Midwife, Ms C

Opinion - Case 98HDC14872

Complaint

The Commissioner received a complaint from the consumer, Mrs A, about treatment she received from Ms C, a midwife. The complaint is summarised as:

- *On 7 October 1997 Mrs A, who was nine days overdue, received Cardiotocograph monitoring and assessment at the Maternity Unit. Mrs A experienced mild contractions during the assessment and thought she would be delivering soon. The contractions stopped shortly afterwards. Mrs A was not referred to MAFAU* [Maternal and Foetal Assessment Unit]*, at a public hospital for assessment when it was established she was not in labour and this option was never raised by her midwife, Ms C.*
- *Later that week Mrs A requested a scan. Ms C did not inform her that the appropriate place for this to be done was at MAFAU.*
- *Mrs A was referred to the radiology centre for the scan on Friday, 10 October 1997. Ms C did not request that the information about the scan be telephoned to her that afternoon.*
- *The scan report noted features of post maturity. Ms C had knowledge of the decreased liquor on 10 October 1997 but, although the pregnancy was no longer normal, did not refer Mrs A to hospital.*
- *Mrs A delivered at the Maternity Unit. She was not given the choice of an assessment at MAFAU. Ms C asked Mrs A what she wanted, but did not give enough information to enable Mrs A to make an informed choice.*
- *Ms C did not discuss monitoring choices during labour or the relevance/importance of monitoring.*
- *Monitoring during labour was infrequent. Warning signs, indicating the need for transfer to the public hospital, would only be detected with frequent monitoring and Mrs A was not advised that this should be done. Ms C did not offer continuous monitoring or inform Mrs A that continuous monitoring was difficult because she was moving about.*
- *Ms C did not monitor during contractions, only in between contractions.*

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Complaint ***continued***

- *After Mrs A's waters were broken Ms C attempted, unsuccessfully, to find the foetal heartbeat. Ms C provided very little information during this 28 minute period and did not convey the seriousness of the situation.*
- *Ms C then left the room to go to the 'office'. She said, on her return, that she had telephoned another midwife to attend the delivery. Ms C did not telephone for other medical assistance or contact the public hospital for advice even though she was in a situation that called for different skills to those which she possessed.*
- *Twice, between the breaking of the water and the birth, Ms C mentioned the public hospital. There was no discussion about transfer either with Mrs A or, if she was 'distracted', her partner, Mr B.*
- *Subsequent to the birth, Ms C maintained that the baby had not been distressed during the labour. Ms C's explanation of the meconium showed either that Ms C did not recognise that the baby was distressed or illustrated the lack of information Mr B and Mrs A received about the gravity of the situation.*
- *On 27 October 1997 Ms C visited Mrs A at home. Ms C told Mrs A that the protocol for the length of resuscitation was 15 minutes. She justified her actions in stopping efforts to resuscitate the baby after 12 minutes because she believed Mr B did not 'want' a brain injured child. The decision to stop inside the prescribed period was made without reference to either Mr B or Mrs A.*
- *Ms C did not inform Mrs A of the exact nature of the relationship between midwife and mother. Mrs A relied on Ms C for all maternity advice during the pregnancy.*

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Investigation Process

The complaint was received by the Commissioner on 21 May 1998 and an investigation was undertaken on 26 May 1998. Information was obtained from:

Mrs A	Consumer
Mr B	Consumer's Husband
Ms C	Provider / Midwife
Ms D	Provider / Midwife
Ms E	Practice Manager, the radiology centre

Mrs A's clinical records were obtained from Ms C and the radiology centre. Mrs A's medical misadventure file was obtained from Accident Rehabilitation and Compensation Insurance Corporation (ACC).

The Commissioner also obtained advice from an independent midwife.

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Information Gathered During Investigation

The consumer, Mrs A, had received midwifery services from midwife, Ms C, for her second and third children in 1992, 1994. Mrs A again contracted Ms C as her lead maternity carer (LMC) for her fourth child, which was due on 28 September 1997. Mrs A's first child was 15 days overdue, the second child three days overdue, and the third child 11 days overdue. There was no specialist involvement in Mrs A's fourth pregnancy.

On Tuesday, 7 October 1997, Mrs A had cardiotocograph (CTG) monitoring at the Maternity Unit, which is part of Crown Health Enterprises, as she was nine days overdue. The CTG trace appeared in the records to be approximately ten to thirteen minutes long. Ms C advised the Commissioner that the CTG equipment at the Maternity Unit is about 10 years old and that apart from the machine putting the incorrect date on printouts at times, she has not experienced difficulties with the quality of the printouts. Ms C stated that the trace appeared to have been torn off while the foetal heart-rate was still being monitored and so may not be a complete record of the length of the CTG. Ms C noted that a midwife pushes a button when a movement is felt to record it on the tracing and stated that the button on that particular CTG machine was temperamental. Therefore the record of the movements may not have been a true reflection of how many movements actually occurred. Ms C stated that there was no protocol at this time in the town that a CTG should last 30 minutes.

