTG tracing and [Ms C] would have known I was relying on her. … A CML also has the responsibility of helping the LMC if the team is not immediately available and either arranging alternative assistance or should advise the LMC on who else she should contact for help."

Ms B informed me:

> "I went and advised the senior midwife in Delivery Suite (Clinical Midwifery Leader, [Ms C]) at this time (1445hrs) of the CTG changes indicating possible foetal distress and that we still hadn't seen the Registrar and that I needed him to review the trace. [Ms C] threw her hands up in the air and told me that [Dr D] was back in theatre and would be available in 10-15 minutes."

There is a discrepancy in the information provided by Ms B and Ms C about this consultation at approximately 2.50pm. Ms B states that she left the labour room to locate Ms C, whereas Ms C says that she entered the labour room to answer the call bell activated by Ms B.

Mr A recalled:

> "[Dr E] put the epidural in. [Ms B] helped [Ms A] to be set up and in position and the epidural went in fine. [Dr E] hung around asking if [Ms A] could feel anything. [Ms A] told her 'No', she couldn't feel the contractions now and [Dr E] left.
>
> A little while after [Ms B] said to [Ms A], [Ms A's mother] and I, that there had been some decelerations on the scan. She said that she didn't think it was anything to worry about, but she would get the leading midwife to check it. She then left the room and when she came back she said, '[Ms C] is coming.'
>
> When [Ms C] came, she said it could be due to the epidural going in. She agreed that there was a deceleration, 'But it's popped up again reasonably quickly. There are no further decelerations so just keep an eye on it. The doctor will turn up when he is available'. She seemed to be not too concerned."

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Ms C informed me:

> "I was not involved with this client until after the epidural was inserted – I remember this because the client was now comfortable and pain free when I first met her and her partner in response to the LMC ringing the bell.
>
> When I entered the room, [Ms B] told me that there were some early decelerations (Type I) in the foetal heart rate that had now recovered. [Dr D] (O&G Registrar) was in theatre at the time, which I explained to [Ms B]. I was not requested to call the consultant or another Registrar. Had I been requested to call another doctor, it would have been my usual practice to encourage the LMC to make the phone call while I stayed with their client. This way there is less chance of miscommunication; the LMC knows the exact situation of their client and is better placed to answer any questions from the Consultant. My role, as the midwife in charge, was to facilitate the stay, not to usurp the LMC's duty of care.
>
> I was told by the LMC that everything had settled and there were no further decelerations of the heart rate noted during the short period that I was present. I then left to attend to the rest of my work in Delivery Suite. The situation was never relayed at any time as an urgent request."

Ms C further stated:

> "At no time during my contact with the LMC [Ms B] and this client during labour was the care transferred to the hospital midwifery staff.
>
> …
>
> Although clients who receive epidural pain relief have to be referred to the medical team under the section 51 referral guidelines, it is usual practice at [the hospital] for the LMC to continue midwifery care and responsibility for their client unless they do not hold current [the hospital's] Epidural Certification.
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> …
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> [The hospital's] midwives were not involved with the care of this client and as far as I was aware, as the charge midwife, labour was progressing as expected and there were no problems."

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Ms C also advised me that Ms B did not ask her to view the CTG tracing and that she was not informed about the "history of poor progress in labour, prior tachycardia and the possible presence of meconium". Nor was she informed about Ms B's concerns about foetal distress.

Ms B changed the paper in the CTG machine at 3.24pm. At that time the foetal heart rate baseline was 140 to 165 bpm with decelerations down to 105 bpm.

Second discussion between Ms C and Ms B

At 3.30pm while still waiting for Dr D, Ms B observed that the foetal heart baseline had dropped to 100-130 bpm. She assisted Ms A to change her position in an effort to improve the oxygen supply to the baby. Ms B informed me that she then went to the Delivery Suite office to inform Ms C of the continuing foetal distress and lowering baseline, and stressed the urgent need for medical review. Ms B returned to Ms A.

Ms B stated:

> "I wanted [Ms A] to be seen as I was concerned about the trace and just knew I had to keep going back to find out when [Dr D] was arriving."

Ms B informed me that Ms C arrived to review the situation at 3.44pm. The baseline had improved slightly to 120-140bpm. Ms C viewed the trace and informed Ms B that Dr D would be only five to ten minutes. Ms B recorded in the notes that she requested Ms C to review the CTG trace. While it is recorded on the CTG trace that Ms C reviewed the trace, no specific time is recorded.

Ms C informed me:

> "A little while later, I am not sure of the exact time frame because I was involved elsewhere (the time was not documented in the notes by the LMC but from reviewing the CTG recording, it was approximately 15.50hrs), the bell rang and again I answered it. I was told that there were further early decelerations in the foetal heart rate that had again recovered as I entered the room. I told the LMC that I would get the registrar to come in as soon as he got out of theatre and as I left the room, [Dr D] was approaching and I asked him to review the tracing. Again, at no time was I requested to contact a Consultant or another Registrar.
>
> I continued with my own workload on Delivery Suite and [Dr D] went to assess the client at approximately 16.00hrs [4pm]. Shortly afterwards [Dr D] informed me that the baseline rate of the foetal heart was now falling and that we needed to go to Caesarean section immediately. I then reorganised staffing and arranged to transfer the client to theatre without delay."

Dr D stated in a report to ACC:

> "I was unaware of any abnormalities regarding the CTG until I came out of the theatre after 4 o'clock and assessed [Ms A]. At that time she was still 6cms dilated and the

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> liquor was clear. I noted a previous bradycardic episode on the CTG at approximately 3 o'clock and the CTG was bradycardic when I saw her. I advised [Ms A] that an urgent Caesarean section was indicated for foetal distress."

Mr A recalled that Dr D walked into the room at 4pm, looked at the trace paper and asked, "How long has this been going on for?" He said that Dr D then examined Ms A, informed them that she was 6cm dilated and explained about a Caesarean section or "putting a drug in". Mr A said that Dr D told them that he advised a Caesarean section and that he was going to ring the consultant.

Ms B recalled that Dr D advanced the CTG tracing paper and took the trace to discuss the management of Ms A with a consultant obstetrician. Ms B started to prepare Ms A for the operation and explained to her and Mr A what to expect in theatre. She said that during this time the foetal heart rate was audible and she did not notice until 4.27pm that Dr D had switched off the trace recording button when he advanced the paper to remove it from the machine. Ms B reactivated the recording and noticed that the foetal heart was 80-100bpm with no variability and a lowering baseline.

Dr D stated:

> "As soon as I came out of the room I advised the anaesthetist, [Dr E], that we would be performing an urgent Caesarean section. I then discussed the case with [the consultant obstetrician] over the telephone who agreed with the decision to perform a Caesarean."

Ms B recorded: "Handed over care to hospital team at 1630hrs."

Dr D informed me:

> "I went back to the room to still find there were decelerations on the CTG and that there had been areas which had not been recorded. Pushed [Ms A], on her bed, into theatre myself and she was transferred to the theatre bed. I did a very quick scrub, a very quick preparation of [Ms A] and an emergency Caesarean section. [The baby] was handed over to the paediatric representative present upon delivery.
>
> On opening the uterus there was thick meconium liquor and the cord blood showed an arterial pH of 6.81."

The baby was born in a very poor state at 4.44pm. There was no evidence of spontaneous heart rate or respiration at birth and she required intubation, ventilation and the administration of adrenaline to stimulate a heartbeat and breathing.

The paediatric advisor to ACC advised that the baby suffered an acute hypoxic (lack of oxygen) event at or during the period prior to delivery. As a result, the baby had no heart rate or respirations at birth, severe hypertonia, mild renal failure and early onset of convulsions. The baby sustained neurological damage from which she will not recover, and is severely disabled.

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Follow-up actions

A meeting was held on 15 December 2000 between hospital staff and the couple's families, to discuss issues related to the birth of the baby. In response to concerns raised about staffing, the Clinical Unit Leader for the hospital explained that there were normally three doctors on call during the day for the hospital's Delivery Suite, but they were also responsible for covering other areas such as the operating theatre and the clinics. On Mondays (Ms A's labour was on Monday 18 September 2000) there was a shortage of senior medical staff. He said that if there were any concerns about a labour, such as an abnormal foetal heart trace, other options were available to midwifery staff to access medical assistance and that doctors could be called away from what they were doing in cases of emergency. This action depended on the perception of the Delivery Suite staff of how urgent the emergency seemed to be.