Mrs A had mild contractions during the CTG trace which stopped soon after the trace ended. Ms C advised the Commissioner:

> "*It was a good reactive tracing and* [Mrs A] *has a copy of that tracing. She was having weak to moderate contractions and I remember we talked about how she would usually do this for a day or so prior to going into labour. I did not refer* [Mrs A] *to MAFAU as the CTG disclosed a healthy baby and this was not warranted at that time.* [The public women's hospital] *MAFAU will only see women after 41/40 for post maturity. They then book an induction date when they can fit it in for some time around 42/40 weeks.*

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Information Gathered During Investigation *continued*

> *It was my normal practice to suggest an appointment with the Maternal and Foetal Assessment Unit (MAFAU) but as we both thought labour was imminent we did not discuss this specifically. I asked* [Mrs A] *how long she would be comfortable for the pregnancy to continue if she did not labour and she said she would see how things went.*"

Mrs A and Ms C were the only people present during the CTG tracing. Mrs A advised the Commissioner that there was no discussion about a referral to MAFAU for an assessment during this appointment. Ms C told Mrs A that if she had not delivered the baby by the following Monday she would book her in for an induction at that time. Mr B was not in the room during the tracing as he was minding the children outside. Mr B entered the consultation room after the completion of the tracing and recalled being told words to the effect of "*that things were pretty well as expected and there was nothing unusual*". An appointment with Ms C was arranged for the following Monday, 13 October 1997.

Mrs A advised the Commissioner that on 7 October 1997:

> "*There was no talk of it* [a referral to MAFAU] *then. If I hadn't delivered by the following Monday* [Ms C] *was going to book me in for an induction then. We didn't really talk about MAFAU, we talked about induction. Even if I had been booked for an induction on Monday, I would still have had to wait after that for the appointment.*"

Ms C advised the Commissioner:

> "[Mrs A's] *preference was to have another vaginal examination and then to have the waters broken to induce her. This is what I was intending to do on 13 October 1997 if* [Mrs A] *hadn't delivered by then. I think I suggested the Sunday, but it was not convenient for* [Mr B]. *I offered the Monday morning, but* [Mr B] *was unable to attend at this time because of work commitments, so the appointment was made for 1pm.*"

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Information Gathered During Investigation *continued*

The consumer and her husband advised the Commissioner that a Sunday appointment was not offered.

Ms C distinguished between two types of induction options:

> "*ARM (Artificial rupture of the membranes) for a mulitparous woman who is presenting favourably is a method of induction. This is the method* [Mrs A] *had chosen.*
>
> *Firstly the baby is monitored for half an hour with the CTG, then the waters are broken, and then another half an hour of monitoring with the CTG is done. If there is meconium in the liquor the woman is transferred to a base hospital. With this method of induction prostaglandins are not needed to soften the cervix as this has naturally occurred, therefore the procedure can be done at* [the Maternity Unit] *rather than a base hospital. A 'Bishops score' is given to assess a woman's suitability for having the waters broken. This assesses factors indicating favourability such as the descent of the head being a minimum of station –2 and the cervix being soft and a minimum of 3cm dilated.*
>
> *The alternative option was an induction at* [the public women's hospital] *.... In that situation prostagladins are inserted at* [the public women's hospital] *to assist the cervix to become soft, thin and anterior, but if this has naturally occurred (which was what was happening for* [Mrs A]*), an induction can proceed straight to an ARM at* [the Maternity Unit] *instead of at delivery suite at* [the public women's hospital].

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Information Gathered During Investigation *continued*

Our appointment on the 7/10/97 was when [Mrs A] *stated her preference for an induction, was at* [the Maternity Unit] *by Artificial Rupture of Membranes on the 13/10/97 if the baby was not birthed by then. There would be no further delay, this appointment was booked and I was confident that* [Mrs A's] *cervix would be favourable for an ARM (what I now clarify to women as a part induction) because:*

A. *There had been a reasonable change in the*
  (i) *Station of the presenting part*
  (ii) *Dilatation of the cervix*
  (iii) *Position, consistency and thinning of the cervix between 40 and 41 weeks gestation.*

B. *The contractions that* [Mrs A] *was experiencing would further assist the cervix to ripen more.*

I did not explain in detail what [the] *full induction at* [the public women's hospital] *involved, such as:*
eg *1.* *MAFAU assessment to obtain the induction date*
  2. *On that date, arriving at delivery suite at 0800 and having two lots of prostaglandins, six hours apart before ARM and if needed syntocinon etc.*
The reason for this was because our focus was on trying to achieve [Mrs A's] *preference to birth* [in the town] *if at all possible.*
Although the 'Handbook of Practice' for Midwives ... sets out the ... decision point as being at 42 weeks for discussion of referral, we had already set in place a plan at 41 weeks and [Mrs A] *had indicated that her preference was to be induced by ARM on the 13/10/97 if the baby had not arrived.*"

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Information Gathered During Investigation *continued*

The consumer and her husband disputed Ms C's comments that Mrs A did not want to deliver at the public hospital. The consumer and her husband advised the Commissioner:

> "[Ms C's] *statements that* [Mrs A] *did not want to deliver at a base hospital are not correct. She was never told to deliver at* [the public hospital]."

Ms C continued:

> "*Basically we knew she* [Mrs A] *would be* [favourable for an ARM on Monday 13 October 1997] *as her cervix was softening and starting to open up, and the head was already descending on 7 October 1997.*"

Ms C telephoned Mrs A on Wednesday, 8 October 1997. Ms C advised the Commissioner:

> "*I rang her the next day (Wed) and everything had settled down* [the contractions had stopped]. [Mrs A] *said that she would see what happened over the weekend.*"

Three days later on Friday, 10 October 1997, at 12 days overdue, Mrs A telephoned Ms C requesting an ultrasound scan. Ms C advised the Commissioner:

> "*She* [Mrs A] *rang on Friday when she was 41 weeks and 5/7 days gestation and said that although she didn't feel ready to have the baby she thought that a scan would help her make up her mind whether an induction or intervention was warranted. I agreed to this and we were able to get an appointment for that afternoon with* [the radiology centre]."

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Information Gathered During Investigation *continued*

Mrs A advised the Commissioner:

> "*With my pregnancy carrying* [the baby] *I knew how to count the movements (10 movements between 9am and 9pm), but I can't remember if I just did this or if* [Ms C] *said to. I was never asked to record kicks.*
>
> *When I was overdue with* [the baby] *I was concerned that she wasn't moving as much, although I still counted 10 movements a day, and that was why I asked for an ultrasound scan, as I wanted to check if the baby was OK. I remembered with my first pregnancy when I was overdue by about the same amount, I was referred to a specialist at* [the public women's hospital] *and he arranged for me to have a scan, so that was why I asked for one.*"

Ms C advised the Commissioner that Mrs A did not inform her of any decrease, or deviation from normal, in the baby's movements. Ms C stated that the pattern of baby movements was part of the discussion at each assessment, particularly from 36 weeks onwards. On 7 October 1997, Ms C had recorded in the notes that the baby had been moving frequently.

Ms C advised:

> "[Mrs A] *understood the importance of being aware of her baby's activity and to call me any time there was a diversion from this. I had been involved with three babies with* [Mrs A] *and this was part of the assessment each time.*"

Ms C also commented:

> "*... I know of no midwives in our area who use kick charts as they are increasingly seen as falsely reassuring and ignore the individual variations in a baby's activities. It is more relevant to talk to the woman about the normal pattern of movements and ask her to ring if this changes in any way. The same thing is being achieved but it is just a different way of obtaining the necessary information. ...*"

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Information Gathered During Investigation *continued*

Ms C telephoned Mrs A that evening and asked about the scan results. Mrs A informed the Commissioner that she advised Ms C that there was decreased liquor (waters) and that the baby was small for a full term baby. Ms C disputed that Mrs A told her the baby was small. She stated that the 39 week assessment indicated that the baby was bigger than Mrs A's other children. Had Mrs A mentioned that the baby was small this would have indicated to Ms C that she needed to follow up the results with the radiologist.

Ms C did not contact the radiology centre after this conversation. The radiology centre advised the Commissioner that 24 hour access to radiology reports was available at that time, with staff available on site or on call. Mrs A advised the Commissioner that the radiographer also asked "*if an induction had been booked*", although she did not mention this to Ms C, as she was recalling the consultation and did not have any notes to refer to when speaking to Ms C. Mr B did not attend the ultrasound scan on 10 October 1997.