The Clinical Unit Leader stated that the hospital had recognised for some time that there was a shortage of senior medical staff and consultants in the Delivery Suite who were free of other commitments and able to cover for emergencies when required.

The consultant obstetrician informed the meeting that at no stage on 18 September was he called to Delivery Suite, even though he was working in the clinic one floor away. He said: "Delivery Suite always takes precedence over other clinics."

ACC

In January 2001 Ms and Mr A submitted a claim to the medical misadventure unit of ACC in relation to the care provided to Ms A by Ms B and Ms C. ACC obtained the advice of an independent obstetrician and an independent paediatrician. (It does not appear that advice was obtained from an independent midwife at this time.)

On 14 September 2001 ACC advised Ms and Mr A that their claim was accepted as medical error.

Ms B informed ACC on 20 December 2001 that she did not accept the decision.

Ms C requested a review of the decision as she had not had an opportunity to make submissions. A review hearing was held on 14 June 2002. In support of her application Ms C and the hospital submitted reports from the Professional Advisor Midwifery for the hospital, and the Maternity Team Manager for another public hospital. (The hospital also submitted statements to ACC, subsequent to the review hearing, from the Clinical Charge Midwife at a third public hospital, and the Midwifery Co-ordinator at a fourth public hospital.)

In summary, these reports concluded that there was insufficient evidence that Ms C had information available to her that would have given her cause for concern. They also noted that there was no formal hand-over of care until 4.30pm when Dr D reviewed the tracing.

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The reviewer quashed the decision on the grounds that Ms C was not given a fair chance to present her view on the circumstances before the finding of medical error was made against her. The reviewer directed ACC to fully consider all the information and submissions presented by Ms C and to seek specialist advice in light of this information.

Further independent advice was provided to ACC by a midwife and an obstetrician. The midwife advised ACC:

> "[Ms B]
>
> …
>
> While [Ms B] did communicate to the CML, [Ms C], her concerns about the FHR [foetal heart rate] it is likely that she has failed to communicate the seriousness of the finding of foetal distress. She also failed to make direct contact with a medical officer regarding the FHR. There is very poor documentation by [Ms B] around this time.
>
> …
>
> [Ms C]
>
> In her role as CML for the shift [Ms C] was in the unique position to know the state of busyness of the ward, the availability of the registrar and the whereabouts of other medical staff, especially the consultant. It was her duty to notify the registrar of the FHR abnormalities present in [Ms B's] client. It appears she did not do this. It was her duty to notify another medical practitioner, namely the consultant if the registrar was unavailable. It appears she did not do this. While the responsibility for care remains with the LMC unless there is a conscious and formal handover, the CML has a right to take control when extraordinary circumstances exist.
>
> I would conclude that [Ms C] was in the position to make that judgement call and that she was in possession of enough facts in this case to intervene earlier. Therefore I conclude that [Ms C] has failed to observe a standard of care and skill reasonably to be expected in the circumstances."

The obstetric advisor advised ACC:

> "In summary, [Ms B] has contributed to the medical error because
>
> - she did not inform [Dr D] of the foetal tachycardia when she arranged to transfer [Ms A] to [the hospital],
> - she possibly did not recognise, but certainly did not react to, [Ms A's] failure to progress and the abnormal CTG on admission,
> - she did not transfer care to the hospital team soon after admitting [Ms A], and/or
> - she did not ensure that [Ms A] got medical help promptly.

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> …
>
> [Ms C]
>
> … There was foetal compromise from 1410 hours and [Ms C] should have been aware of this when she saw [Ms A] at about 1500 hours. Even though [Ms B] had not transferred care to the hospital team at that stage [Ms C] should have called a consultant. This would not have overridden [Ms B], who had been trying, albeit without urgency, to get medical help. Thus, I conclude that [Ms C] contributed to the medical error because she did not fulfil her responsibilities as the Clinical Midwifery Leader."

The Medical Misadventure Panel recommended that the claim be accepted as medical error on the grounds that Ms C did not appraise herself adequately of the circumstances.

On 12 December 2002 the recommendation was accepted and ACC reported a finding of medical error. Ms C submitted a further appeal.

ACC decision dated 17 June 2003
A hearing was held on 20 May 2003. The outcome of the review was that Ms C's action did not constitute medical error and accordingly the decision of December 2002 was quashed. The reviewer stated:

> "I conclude that not only did [Ms C] not know of the difficulties that were occurring, but additionally there were insufficient indications that she needed to adopt a more proactive or investigative role in ascertaining the situation in [Ms A's] room. She did not fail to observe a standard of care and skill reasonably to be expected in these circumstances.
>
> I find it unnecessary, therefore, to address any further the other elements of medical misadventure: causality and injury. I note that I would not agree with the Panel's assumption that because a causal link is established between [Ms B's] conduct throughout the day and [the baby's] injury, that it necessarily follows that there is a causal link between [Ms C's] conduct over the period of an hour and the injuries – it may be that the damage was already done by that time.
>
> I have taken note of concerns about the process used by ACC in reaching its decision. However I heard no argument that parties had been unable to fully and fairly put their cases to hearing. I do not find it necessary to rule on the processes used earlier by ACC.
>
> My substantiative finding is that ACC's decision that medical error was attributable to [Ms C] is incorrect. [Ms C] is successful in her application for review and I **quash** the decision of ACC of 10 December 2002."

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The hospital's documents

The hospital's 'Terms and Conditions of Compliance to the Access Agreement for Maternity Facilities' (1998) state:

> "**CONSULTATION**
>
> A practitioner will take into account the Referral Guidelines and refer to a Consultant where a woman has factors associated with complicated or abnormal outcomes …
>
> Until such time as transfer to secondary or tertiary care is required, the independent practitioner is solely responsible for the management of care except in cases where delegated medical care is undertaken.
>
> The independent practitioner will consult with the woman and the other appropriate health professionals involved with her care, … to ensure that:
>
> …
>
> (c) all such consultations and decisions are documented in the case notes.
>
> **HAND-OVER TO PRIVATE SPECIALIST RESPONSIBILITY OR TEAM SPECIALIST**
>
> Responsibility for an independent practitioner's client will lie with the independent practitioner until and/or unless there is a conscious and formal hand-over of primary responsibilities or an event occurs which automatically enacts this policy.
>
> The Clinical Midwifery Leader in Delivery Suite, has the responsibility for the co-ordination and provision of midwifery care for all women in the Delivery Suite area.
>
> Where the staff become aware of circumstances causing concern for the safety of the client and/or baby, the Clinical Midwifery leader in the Delivery Suite will:
>
> – Draw this to the attention of the independent practitioner
>
> – Inform the Consultant of the day of the situation
>
> – Give the woman a full explanation of why the referral to a consultant is indicated."

The hospital's 'Position Description' – Clinical Midwifery Leader (1998) states:

> "Reports to: Clinical Unit Leader and Manager – Women's Health
>
> **1 Purpose of Position**
>
> To provide expertise and support for operational, clinical and professional related issues in accordance with the agreed Women's Health business plan.

To provide the clinical, operational and educational interface between the CUL / Manager partnership, the clinical staff, Administrators and Midwifery Professional Advisor.

…

3 Key Accountabilities

…

3.2 Service Delivery Management: To ensure contracted service outputs are delivered with appropriate standards of clinical care, through clinical leadership, provision of expert clinical advice, education and the promotion of safe and best practices.

…

3.5 Risk/Quality: To ensure compliance with government legislation and the hospital policies in respect to clinical quality and risk at the client interface through the implementation and monitoring of systems, processes and improvements.

…"

Independent advice to Commissioner

The following expert advice was obtained from an independent midwife, Ms Chris Stanbridge:

"**Interface of Lead Maternity Carer and base hospital staff**:

Accepted practice, and as the the hospital Access Agreement for Maternity Facilities expects, is for the Lead Maternity Carer (LMC), in this case [Ms B], to be responsible for the care of the woman booked under her care until, or unless, she specifically hands that responsibility to another practitioner (eg if on leave, a back-up midwife; handed on to secondary care). This should be clear at the time to the LMC, the woman, and the person care is handed on to, and should be documented. Consequently [Ms B] retained the prime responsibility for [Ms A's] care until she consulted with [Dr D], when he accepted medical responsibility and she continued with midwifery responsibility. Total care was transferred to [Dr D] and the hospital team at 4.30pm (from [the hospital] notes).