Ms C advised the Commissioner:

> "*The policy of* [the radiology centre] *was to notify the referring practitioner immediately if any concerns were identified during the procedure. Such phone calls were established practice and did not need to be specifically requested by the referring practitioner. If the scan was normal then a written report was sent and received a couple of days later. I understand that this form of notification is not unusual. The scan had not been requested for any specific clinical concern and when the radiology did not notify me of any abnormality, I considered that the scan must be normal.*

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Information Gathered During Investigation *continued*

> *I had rung* [Mrs A] *that evening to see how the scan had gone and she said that she had been told that the baby measured around 40/40 weeks and that she was not entirely sure but they might have said that the liquor was* <u>*slightly*</u> *decreased and as it turned out this was the case. ...* [Mrs A] *said that she would keep a good eye on the movements over the weekend and we arranged that she would come back to* [the Maternity Unit] *on Monday when 42 weeks for another assessment with a view to induction or active management depending upon the situation.*"

The radiology centre advised the Commissioner that it endeavours to contact the referring provider if results are abnormal. If the provider is unable to be contacted, a hand-written account of the findings is given to the consumer. The responsibility is then returned to the provider to contact the radiology centre. The radiology centre advised the Commissioner that when a consumer gave a verbal report of abnormal findings to a provider, it would expect the provider to make contact and discuss the results. Mrs A advised the Commissioner that she could not recall being given a hand-written note by the radiology centre. A hand-written report was present in the medical records as well as a typed report dated 10 October 1997.

Ms C stated that she was available 24 hours a day on a mobile telephone if the radiology centre wanted to contact her.

Ms C stated to the Commissioner "*... if there had been abnormal CTG's or any significant problem with the scan then it may have been different but everything looked satisfactory*".

Ms C outlined to the Commissioner her reasons for considering the scan results to be normal:

> "[Mrs A] *said that in general things were OK. I asked if they* [radiology] *had mentioned the liquor. She couldn't quite remember but thought it was a little bit decreased, but OK.*

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Information Gathered During Investigation *continued*

Any baby from 39-40 weeks can show slightly decreased liquor, this is an expected finding. If there are problems, the radiologist will say things like 'no liquor', 'minimal liquor', or 'greatly reduced liquor'. 'Slightly reduced liquor' is not a warning bell on its own."

Ms C also advised that the radiology centre had been reliable about reporting abnormal results to her in the past. Ms C considered that the reason that the radiology centre did not contact her in this instance was because they did not consider the results of the scan to be abnormal.

Mrs A advised the Commissioner that Ms C did not mention a referral to MAFAU or a specialist after she was told the ultrasound results. Mrs A monitored the baby's movements over the weekend and advised Ms C of this. It had been arranged that Mrs A was to return to the Maternity Unit on Monday.

Ms C advised the Commissioner of her recollections regarding a referral to a specialist for Mrs A:

> "*... When I first saw* [Mrs A] *for this pregnancy and was taking her history, she said she had had anaphylactic shock (since the last time I had seen her for a previous pregnancy), and had seen a specialist. The specialist told* [Mrs A] *that the anaphylaxis could be due to food or stress.* [Mrs A] *carried an injection around with her in case it occurred again.*
>
> *I discussed with* [Mrs A] *that the most appropriate place for her to deliver may be* [the public women's hospital] *in light of this information as this was a medical problem not specifically related to midwifery, and was beyond the normal sphere.* [Mrs A] *definitely did not want to do that. She wanted to deliver at* [the town Maternity Unit], *as her first baby's delivery had been a bad experience at a base hospital.*

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Information Gathered During Investigation *continued*

With her first baby [Mrs A] *had experienced prolonged pushing for 3-4 hours and a third degree tear (which is one that involves the anal sphincter and requires stitching up by a specialist). The first time I was caring for* [Mrs A] *during her pregnancy (with* [her baby]*), I told her that for these reasons, she may be best to deliver at a base hospital in case things went the same way again, or at least be prepared that she may have to transfer, but* [Mrs A] *did not want to.*

About a month before [the baby's] *birth* [Mrs A] *rang me at home. She had a lot of trouble with varicose veins during pregnancy. Things had become so bad that she was unable to alleviate the pain. I suggested that we either admit her to* [the public hospital] *or she see a specialist for treatment. I explained that treatment was usually with aspirin, and this would mean that* [Mrs A] *would have to deliver at* [the public hospital] *due to the increased risk of haemorrhage.* [Mrs A] *stated she did not want to birth at* [the public hospital] *so refused to see a specialist for her veins, and managed the situation herself conservatively instead with extra rest. I have no reference to this telephone conversation in the records.*"

The consumer and her husband advised the Commissioner:

"[Ms C] *was advised by* [Mrs A] *of the anaphylaxis.* [Mrs A] *sought* [Ms C's] *advice about delivery* [in the town]*, as she thought that that condition may necessitate delivery at a base hospital.* [Ms C]*, while saying that it was not really her area, did say that she did not think it was too much of a problem.* [Ms C] *did, however, seek further medical advice to confirm her earlier advice.* [Ms C] *confirmed that delivery* [in the town] *would be appropriate and that delivery at* [the public hospital] *was not required.*"