However, the clinical midwifery leader in Delivery Suite has the responsibility 'for co-ordination … of care … for all women in the Delivery Suite area' (page 17 [of the hospital's] Access Agreement, Jan 1998). She also has a responsibility to inform the

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consultant of the day where there are 'circumstances causing concern for the safety of the client and/or baby' (pages 17-18 [of the hospital's] Access Agreement).

The expectation of the charge midwife (CM) is to co-ordinate various categories of staff (eg core and independent midwives, medical staff) and what needs to be done, commonly liaising with and guiding medical staff on priorities as individual midwives' (core and independent) prime focus is with the woman she is caring for.

The expectation is for core staff to provide assistance in any emergency.

The CM is usually a senior and experienced midwife and her (possibly unexpressed) opinion is heeded as reassuring. [Mr A] reports [Ms C] 'seemed not too concerned' about the two times he recalls her assessing the CTG trace. In this situation her lack of action (i.e. calling or advising calling medical care in urgently) implies she was comfortable with the situation and didn't see anything that caused alarm or the need to hasten medical assessment beyond when the registrar was free.

Although formally a consultation is with the obstetrician on call the culture in delivery suites tends to be that the registrar is the person of contact with the medical staff.

The charge midwife can play a gate keeping role and it is reasonable for [Ms B] to be reassured by [Ms C's] apparent lack of concern about the baby's heart rate.

Despite her obvious anxiety (repeatedly seeking CM's assessment and asking for registrar) and her (legal) responsibility to link with the registrar, or consultant directly, it is unusual and difficult for a visiting practitioner to override common practice in the unit by going directly to the consultant if the registrar is not freely available.

It would be more likely for the CM to call in the consultant if the workload in the unit required it, having an overview of all the demands on the registrar at any one time, and being aware of midwives' concerns.

[Ms C] is responsible for any midwifery decisions or actions she takes. Although not directly responsible for [Ms A's] care, she was responsible for acting on any concerns she might have – usually by advising the lead maternity carer, and/or advising the medical staff of her concerns.

Foetal Distress:

Foetal distress is a general term indicating a possible/lack of well-being of the unborn infant. It is not a black and white situation and is based on a collection and correlation of a number of issues. Frequent monitoring of the baby's heart rate while in utero, the speed, accelerations, decelerations, timing of them linked to contractions, movements, and the colour of the liquor can all give clues to the baby's well being.

In [Ms A's] situation [Ms B] noted a low grade but variable foetal tachycardia (faster heart rate) through the late morning of her labour. This may have been an indicator of foetal distress. However, her documentation notes frequently listening to and listening

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throughout and after contractions which should pick up any slowing of the heart rate, which if slow to return to its normal rate, may indicate distress. When an audible deceleration was heard at midday it was at the peak of a contraction and rapidly returned to baseline with no further decelerations noted over a number of contractions. The deceleration at the peak would be acceptable especially as labour progresses, and with rapid return, and the lack of further decelerations being noted, further reassurance.

Clear liquor throughout (still noted to be clear at the final internal immediately prior to Caesarean Section) would have been reassuring. Immediately after delivery meconium was found in the upper airway but not the trachea. This would suggest the meconium had been present prior to birth, but not sucked in by baby nor blown in by artificial ventilation. The presence of the meconium in the upper airways could be expected if there was meconium present in the liquor, and if suctioned out before the baby inhales should not pose a problem to baby's breathing. Presence of meconium, if seen during labour, can suggest foetal distress.

Fast baby heart rate can also be associated with a rise in maternal heart rate and/or temperature. [Ms A] needed the use of a fan and ice water flannels to cool her through labour – these are common aids and she had a normal temperature recorded at mid morning. She had no history of prolonged ruptured membranes nor signs of infection which may have adversely affected the baby in utero.

Of note is there were at least two episodes of decreased movement through [Ms A's] pregnancy (at 30 and 36 weeks). Both reportings were appropriately followed up by her LMC with a cardiotocograph (CTG) – a tracing of the baby's heart rate, both of which were reactive and normal. She also had a scan with growth in the normal range and adequate liquor.

There is research to suggest such episodes may be reflecting some event the infant is experiencing that reduces the baby's oxygen and/or nutrient flow, and consequently may damage the baby. This damage may not be apparent until birth or later. Cerebral palsy is known to be mostly caused during pregnancy, and these episodes may give a clue to this happening.

While it seems obvious [the baby] was critically affected at birth, it may be these previous episodes damaged her significantly, and may have reduced her tolerance to labour.

Assessment of cardiotocograph tracings:

CTGs are a tool in helping assess the baby's well-being while it is still in utero. Once again, it is not always clear cut what it is telling us and there is variation in different readers' assessments and what they may indicate.

In [Ms A's] situation [Ms B] appropriately traced [Ms A's] baby's heart rate with a CTG because of an impending epidural (which may alter the heart rate), because of minimal progress in labour, and the low grade tachycardia noted before transfer.

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Remembering that [Ms A] was labouring and would have required support through each contraction, [Ms B] appropriately inserted an intravenous cannula (needed prior to an epidural), took blood samples and sent them to the laboratory (needed in case intervention eg Caesarean Section was needed), and checked internally the dilatation of the cervix as [Ms A] was wanting to push (a sign of possible second, or pushing, stage of labour). She applied a clip directly to the baby's scalp (during the internal examination) to monitor the baby's heart rate more clearly as [Ms B] had concerns with not being able to easily monitor the baby's heart rate with the abdominal transducer.

The CTG trace was clearer following this and showed a heart rate above 160 which ideally should have been discussed with the registrar involved.

The epidural was inserted and effective. [Ms B] was obviously not happy with the foetal heart rate and its responses and advised, then asked the charge midwife to view as the registrar was unavailable immediately. This was an appropriate consultation and it would be expected that [Ms C] would have viewed the trace to date, and if concerned asked for more detail of the labour if she was not already aware of it. It appears she had no immediate concerns.

It is reasonable for the LMC to respect the opinion of the charge midwife (in this case the implied interpretation it was fine to continue as things were, and not hasten the medical consultation).

Both midwives bear the responsibility of responding to their interpretation of the CTG.

[Ms B] recognised the possibility of a distressed infant and responded to that. She

- made repeated attempts to get the registrar to review
- sought opinion of the charge midwife several times
- expressed her anxiety about the trace to the family
- tried position changes for [Ms A] which will sometimes improve the blood flow to the baby and consequently improve the heart rate.

She clearly indicated she was increasingly concerned, with good cause, and it was ultimately her responsibility to insist on the registrar, or consultant, being asked to come and review the situation. She, along with [Ms C], did not appear to appreciate the severity of the problem until it declared itself with the baby's prolonged slowing of heart rate after the registrar was present.

It is easy in retrospect, knowing the outcome, to read into the CTG signs of marked foetal distress. It is not always so clear cut at the time. By the time the registrar was free, there was a clear persistent slowed baby heart rate (seen on the CTG as commencing at 4.05pm) which showed a clear need for intervention and Caesarean Section was begun at 4.39pm.

However two factors make me think none of the staff were aware of the critical state of the baby in utero.

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1) According to [Ms B's] letter 'E' [Dr D] raised the possibility of a foetal scalp blood sample (used to assess the pH – the acidity of the blood which gives clearer information on whether the baby is coping or not). If he was highly concerned about the infant at his initial contact he would have recommended immediate Caesarean rather than considering a scalp pH.

   Once the marked slowing of the heart rate was heard the need for intervention was clear.

   Mr A recalled '[Dr D] then explained about a C-section or putting another drug in for [Ms A]'. This may be the foetal blood sampling he is referring to, or the use of Syntocinon to enhance labour's progress. Either way it seems that at that stage there was sufficient confidence to allow consideration of alternative management to Caesarean Section.

2) If a severely affected infant was expected to be delivered, a registrar or consultant paediatrician would normally be called prior to the delivery and expected to attend as the most experienced people are [indicated]. Rather it seems a SHO had been paged, and a neonatal nurse (not noted to be a NNP) attended.

[The hospital's] Access Agreement covers emergency situations and states (page 20) 'in an emergency situation the Neonatal Registrar / Neonatal Nurse Practitioner (NNP) is called.'

The assumption is that staff attending [Ms A] did not expect such a severely affected baby to be delivered.

Progress in labour:

Progress in labour is, once again, not a black and white situation.

Many factors can influence the time taken to birth a baby eg whether first or subsequent baby; position of the baby; strength, length and frequency of contractions; position and activity of mother; maternal and infant anatomy.

[Ms B's] actions indicate she was aware of the possibility of problems when she arranged transfer of [Ms A] to [the hospital]:

– she discussed with [Ms A] and her family the findings of her internal examination
– [Ms A] requested an epidural for pain relief, and
– an awareness of the baby's higher heart rate.

It was a reasonable transfer.

On admission to the base hospital she proceeded with preparation necessary for an epidural while supporting and monitoring [Ms A].

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While an epidural was requested by [Ms A], it is also common practice to use an epidural where progress has been slow (and there is no contraindication). Often the relaxation that comes with relief from pain and altered muscle tone will allow rapid progress in dilatation of the cervix. If this doesn't occur, and no other signs of problems are present (in this case there was concern about the baby's heart rate), then medication (syntocinon intravenous infusion) is commonly used to enhance uterine activity. This is done under the direction of the medical staff.

It appears [Ms B] did not clearly articulate the minimal progress in labour to the registrar, and it may have sped his availability to assess [Ms A] if she had been more specific about the history and symptoms of which she was aware. The busy-ness of the unit no doubt influenced her communication with the registrar, and certainly her access to him. The go-between nature of her communication with him when first at the hospital would have impacted on how much she communicated to him, and at that stage permission for the epidural would be her initial focus. It was reasonable to assume he would visit [Ms A] when he was free.

She did make repeated efforts to get assistance which was delayed due to the medical workload of the day and no easily and freely available medical staff being present on the unit.

Until the late and prolonged slowing of the baby's heart rate, it is probable the management would have been the same or similar to what happened.

ie
- the monitoring of baby's heart rate
- pain relief
- assessment of the cervix, baby's position and descent, maternal well-being
- possible FBS
- possible syntocinon infusion if still no progress after the epidural effective.

Given the busy-ness of the unit it was not unreasonable to continue with what was happening while awaiting the registrar's availability, and with the charge midwife's lack of active concern about the baby's condition.

In summary there are, certainly in retrospect, signs of foetal distress that optimally would have been responded to by both the midwives involved. Given the state of the unit, the difficult access to medical staff at the time, and the anticipation the registrar was coming as soon as he was available, it is reasonable that care was continued as it was while awaiting his arrival. However, both midwives could have taken the step of seeking consultant assessment despite this being outside the norm.

The slow progress in labour was a secondary issue to be addressed by the registrar, and would normally be expected to have followed his reviewing the baby's heart tracing."

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Additional expert advice was provided by Ms Stanbridge:

> "Thank you for asking me to clarify my opinion on the midwifery services provided by [Ms B] and [Ms C] to [Ms A] in 2001.
>
> It was reasonable to expect [Ms B] to have anticipated the registrar would come and review [Ms A's] situation as soon as he was able, given
>
> – he'd been notified of [Ms A's] impending transfer
> – she had been admitted at 1330 hours
> – he definitely knew of her admission at 1410 hours
> – she was an acute admission
> – the registrar would be frequently prioritising the order of need for his attention, normally by asking the charge midwife for a verbal summary of what was happening with the women awaiting attention
> – and that [Ms B] could reasonably have assumed the charge midwife had passed on her concerns about the CTG.
>
> It was reasonable for [Ms B] to have awaited his arrival as far as progress was concerned.
>
> It was reasonable for [Ms B] to have sought another opinion before, or by, 1450 hours following a period of baseline tachycardia, and then deceleration of the baby's heart rate. There is the expectation that medical assistance will be forthcoming when an LMC expresses concern, and that it was a reasonable assumption of the LMC that there must be more severe problems being attended to by the medical staff when the registrar wasn't available at that time. It was reasonable that this opinion was then sought from the charge midwife in these circumstances.
>
> The barriers imposed by the normal processes of consultation would have made it an unusual step to have taken but it would have been reasonable for [Ms B] to have insisted [Ms C] seek, or sought herself, the registrar or consultant given [Ms B's] continuing anxiety about [the baby's] trace ie when [Ms C] was called the second time or before.
>
> It was reasonable to expect [Ms C] to have
>
> – passed on to the registrar [Ms B's] concern about [Ms A's] CTG, at least as soon as he finished the first Caesarean, and again when she was called to re-assess the trace the second time
> – sought consultant input given the registrar was still not available at 1540 hours, or before
> – accepted responsibility for her interpretation of the situation and CTG and to have acted accordingly.
>
> I find it difficult to be cut and dried about these decisions given the situation is being reviewed in retrospect and none of the three practitioners involved at the time appeared to appreciate the problems this baby was experiencing until the terminal bradycardia. It

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seems [Ms B] was the most aware of the potential issue, and neither the charge midwife nor registrar acted with urgency until the bradycardia about 1610 hours.

Because of this I have reviewed the relevant information (primarily the CTG trace, and the time line) with my midwifery colleague … (also a HDC midwifery adviser)."

Response to Provisional Opinion

Ms F, corporate solicitor for the hospital, responded to the provisional opinion on behalf of Ms C.

She stated:

"With respect, [Ms C] and [the hospital] oppose the provisional opinion as it relates to the findings that they have breached the Code (the findings) because:

i) the findings are based on incorrect facts.

ii) the findings are based on an incorrect understanding of the professional relationship between the Independent Practitioner, [Ms B] and the Clinical Midwifery Leader, [Ms C].

iii) HDC does not have extensive evidence showing that [the hospital] had excellent processes in place at the time of this incident to ensure that [Ms C's] practice was within acceptable parameters."

Ms F submitted that the Commissioner's finding, based on Ms Stanbridge's expert advice, was that Ms C was in possession of sufficient facts to realise the need for earlier intervention and knowing that Dr D was unavailable, was in a position to make the judgement to call for back-up obstetric assistance. Ms F stated that this was based on a misunderstanding of the role of the Clinical Midwifery Leader (CML). Ms F pointed out that my expert advisor misquoted the 1998 Maternity Facilities Access Agreement when she stated: "The clinical midwifery leader in Delivery Suite has the responsibility for co-ordination … of care … for all women." The word "midwifery" has been omitted and the agreement reads that the CML has responsibility for "midwifery care". The CML at the hospital "does not have the responsibility for the co-ordination and provision of medical care for women in Delivery Suite" or of "midwifery care where that care is provided by an independent practitioner".

Ms F stated:

"The expert refers to the requirement in the access agreement that the CML informs a consultant where she is aware of the circumstances causing concern for the safety of the client or the baby. This has no significance in this case as there was no reason why [Ms C] should or could have known that there was a safety concern. [Ms C] was reassured

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> by a very experienced practitioner that any cause for concern had resolved by the time she entered the room. [Ms B] did not request a consultation from [Ms C].
>
> …
>
> The interactions that occurred between these two practitioners is common in delivery suite at the hospital. CMLs will only take control of an independent practitioner's practice where it is clear without self initiated investigation that something has gone or is going horribly wrong. …"

Ms F further submitted that Ms B did not request a consultation from Ms C; had she done so, Ms C would have performed a full midwifery review and recorded her findings. Ms C disputed that her interaction with Ms B was a consultation, as described by my expert, and advised that the conversations that did occur are common in the delivery suite at the hospital. Ms C considered the relationship between her and Ms B as "one of equal colleagues", and that she did not reassure Ms B; rather, Ms B reassured her, "saying that there has been early decelerations that were recovered by the time [Ms C] answered the bell". Ms C did not view the CTG recording as she was not asked to, nor was she informed that there were concerns about foetal distress, poor progress of labour, tachycardia, or the possible presence of meconium. She was informed only of the early deceleration of the foetal heart rate which recovered to the baseline, a common phenomenon in advanced stages of labour and "on its own, not a cause for concern".