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Information Gathered During Investigation *continued*

Ms C did not see Mrs A again until labour began. Mrs A went into labour around 7.30pm on Sunday, 12 October 1997, and telephoned Ms C. Mr B and Mrs A met Ms C at the Maternity Unit at 9.00pm. In a letter to the Commissioner, Ms C advised:

> "*Initially when* [Mrs A] *first went into* [the Maternity Unit]*, the CTG was applied. The heart rate was reactive, in that it sped up prior to a contraction (acceleration), there was good beat to beat variability, although that is a term not being used so often now, and the baseline was normal. I listened over a period of minutes before a contraction came and* [Mrs A] *requested me to let her move.*"

Ms C continued:

> "*With our CTG monitor at* [the Maternity Unit] *we have difficulty in obtaining a good reading printout when women stand and move as contact is frequently lost. However there was nothing to indicate any problem at that stage and as the monitor was restrictive to* [Mrs A] *and we could not maintain contact I removed it*."

Ms C advised the Commissioner:

> "*On admission there were no indications that* [Mrs A's] *baby was in distress so as to warrant continuous monitoring. If there had been such indications then I would have discussed this and advised immediate transfer to* [the public women's hospital]."

There was no record of the CTG monitoring taking place in the progress notes and no CTG trace in the records.

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Information Gathered During Investigation *continued*

Ms C explained the absence of the CTG trace to the Commissioner:

> "*I don't have a copy of that trace. With such a short trace, the printout is often left on the machine, and then after the delivery when the enrolled nurse cleans the room, it may be thrown out. … It probably was not retained. After the delivery it was really the last thing on my mind.*"

Mrs A advised the Commissioner that at no time during the baby's delivery on 12 October 1997 did Ms C apply the CTG monitor, but used a hand held foetal heart rate monitor only.

Ms C advised:

> "*The* [Maternity Unit] *CTG monitor used on* [Mrs A's] *arrival in labour was hand held by me and not strapped on to* [Mrs A's] *abdomen so* [Mrs A] *is correct in saying that at all times I 'hand-held' the monitor. It was necessary to hold it to obtain a printout of the baby's heartbeat.*"

Mr B advised the Commissioner that he was present throughout the labour and delivery and said that there was no CTG monitoring done on arrival or during labour.

Ms C advised the Commissioner:

> "[Mr B] *was getting all the bags in from the car. The CTG was only on for about three minutes.* [Mrs A] *was standing and the trace was from one contraction to the next.* [Mrs A] *asked me to remove it as she wanted a backrub.*"

Mr B stated that Ms C was not in the delivery room with him and his wife much from 9.00pm until 11.15pm when his wife was in the bath.

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Information Gathered During Investigation *continued*

Ms C advised:

> "*I do not ever leave a woman in active labour for any extended period and I did not on this occasion. Several incidences did occur which did require me to leave and they took a little time to correct.*"

One example offered by Ms C was that the bath overflowed making the floor wet and unsafe, and this needed to be attended to.

Mr B advised the Commissioner that, "*only the hand held monitor was used on arrival. Hand held monitoring was carried out when* [Mrs A] *was in the bath, but we dispute with* [Ms C] *the number of times this occurred. When* [Mrs A] *got out of the bath another monitoring with the hand held monitor was done*."

The progress notes recorded that Ms C monitored the baby's foetal heart rate with a hand held monitor intermittently at 9.15pm, 10.30pm, 11.00pm, 11.15pm and 12.15am, with readings ranging from 130-150 (120-160 normal range), although no range was recorded at 11.15pm. The foetal heart rate was last heard at 12.15am with a reading of 130. Ms C advised the Commissioner that:

> "*My case notes do not completely reflect my commitment to detecting abnormalities in the baby's well-being as the entries of the foetal heart rate are not recorded half hourly. I did listen to the heartbeat more frequently than the notes reflect and one thing this case has taught me is that regardless how busy I become providing the actual midwifery care, I need to note every time I actually listen instead of just noting them when there was a lull.*"

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Information Gathered During Investigation *continued*

Mrs A disputed that Ms C monitored the baby's foetal heart rate any more frequently than is recorded in the notes, and advised the Commissioner that:

> "*The whole time I was in the bath (from around 9.25pm until 11.15pm) I was monitored only once (although the case notes indicate a second reading???). I remember this one occasion clearly as I had to lift myself up so that the portable monitor could be placed on my stomach. Further, at no stage did* [Ms C] *monitor during the contractions, only in between contractions.*"

Ms C stated she is aware that the best time to listen is immediately after a contraction.