Ms F stated:

> "In such circumstances it is totally inappropriate to view the CTG recording. … There was nothing untoward communicated and nothing to alert [Ms C] that further questioning was required. [Ms B] was an experienced practitioner who should have been able to interpret a CTG recording without referral to another midwife."

In Ms F's view, Ms B had a professional responsibility to "communicate her concerns, explicitly, concisely and in a timely manner requesting a formal consultation from [Ms C] and calling the consultant direct".

Ms F submitted that as Ms C did not breach the Code, the hospital was not vicariously liable. In any event the hospital had satisfactory systems in place to appraise Ms C's competence at the time of this incident, and provided her with ongoing training and support. (Copies of the hospital's nursing certification and performance review and assessment documentation for Ms C was provided.)

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Additional advice to Commissioner

The following additional advice was provided by Ms Stanbridge:

"In response to the [hospital's] Corporate Solicitor's response (2.4.03):

Clinical Midwifery Leader (CML) role:

In note 3 of this report [Ms F] quotes the [hospital's] Access Agreement ...

'The CML in Delivery Suite has the responsibility for the coordination and provision of midwifery care for **all** women in the Delivery Suite area.' (My emphasis.)

This re-affirms my opinion that [Ms C's] role included the coordination and provision of [Ms B's] midwifery care to [Ms A].

In response to note 9 I used 'staff' in the context of 'a specific group of workers' (Collins Pocket Dictionary 1987 London), not necessarily employed.

It seems extraordinary that the CML has no role with the Lead Maternity Carer (LMC) midwives. If she were co-ordinating only [the hospital's] midwives, why was there any interaction with [Ms B]?

Note 31. I continue to believe, and support the Commissioner's opinion (A report by the Health and Disability Commissioner: [Ms B], [Ms C], the hospital para 1, page 24), that there is responsibility on the part of the CML to coordinate and supervise and provide expert clinical advice.

There is an expectation for her to be pro-active in seeking information, especially when doubts are raised about the well being of the woman or baby – in this case a woman transferred in and needing epidural pain relief, and possible concern about the baby's heart rate.

Because her role involves coordination of midwifery services (which I believe should and does include Access Agreement holder midwives) it seems reasonable for the CML to have a summary of the history of each woman in Delivery Suite, and be mindful of their progress.

CML Consultation:

Ms F states in note 5 that '[Ms B] did not request a consultation from [Ms C]'. I agree there is no documentation by [Ms C] about a consultation between herself and [Ms B]. However there are several factors to be considered.

Maternity Facility specifications require the Maternity Facility to provide consultation and a back-up service to the LMC. They expect the Facility

'... to provide occasional advice to the LMC;' (3.2.3 (ii)) and that

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'a midwife is available 24 hours / day, 7 days / week to provide support to the LMC during labour and birth.' (3.2.3 (i).)

They also expect 'a good working relationship between the facility and each woman's LMC so that women receive appropriately coordinated care.' (5.2 (ix).)

Secondary Maternity Services specifications expect the provision of '… access to a multidisciplinary team that includes obstetricians, anaesthetists, … midwives … who will provide: … a 24 hours / day, 7 days / week consultation service for women / babies who are under the care of a LMC and, in reference to the Referral Guidelines, require a consultation with a Secondary Maternity Service.' (3.1 a.)

I believe some of the onus is on the facility, and thus its (employed) staff, to make the system work. There needs to be easy access for LMCs to the multidisciplinary team.

Given that the CML would not normally be directly involved in the care of a woman by a midwife LMC, being invited into the woman's room is tantamount to a consultation. As [Ms F] states in note 38 this type of interaction is common in delivery suite. It occurs for a reason – there is concern for the woman and/or her baby's well-being, or for updating the CML on the status of the woman's labour. They are not random events with no significance. They may be relaxed and informal but nevertheless involve communication about the woman and her well-being.

If no concerns were communicated to [Ms C], why was she involved or visiting [Ms A]?

As a registered midwife, [Ms C] is professionally responsible for any interaction, assessment, and management she has with any woman and / or health professional she relates to in a midwifery role. This involves a responsibility to seek further information to form an opinion or make a decision.

This situation might be common at a base hospital, but it is not normal. [Ms A] had planned to labour and birth at an outlying hospital without the aid of an epidural. She was experiencing abnormal pain which necessitated her changing her birthplan to transfer and seek epidural pain relief. This is no longer a normal labour. Added were the documented slow progress of dilation, and some changes to the baby's heart rate.

Given [Ms C] knew of [Ms A's] transfer in for an epidural – two common but abnormal situations, and then a call or visit from the LMC, it is reasonable to expect her to review the situation closely with the LMC.

In regard to note 10 in [Ms F's] response the '… (possibly unexpressed) opinion is heeded as reassuring' refers to [Ms C's] inaction in response to her assumed review of the CTG and [Ms B's] concerns and request for medical / midwifery review of the trace.

In summary: [Ms C] visited [Ms A] twice having the opportunity to review the CTG, and / or seek any further information she thought appropriate. It seems pointless responding to a request for help (either by bell or being sort out in person) if she did not

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respond to the situation, particularly on the second occasion and given this was no longer a normal labour (transfer, epidural). [Ms B] may well have been reassuring. However, [Ms C] still has a responsibility to make her own assessment and respond accordingly.

Handover:

There can be medical (and not necessarily midwifery) consultation or handover i.e. on arrival at the hospital delivery suite there was a medical consultation with the Registrar (with resultant verbal consent for an epidural) and the LMC retained responsibility for midwifery management.

Secondary medical care can be instigated without secondary midwifery care i.e. medical care was initiated at approximately 1.30pm while [Ms B] continued (LMC role and) midwifery care.

Midwifery care was not handed over until 4.30pm i.e. at that time total care was then the responsibility of the [hospital] team.

It is recognised that women requiring an epidural often have a need for obstetric involvement in their labour, sometimes at short notice. Consequently the College of Anaesthetists expects obstetrician involvement with care of women having epidurals in labour, and that this is instigated before an epidural is commenced. I would assume [hospital's] policy reflects this expectation and that the norm would be for medical staff to visit and review the woman (for whom they had given approval for an epidural) as soon as possible, if not before the epidural is commenced. If this doesn't happen, one wonders why involve them at all.

Specific issues:

Note 16: Intravenous lines are inserted because of the potential hypotension (drop in blood pressure) that can be associated with insertion of an epidural, and its potential to influence blood flow to the placenta and baby.

Blood samples are 'standard procedure' because of the increased potential of a Caesarean Section for any women requiring an epidural, even when no problems are anticipated.

Note 17: I do not have the original notes to review. However, I based the '[Ms B] was obviously not happy with the foetal heart rate and its responses ...' comment on the reported

- repeated attempts to have medical then midwifery review of the CTG
- discussion with the family
- trial of position changes to improve blood flow to the baby.

Notes 19 and 20: It is possible to recognise the possibility of foetal distress AND not appreciate the severity of the problem.

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Note 21: I don't recall saying the epidural was inserted for slow progress but that the use of an epidural and / or augmentation is one form of management for slow progress.

Notes 22 and 23: I do not exonerate [Ms B] for responsibility for her care.

I do expect [Ms C] to have provided reasonable care in response to her interaction with [Ms A] and [Ms B].

If 'There were signs of foetal distress that should have been obvious to [Ms B] …', why were they not also obvious to [Ms C]?

Note 25: This was an 'acute' unplanned admission. [Ms A] was booked for labour and birth at [the] Maternity Unit in …. It may well be common ('routine') to have transfers to the base hospital for pain relief / epidural, but it is not normal or planned.

[Ms C] should be capable of forming her own opinion of the CTG recording. She says she was present for a 'short period' (A report by the Health and Disability Commissioner: [Ms B], [Ms C], [the hospital] page 7) and 'entered the room' (ibid page 8). Both were opportunities to review the situation, and / or discuss the issues – especially on the second occasion.

Why would [Ms B] have called for assistance if she had no concerns?

I think it is reasonable to have expected [Ms C] to have acknowledged [Ms B] had called with concerns about the CTG, and even if these appeared to have settled, to have passed her reservations on, at least mentioned them, to the Registrar.

Note 28: I do not seek to blame [Ms C]. I simply state I believe it was reasonable for her to have responded to the situation more actively.

Note 29: I agree medical opinion may not be appropriate. I have no pre-existing knowledge of the family nor the midwives involved. I have worked as a charge midwife in delivery suite in a base hospital as well as an LMC.

Note 32: [Ms B's] notes, written at the time, did include vaginal examination findings (showing minimal progress), [Ms A's] request for more pain relief, and documentation of the baby's heart rate.

Note 38: I did not suggest [Ms C] 'take control of [Ms A's] care' – rather that she pass on [Ms B's] reported concerns and that it was reasonable to expect [Ms C] to assess the situations she was drawn into i.e. reports of two interactions with [Ms A], and reported other interchanges with [Ms B].

Note 39: There is no transfer of blame. Each midwife is responsible for her own actions.

Given the different recollections and interpretations of events, a practice that is used in other hospitals might have some merit in this area. That is for any practitioner, other than the LMC whom one assumes is observing the recordings continuously, to sign the

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CTG at the time of visit to the woman to acknowledge having seen the CTG, and / or make a note in the clinical notes to record their involvement, however brief.

Given the new information I remain firm in my opinion that [Ms C] had responsibilities as a midwife and as a Clinical Midwifery Leader and it was reasonable to have expected her to have assessed the situation more fully, and passed on concerns apparently expressed by [Ms B], sought medical input, and accepted responsibility for her actions."

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

1) *Every consumer has the right to have services provided with reasonable care and skill.*

2) *Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.*

…

5) *Every consumer has the right to co-operation among providers to ensure quality and continuity of services.*

Professional Standards

The Midwives' *Handbook for Practice* (New Zealand College of Midwives, 1993) describes 'The Scope of Practice of the Midwife' as:

"The Midwife must be able to give the necessary supervision, care and advice to women prior to, and during pregnancy, labour and the post-partum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant.

This care involves preventative measures, detecting complications in mother and child, accessing medical assistance when necessary and carrying out emergency measures …"

The *Handbook*'s 'Code of Ethics' states:

"**Responsibilities to clients**

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…

k) Midwives have a professional responsibility to refer to others when they have reached the limit of their expertise."

Transitional Health Authority Maternity Project (Formerly joint RHA Maternity Project), 'Guidelines for Referral to Obstetric and Related Specialist Medical Services' (July 1997)

"Timing of Referrals

Referral to a specialist should occur as soon as a problem is suspected or identified.

The Referral Process

Referral for most of the criteria will be to an Obstetrician and, for those listed under Services Following Birth, to a Paediatrician. However, in some instances, particularly those criteria involving associated medical conditions, a referral to another Specialist such as a Physician, Anaesthetist, Surgeon, Paediatrician, Infectious Diseases Specialist or Psychiatrist, may also be appropriate or be more appropriate. For some situations a multidisciplinary team will be necessary. Many of the criteria under Labour and Birth Services will require both Obstetrician and Paediatrician.

It is recognised that referral to a woman's usual GP may be appropriate in some circumstances. However these guidelines refer specifically to medical Specialists as on the New Zealand Medical Specialist Register.

These Guidelines for Referral define three levels of referral and consequent action

1 = the Lead Maternity Carer **may recommend** to the woman (or parents in the case of a baby) **that a consultation with a specialist is warranted** given that her pregnancy, labour, birth or puerperium (or the baby) is or may be affected by the condition. The specialist will not automatically assume responsibility for ongoing care. This will depend on the clinical situation and the wishes of the individual woman.

2 = the Lead Maternity Carer **must recommend** to the woman (or parents in the case of the baby) **that the responsibility for her care be transferred** to a specialist given that her pregnancy, labour, birth or puerperium (or the baby) is or may be affected by the condition. The specialist will not automatically assume responsibility for ongoing care. This will depend on the clinical situation and the wishes of the individual woman.

3 = the Lead Maternity Carer **must recommend** to the woman (or parents in the case of the baby) **that the responsibility for her care be transferred** to a specialist given that her pregnancy, labour, birth or puerperium (or the baby) is or may be affected by the condition. In most circumstances the specialist

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will assume ongoing responsibility and the role of the primary practitioner will be agreed between those involved. This should include discussion about timing of transfer back to the primary practitioner."

The Guidelines list 'Level of Action' status (ranging from levels 1 to 3) for a variety of situations occurring in pregnancy and labour to guide the practitioner when deciding the level of referral and consequent action, for example:

Code	Condition Heading	Condition Subheading	Measure of Severity	Level of Action
3002	Abnormal CTG		Refer to RNCOG guidelines for the interpretation of CTGs	3
3014	Foetal Distress		Abnormal Rhythm, Bradycardia, Tachycardia	2

The Nursing Council of New Zealand's Code of Conduct for Nurses and Midwives states:

"**Principle Two**

The nurse or midwife acts ethically and maintains standards of practice.

Criteria

The nurse or midwife:

…

2.4 demonstrates expected competencies in the practice area in which currently engaged ; …

Principle Four

The nurse or midwife justifies public trust and confidence.

Criteria

The nurse or midwife:

…

4.6 takes care that a professional act or any omission does not have an adverse effect on the safety or well-being of patients/clients; …"

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Opinion: No breach – Ms B

Failure to recognise lack of progress of labour and foetal distress
Ms B noted the low grade but variable foetal tachycardia through the late morning of Ms A's labour on 18 September. Ms B's documentation indicates that she listened to the foetal heart rate throughout and after contractions. When she detected an audible deceleration at midday, she recorded that she heard it at the peak of the contraction, and although she listened throughout the next several contractions she heard no further decelerations.

At this time she was aware that Ms A had been in active labour since 8am, but had only progressed 2cm in dilatation of the cervix in this time. Ms B advised Ms A that she would be more appropriately managed in a larger centre and organised her transfer from the Maternity Unit to the hospital. Ms B spoke with Dr D and briefed him on her reasons for the transfer, although there is some dispute about what information Ms B relayed to Dr D.

At the hospital Ms B inserted an intravenous cannula, took blood samples and sent them through to the laboratory in case Ms A proceeded to a Caesarean section. She was unhappy with the CTG trace produced by the abdominal strap and applied a foetal scalp clip to more accurately monitor the foetal heart rate. The foetal heart rate was recorded at 160 bpm.

My midwifery expert commented that Ms B was obviously not happy with the foetal heart rate and its responses. She advised Ms C about the situation and, as the obstetric registrar was unavailable, asked her at approximately 3.44pm to review the CTG trace.

I note that Ms Stanbridge recorded:

> "[Ms B] recognised the possibility of a distressed infant and responded to that. She
> - made repeated attempts to get the registrar to review
> - sought opinion of the charge midwife several times
> - expressed her anxiety about the trace to the family
> - tried position changes for [Ms A] which will sometimes improve the blood flow to the baby and consequently improve the heart rate.
>
> She clearly indicated she was increasingly concerned, with good cause."

I am satisfied that Ms B recognised the developing foetal distress and that labour was not progressing as expected, and that in this respect Ms B did not breach the Code.

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Opinion: Breach – Ms B

Failure to seek assistance from other available providers
The New Zealand College of Midwives' Handbook's 'Code of Ethics' states that midwives have a professional responsibility to refer to others when they have reached the limit of their expertise.

Ms B admitted Ms A, in labour, to the Maternity Unit at 8am on 18 September 2000. She transferred Ms A to the hospital's Delivery Suite at midday when she noted that the foetal heart rate was abnormal, and Ms A's labour had not progressed since admission, although she recorded in the notes that the reason for transfer was "pain relief".

When Ms A and Ms B arrived at the hospital's Delivery Unit at 1.30pm, Ms B spoke with Dr D, who was in theatre performing a Caesarean section, to inform him that Ms A had been admitted. Ms B communicated the information about Ms A's labour to Dr D through an intermediary and obtained his permission to commence an epidural anaesthetic.

My midwifery expert stated:

> "It appears that [Ms B] did not clearly articulate the minimal progress in labour to the registrar, and it may have sped his availability to assess [Ms A] if she had been more specific about the history and symptoms of which she was aware. The busy-ness of the unit no doubt influenced her communication with the registrar, and certainly her access to him."