> "*No midwife can pick up the most serious late decelerations which may indicate possible foetal distress, without listening after the contractions and I agree that this is fundamental to good monitoring. I was doing this as I always have done.*"

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Opinion – Case 98HDC14872, continued

Information Gathered During Investigation *continued*

Ms C advised the Commissioner:

> "*The labour was intense and becoming increasing difficult for* [Mrs A] *and I suggested a vaginal assessment.* [Mrs A] *asked if I could break her waters to hurry things along. The cervix was eight centimetres, the head at station 0, there was no cord below the presenting part and the waters were bulging. I ruptured the membranes* [at 12.30am] *and found thick meconium* [the first stools of a baby, the presence of meconium in the amniotic fluid during labour indicates fetal distress] and when I listened for the FHR [foetal heart rate] *(after 0032 by this time) I could not hear it.* [Mrs A] *had moved and was kneeling into the back of the bed and I explained that this is a time when the baby descends deep into the pelvis and that in this kneeling position it is not always easy to pick up with the CTG monitor. It is usually necessary to turn over to obtain a clear reading. At this point I was thinking that the position was affecting our hearing of the foetal heart as it had been very clear until the waters broke. I wondered if the monitor was faulty and changed to use my handheld sonacaid again. I was picking up a heartbeat and checked* [Mrs A's] *pulse to ensure that I was not picking up maternal pulse. In fact I was and so continued for a few minutes to try to pick up the foetal heartbeat. Over this time the seriousness of the situation was being revealed.*"

Ms C later advised:

> "*Despite the view that* [the membranes could have been ruptured] *earlier, I had picked up no problem with the baby's heart rate and it is not my usual midwifery practice to rupture the membranes without clinical reason to do so.*"

Ms C also advised that early rupture of membranes, "*can compress the cord, cause occlusion or prolapse and interrupt the oxygen supply to the baby ...*".

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Information Gathered During Investigation *continued*

Mrs A advised the Commissioner:

> "*She* [Ms C] *said she couldn't find the baby's heart rate, and the baby must be behind the pelvic bones. She tried to hear the heart rate all over my abdomen and asked me to lie flat. I knew I was close to delivering and that something was wrong, so I didn't lie flat, but turned around onto my knees to deliver.*
>
> *I can recall* [Ms C] *saying 'thick meconium' but we didn't know exactly what that meant.*
>
> *The midwife who came to assist documented that she had been called in to suction the baby on delivery as there was a low foetal heart rate, but that's not right. There was no foetal heart rate when she was called in, none from 28 minutes out from delivery.*"

Mr B recalled:

> "*We had heard the heart beat at 12.15am, and this was the last time we heard it. The waters were broken at 12.30am.* [Ms C] *made a statement about meconium being present at that stage, but there was no comment made about what this meant. I saw the brownish substance when the waters were broken, but I wasn't too alarmed at that stage.*
>
> [Ms C] *then went to find the foetal heart rate over all parts of* [Mrs A's] *abdomen, even right up under the rib cage, which seemed an odd place to listen.* [Ms C] *was picking up* [Mrs A's] *heartbeat and saying she thought it may be the baby.* [Ms C] *spent a long time looking for the foetal heart rate, several minutes.* [Ms C] *made a comment about the baby having passed under the pubic bone, which we have been told since … was unlikely. If* [Ms C] *thought that the baby had passed under the pubic bone, why was she listening for the foetal heart up near* [Mrs A's] *ribs?*
>
> *In hindsight,* [Ms C] *listening for the foetal heart rate up near* [Mrs A's] *ribs caused me to wonder about her level of skill.*

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Information Gathered During Investigation *continued*

> …
>
> [Mrs A] *was lying down during the time* [Ms C] *was looking for the foetal heart rate.* [Mrs A] *cut things short and said she couldn't stay lying down anymore. She turned around into a kneeling position with her hands on the head of the bed. Although* [Mrs A] *was busy with contractions and the delivery she was asking questions during the time the foetal heart rate was being sought by* [Ms C] *like 'Is everything alright?', 'There's no problem is there?'.* [Ms C's] *answers were along the lines of 'You focus on the contractions* [Mrs A] *and delivering the baby'.*"

Ms C later noted:

> "*… Sometimes when the baby is low, the foetal heart will echo back and be clearer in a higher location; sometimes a midwife misses a breech position and an indicator of this is that the foetal heart is heard just under the ribs or in the upper quadrants and as I have experienced head down baby's turning to breech in labour, this is what I was ruling out. I do not believe that I could be said to have listened thoroughly without listening at all possible locations. While I was doing this I informed* [Mrs A] *and* [Mr B] *what I was doing and I must reassure you that this was no sign of a lack of skill.*"

Ms C left the room and arranged for an enrolled nurse to contact a second midwife, Ms D, to assist with the delivery. Mr B advised the Commissioner that no one else was present during the labour until Ms D arrived to assist Ms C, and that a third nurse arrived to deliver the placenta. Ms C was absent for around three or four minutes saying she needed to make a phone call, and explained upon her return that she had called another midwife to assist her.

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Information Gathered During Investigation *continued*

Ms D arrived at 12.55am and the baby was born at 12.58am with no signs of life. "*The cord was not pulsating, she had no heart rate, no breathing, no reflexes and no muscle tone*." Ms C and Ms D attempted to resuscitate the baby for 12 minutes and then declared her stillborn. Ms C advised the Commissioner that she and Ms D:

> "*... Did discuss together following the birth and while actively resuscitating* [the baby] *if medical assistance should be called but at that point there had been;*
> *- no heart beat for over 35 minutes*
> *- no heart beat at the birth*
> *- no response from the ambubag and oxygen*
> *- no response to cardiac massage*
> *- no response at all to intubation*."

Ms D advised the Commissioner that she could not recall what information was given to her over the telephone by the enrolled nurse who telephoned requesting she assist Ms C. Ms D said on her arrival "*the situation was calm*" and she was introduced to Mr B and Mrs A. Ms D recalled:

> "[Mrs A] *was on her hands and knees, concentrating on breathing through each contraction.* [Mr B] *was being supportive at the head of the bed.* [Ms C] *talked briefly to me about being able to hear a heart rate but she was unsure whether this was the baby's or mother's and since* [Mrs A's] *membranes had ruptured there was lots of old thick meconium present.*
>
> *Our conversation took place around resuscitation equipment that was already set up and I checked that everything that I required was ready.*
>
> *Birth was imminent on my arrival. After an introduction to* [Mrs A] *and* [Mr B] *and checking of necessary equipment, it was evident to me that birth was occurring. There was inadequate time to accurately monitor contractions and foetal heart rate due to* [Mrs A's] *position and expulsive contractions.*

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Information Gathered During Investigation *continued*

As two experienced professional Midwives who had worked together at births, we did not need to discuss in great depth what needed to be done, we were actively achieving it in the time that we had. Everything I did during the resuscitation, I verbally reflected to [Ms C], [Mrs A] *and* [Mr B].

Conversation went along the lines of:

- *there is no heartbeat*
- *I am suctioning*
- *There is a lot of meconium pooling in the oesophagus*
- *I am giving the baby oxygen by bag and mask*
- *I am doing cardiac massage*
- *I need to intubate.*

Prior to discontinuing active resuscitation, I asked [Ms C] *if extra medical support would be helpful, and this was declined in view of the anticipated outcome and with the knowledge that* [Ms C] *had prior to birthing – that is, the loss of foetal heart rate for some time before birth.*

I was personally satisfied that all had been done to achieve meaningful life for this baby, and discussed this with [Ms C] *in* [Mrs A] *and* [Mr B's] *presence before we extubated.* [Mr B] *commented during resuscitation that he didn't want a brain damaged child and this comment influenced our decision given that approximately thirteen minutes after birth it was clear foetal mortality had occurred.*

I did not discuss anything during the actual birth with [Mrs A] *and* [Mr B] *as I had come in as a second midwife and* [Ms C] *was encouraging* [Mrs A] *with pushing at the time.*

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Information Gathered During Investigation *continued*

After the birth, [Mrs A] *and* [Mr B] *were aware of our conversation and that our focus was primarily on resuscitating their baby.* [Mrs A] *and* [Mr B] *were part of our conversation that centred around what we were trying to achieve during the resuscitation. There was no request from either parent for us to continue beyond the point when we stopped.*

Approximately thirteen minutes had elapsed with no response, no heart rate and no signs of circulation or life. The baby was clearly stillborn and we could see our attempts were futile.

Yes I believe they [Mrs A and Mr B] *were involved in the whole process from birth to the time we ceased resuscitation attempts.*

They were both present in the room, with the bed close to the resuscitation unit. [Mrs A] *and* [Mr B] *could see and hear all that we were doing and were part of the process as we relayed information to them.*

[Ms C] *and I told* [Mrs A] *and* [Mr B] *that we were going to extubate their baby because there had been no response from the baby.*

[Mr B] *reiterated to* [Ms C] *and myself that he did not want a brain damaged baby, I interpreted this as consent to stop. They did not ask us to continue resuscitation once this decision had been made.*

In 1997 I cannot recall any resuscitation protocols being in place at [the Maternity Unit].