This was confirmed by Dr D, who informed ACC that Ms B did not express any concerns to him about Ms A's labour.

Ms B arranged for the anaesthetist to attend, and continued to monitor and support Ms A while the epidural was being inserted some time after 2.20pm.

At approximately 2.50pm Ms B noted a deceleration of the foetal heart, dipping to 100 bpm, and that there had been no further progress in the dilation of the cervix. Ms B was aware that Dr D was operating. She advised Ms C of her concern and that she needed to have the CTG tracing checked by the registrar. Ms C told Ms B that Dr D would be available to view the CTG in 10 to 15 minutes. Ms C said that Ms B did not ask her to contact any other member of the obstetric team given that Dr D would be delayed. Nor did Ms B ask her to review the CTG trace or inform her of any concerns about foetal distress.

At 3.24pm Ms B noted that the foetal heart baseline rate was 145-165 bpm and there was a further deceleration to 105 bpm. At 3.30pm she observed that the foetal heart baseline had dropped to 100-130 bpm. She notified Ms C of the lowering baseline and the further need for medical review. Ms C checked the CTG, which had returned to normal levels. She did not express any concern, but told Ms B that Dr D would be available to assess the situation in 5 to 10 minutes. Ms B retrospectively recorded the consultation with Ms C in the notes.

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Dr D arrived shortly after this and checked the CTG. He told Ms A that she would need a Caesarean section and notified the anaesthetist. He then removed the paper trace of the foetal heart rate from the CTG machine and took it to the Delivery Suite office to discuss the situation with the consultant obstetrician.

In summary, Ms B was concerned about the progress of Ms A's labour from midday when she contacted the hospital and arranged for her to be transferred. She briefed Dr D, the on-duty registrar, and spoke to him again on her arrival at the Delivery Suite at 1.30pm. However, despite the continuing foetal tachycardia, it was not until approximately 2.50pm that she informed Ms C, the Clinical Midwifery Leader, that she was concerned about the CTG and sought a medical review. Ms C informed Ms B that Dr D was in theatre at the time. Ms B did not ask Ms C to locate another consultant. Ms B continued to observe a deteriorating situation, but it was not until 3.30pm when the CTG was indicating severe foetal distress that she called Ms C again.

There is some dispute about what Ms B told Dr D and Ms C. Ms B believes she relayed her concerns about the deteriorating situation of Ms A's labour and that Ms C failed to act upon her concerns. Ms C strongly disputes this.

Exactly what was said, and the urgency with which it was conveyed, cannot be determined at this point. Ms B's notes do not record her first consultation with Ms C. The hospital's Terms and Conditions of the Access Agreement for Maternity Facilities state that the practitioner (in this case, Ms B) is required to document all consultations in the case notes. The agreement also states that responsibility for an independent practitioner's client will lie with the independent practitioner until and/or unless there is a formal hand-over of primary responsibilities or an event occurs that automatically enacts this policy. Until such time as transfer to secondary or tertiary care is required, the LMC is solely responsible for the management of care. As LMC, Ms B therefore had responsibility for the complete care of Ms A until a formal transfer of care had taken place.

Prior to Dr D's review of Ms A, there was no event that triggered a transfer of care, in accordance with the hospital's Access Agreement. Ms B called Ms C to say there had been a deceleration in the foetal heartbeat but that it had recovered. She did not record this interaction and did not ask Ms C to view the CTG trace. Nor did she inform Ms C of her previous concerns about the failure to progress; if she did so, she made no record.

The Access Agreement is intended to set out the responsibility of LMCs and provide clear guidelines on when and how communication with hospital staff should occur. Ms B was an experienced LMC who had completed the hospital's requirements for access to the maternity facilities. My advisor considered that the first discussion between Ms C and Ms B was "tantamount to a consultation", in terms of the Access Agreement. My own view is that the interaction was an informal discussion between colleagues, in contrast to a formal consultation of the nature referred to by the Access Agreement. If Ms B wanted a formal consultation and/or transfer of care she should have clearly stated this and recorded her request.

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Ms B had a responsibility to her client and should have been more insistent about the need for a medical review of the overall picture of Ms A's labour. She should have requested that Ms C call one of the other senior obstetric medical staff from the clinics when it became apparent that the obstetric registrar, Dr D, would be delayed. In failing to effectively communicate her concerns, Ms B breached Rights 4(2) and 4(5) of the Code.

Opinion: No breach – Ms C

Failure to recognise lack of progress of labour and foetal distress

As the Clinical Midwifery Leader (CML), Ms C is part of the hospital's team of clinicians. The CML has responsibility for the co-ordination and provision of midwifery care for all women in the Delivery Suite area. In an emergency the CML co-ordinates the response of all team members, beginning with the initial calls for help to make sure things happen as quickly as possible. Her role is one of co-ordination and supervision, involving the provision of expert clinical advice and the promotion of safe and best practices.

Like many public hospitals that provide maternity services, the hospital provides LMCs with access to its facilities. The arrangement is contractual and LMCs are required to undergo an orientation programme and be familiar with communication processes. In many cases the LMC does not need to transfer care of her patient to an obstetrician, but there are clearly times when this must happen and the Access Agreement provides clear guidelines on the process. The Agreement also recognises that, in some instances, the hospital may need to intervene if an LMC is not acting in her patient's best interests. The safety of mother and baby is paramount. When staff become aware of circumstances causing concern for the safety of the woman and/or baby, the CML has the responsibility to draw this to the attention of the LMC, inform the on-duty obstetric consultant and explain to the woman what is happening. To be effective in her role the CML requires the same history of the woman and summary of the current medical situation as medical staff would receive when being consulted.

My provisional view was that Ms B was an experienced, independent midwife who expressed concern about the well-being of a woman and baby in her care and, although Ms C may have viewed the relationship between them as collegial and been reluctant to usurp Ms B's relationship with Ms A, Ms C had been alerted to the fact that there had been a departure from normal on the CTG trace. It was my view that as CML with responsibility for the co-ordination of midwifery services, Ms C should have made it her business to know why Ms B was worried or sought further information about the total picture of the labour, and arranged for a medical review of Ms A.

In her response to my provisional opinion, Ms C disputed that as CML she had responsibility for the "co-ordination and provision of medical care for women in delivery suite". She submitted that there was no reason why she "should or could have known there was a safety concern". Ms C was called to Ms A's room at about 2.50pm and Ms B told her that there had been an early deceleration which had quickly recovered. Ms C said that

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Ms B did not inform her that there was anything untoward about the labour or condition of the baby or prompt her to ask further questions.

My expert advised that because the CML would not normally be directly involved in the care of a woman, being invited into the woman's room "is tantamount to a consultation". This type of interaction occurs for a reason, and is not a random event with no significance. The LMC would initiate the interaction (particularly in a situation where the Delivery Suite was busy) because of concern for the woman's or baby's well-being or for updating the CML on the progress of the labour. However, in my view the discussion that took place between Ms C and Ms B at about 3pm was informal, collegial and not a "consultation", let alone a formal hand-over of care. Although Ms B stated that she "advised [Ms C] of the CTG changes indicating foetal distress", her own notes record that the change in the foetal heart was a "Type I (early) deceleration" (which is common in advanced labour) and she did not, as required, record her discussion with Ms C.

Ms C did not ask Ms B, who was an experienced practitioner, why she had reported an early deceleration or why she was worried. I remain of the view that a prudent CML would have questioned the LMC and would not have been satisfied with the brief explanation provided by Ms B. In this respect I agree with the comment of the ACC reviewer that "[t]he obligations of health professionals are not 'contracted out of' by means of an access agreement" and that the LMC's involvement does not "exclude responsibility … falling upon staff at [the hospital]".

An access agreement can only work when all parties communicate effectively. Such communication requires more than one-way interaction from LMC to CML and other hospital staff. CMLs are, by their position, experienced midwifery staff and should know when and what to ask when dealing with other practitioners, irrespective of whether the staff are hospital-based or independent. However, I am satisfied that Ms B did not effectively communicate her concerns to Ms C and that it is therefore unreasonable to expect her to have recognised, on the basis of one foetal heart deceleration and a request for medical review, that Ms B had serious concerns about Ms A's labour. Accordingly, in this respect Ms C did not breach the Code.

Failure to seek assistance from other available providers
My provisional view was that Ms C, as a member of the hospital management team, would have been aware that the provision of safe levels of staffing in Delivery Suite is critical. In her role as co-ordinator, Ms C was best placed to know what the demands on the services were and to judge whether extra medical assistance was required. She should have called for assistance from other members of the obstetric team when it became apparent that Dr D was delayed in the Delivery Suite.

My midwifery expert commented that the Maternity Facility specifications require the Maternity Facility to provide consultation and a back-up service to the LMC and also expect "a good working relationship between the facility and the woman's LMC so that women receive appropriately co-ordinated care".

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Although the hospital's Access Agreement 'Terms of Compliance' states that the primary responsibility for the patient's care remains with the LMC until there is a conscious and formal hand-over, the Clinical Midwifery Leader in the Delivery Suite has a responsibility to intervene when she becomes aware that there are circumstances causing concern for the safety of the client and/or baby.

Ms C, in her response to my provisional opinion, stated that "CMLs will only take control of an independent practitioner's practice where it is clear (without self initiated investigation) that something has gone or is going horribly wrong", such as the CML entering a room to find a woman unattended and bleeding profusely post-partum. She submitted that her relationship with Ms B was one of "equal colleagues", and that she would not undertake a review unless a consultation was specifically requested.

As noted above, there is no evidence that Ms B communicated her concerns to Ms C or that a formal consultation took place. Ms C submitted that Ms B was "the only person with sufficient information about the progress of labour to fully appreciate the full picture of probable distress". Ms C stated that when an LMC expresses concerns to her about the course of a labour, it is her usual practice to encourage the LMC to communicate directly with the medical team as there is less chance of miscommunication this way. In order to allow the LMC to do this, she will stay with the woman while the LMC briefs the registrar or consultant. There is no indication, either in the clinical records or other evidence, that Ms B asked Ms C to call the consultant or another registrar, even at 3.30pm when the foetal heart baseline had dropped and the situation was deteriorating rapidly, but Dr D was still busy in theatre.

My expert commented that Ms C had responsibilities as a midwife and a CML and "it was reasonable to have expected her to have assessed the situation more fully, and passed on concerns apparently expressed by [Ms B], sought medical input, and accepted responsibility for her actions". I agree with my advisor that Ms C had a professional and ethical obligation to inquire further if she had any doubts about the information she was receiving from Ms B about the progress of the labour. However, as stated above, Ms B did not effectively communicate her concerns to Ms C, at least prior to the request to review the CTG at approximately 3.44pm. Until that time, Ms C was unaware that this was not a normal labour. She knew that Dr D's arrival from theatre was imminent, and she was not asked to arrange urgent medical review from a consultant or another registrar. In these circumstances, Ms C did not breach the Code by her failure to seek assistance from other available providers.

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Opinion: No breach – The Public Hospital

Vicarious liability
In addition to any direct liability for a breach of the Code, employers are vicariously liable under section 72(2) of the Health and Disability Commissioner Act 1994 (the Act) for ensuring that employees comply with the Code. Under section 72(5) it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the employee breaching the Code.

Ms B
Ms B is an independent midwife who had an access agreement with the hospital which enabled her to use the facilities of the hospital. However, Ms B was not an employee of the hospital. In the circumstances, no issue of vicarious liability arises on the part of the hospital in relation to Ms B's breaches of the Code.

Ms C
Ms C was employed as the Clinical Midwifery Leader at the hospital. As an employer, the hospital is potentially vicariously liable for any breaches of the Code by Ms C.

As discussed above, Ms B did not effectively communicate to Ms C her concerns about the lack of progress of Ms A's labour, and the abnormalities of the foetal heart rate. Since Ms C did not breach the Code, there is no issue of vicarious liability on the part of the hospital in relation to Ms C.

Other comments

Uncertainty over primary responsibility for Ms A
This case highlights the uncertainty that can arise where an LMC calls for assistance in a hospital setting but the parties are not clear about their respective responsibilities for the woman in labour. Ms B stated that she thought she had assumed a midwifery support role, and handed over care, once she sought an epidural for Ms A. However, Ms B's own documentation confirms that transfer to the hospital medical team did not occur until after 4pm. Until that time Ms B continued to have primary responsibility for Ms A's care. Ms C informed me that her role as the midwife in charge was to facilitate Ms A's stay in Delivery Suite. She said that it was not her role to "usurp the LMC's duty of care".

The hospital's 'Terms of Compliance to the Access Agreement for Maternity Facilities' (January 1998) state that the LMC is responsible for her clients until there is a formal hand-over of primary responsibilities or an event occurs that automatically enacts this policy. The Transitional Health Authority 'Guidelines for Referral to Obstetric and Related Specialist Medical Services' (1997) recommend that in the event of an abnormal CTG and foetal tachycardia the LMC must recommend to the woman that consultation with a specialist is warranted.

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In my opinion the introduction of section 51 contracts (now section 88) and the increasing use of LMCs has, in some instances, created an atmosphere of tension that may affect the standard of care for women, because of an apparent reluctance or inability of hospital staff and LMCs to communicate effectively with each other. Most, if not all, care provided in a hospital setting requires the concerted effort of a team. Teamwork requires effective communication. Such communication should not be compromised where an LMC is involved.

By definition, a midwife who is an independent lead maternity carer has primary responsibility for her client unless and until she transfers that responsibility. The LMC should be an advocate for the woman if she believes that hospital staff are not providing her client with necessary care. The CML has her own responsibility to intervene in the management of care if she believes the woman and/or baby is at risk. This is clearly envisaged in the hospital's policy. These roles and responsibilities need to be re-emphasised with all staff working in Delivery Suite.

Record keeping
My independent expert noted that this case highlights the difficulties that arise when there is dispute about the events that occurred and suggested that, to avoid future disputes, it would be useful for the hospital to review its recording practice and adopt a process used in some other maternity facilities. I recommend that the hospital review its record keeping practices in light of my expert's comment that any practitioner (other than the LMC) who reviews the CTG or becomes involved in the management of care should sign the CTG at the time of the visit to the woman (to acknowledge having seen the CTG) and/or make a brief note to record his or her involvement.

Workload issues at the hospital
On 18 September 2000, when Ms A was admitted to the hospital, the Delivery Suite was very busy. There were 13 women admitted that day and between 11am and 5pm the obstetric team performed five Caesarean sections. It appears that the registrar, Dr D, was managing the situation as the only senior medical person on duty, supported by midwifery staff.

At the meeting on 15 December 2000 to discuss the circumstances of Ms A's labour, the Obstetrician and Clinical Unit Leader for the hospital, stated that there were normally three doctors on call during the day for the hospital's Delivery Suite; however, they were responsible for covering other areas such as the operating theatre and the clinics. He said that on Mondays there was a shortage of senior medical staff. He stated that the hospital had recognised for some time that there was a shortage of senior medical staff and consultants in the Delivery Suite who were free of other commitments and able to cover for emergencies when required. The consultant obstetrician stated that he was available to assist, as he was working in the Obstetric Clinic one floor away, but was not called on.

It appears that on 18 September 2000 there were insufficient experienced medical staff on duty at the hospital to ensure the safe management of patients in Delivery Suite in the event of a high workload or high risk case load. I recommend that the hospital review its staffing

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levels to ensure that there are sufficient experienced medical staff readily available to cover any obstetric emergencies.

Recommendations

I recommend that Ms B take the following actions:

- Apologise to Ms and Mr A for her breaches of the Code. The apology is to be sent to the Commissioner and will be forwarded to Ms and Mr A.
- Review her practice in light of this report.

I recommend that the hospital:

- Review the record keeping practices in its maternity facilities, in light of this report
- Review its staffing levels in the hospital's Delivery Suite, to ensure that there are sufficient experienced medical staff readily available to cover any obstetric emergencies.

Follow-up actions

- A copy of this report will be sent to the Nursing Council of New Zealand.
- A copy of this report, with identifying features removed, will be sent to the College of Midwives and the Maternity Services Consumer Council, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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