Our small rural unit does not have the same level of service as that available in a base hospital. As independent practitioners, we are taught Infant Resuscitation by [the public hospital] *New Born Unit, Neonatal Nurse Practitioners, this is updated regularly."*

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Information Gathered During Investigation *continued*

Ms D forwarded to the Commissioner a "*Summary and reflection of birth experience*" she had written on 13 October 1997 which stated:

> "*Called to attend as 2nd midwife for birthing. Meconium liquor and low foetal heart rate.*
>
> *M/W1 practitioner* [Ms C]*, skilled in decision making offered her client transfer to* [the public women's hospital] *but client declined and knew that birthing was imminent.*
>
> *On reflection and in hindsight this baby would have been delivered in an ambulance in less than desirable conditions to provide optimal resuscitation – also a changed environment for the birthing client alters the flow of labour and may have delayed birth instead of allowing her to stay in a safe environment and birthing to proceed in the expulsive manner that it was.*
>
> *I arrived three minutes before* [the baby] *was born, all equipment was checked and ready, the parents had been prepared by M/W1 for an unexpected outcome. Baby had no heart rate at birth and despite active resuscitation and intubation failed to breathe on its own or establish any heart rate. Resuscitative measures were discontinued 12 minutes after birth, with the knowledge from M/W1 that this baby had probably died during labour. Thick meconium was present all over baby and pooling in the oesophagus – around the trachea.*
>
> *The environment following birth was very supportive allowing the parents to begin their grieving process in as much time and as naturally as possible.*
>
> *Reflection on M/W* [midwifery] *practice with M/W1.*
>
> *Was there anything that she would do differently or that I could have suggested?*
>
> - *F/H* [foetal heart] *was listened to every ½ hour in labour which is in line with good practice.*

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Information Gathered During Investigation *continued*

- *There was no indication of foetal distress prior to? loss of heartbeat.*
- *No indication of thick meconium liquor until 8cms of labour.*
- *Not a good time to transfer a labouring client especially multigravida.*
- *During active resuscitation I asked M/W1 if extra medical/support would be helpful and this was declined in view of the anticipated outcome and with the knowledge that M/W1 had prior to birthing.*
- *A 3rd M/W was called in to assist mother with birthing the placenta in case of PPH* [postpartum haemorrhage] *– this was a brief time and M/W1 took over care of client once active resuscitation had stopped.*
- *The M/W is experienced and her past practice reflects this, she is also reviewed by com* [New Zealand College of Midwives]."

Ms C informed the Commissioner that:

> "*During the labour, I mentioned that* [Mrs A] *may need to transfer to* [the public hospital], *but* [Mrs A] *was pushing, and there was no time for a transfer*."

Mrs A advised the Commissioner with regard to decisions about a referral to a specialist during delivery:

> "[Mr B] *and I did not respond to her comment about* [the public hospital] *and transfer as it was said as a statement rather than a question, and I was close to delivering, and things just progressed. It was never put to us as a question.*"

Ms C advised the Commissioner with regard to resuscitation decisions:

> "*I probably wouldn't have said* [to Mr B and Mrs A] *'this is what's involved in resuscitation' during the pregnancy. The possibility of an adverse outcome was not discussed as part of the birth plan then.*

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Information Gathered During Investigation *continued*

It came up many times with [Mr B] *that he didn't want a brain damaged baby (due to a past experience with a previous child).*

During the delivery, everyone was in the room and [Mrs A] *and* [Mr B] *would have heard everything that was said. I didn't say 'we have been resuscitating your baby for twelve minutes and there are no signs of life, so is it OK if we extubate your baby?'.*"

Mr B and Mrs A advised the Commissioner that they were not consulted about the decision to stop resuscitation.

Mrs A advised the Commissioner with regard to resuscitation decisions:

"*We didn't really know what was going on, and there was no discussion about resuscitation decisions in the birth plan, during delivery, or after the birth*."

Mr B advised the Commissioner with regard to decisions about a referral to a specialist during delivery and to resuscitation decisions:

"*There was no discussion about anything. ...*

This delivery was about the fifth delivery I have attended. I had an anxiety level and was thinking 'I hope [the baby's] *OK?'. There was no information given about what was going on and no input requested from us about what was happening.* [The public hospital] *was mentioned twice in sentences, but there was nothing discussed about transferring to* [the public hospital] .... *Comments about* [the public hospital] *were said in passing. These comments were not put in terms of a decision to be made, and we were not made aware of the seriousness of the situation. We were looking for* [Ms C's] *lead and we just didn't get any lead.*

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Information Gathered During Investigation *continued*

I can remember when [the baby] *came out; she was a bluey colour and was lifeless. It was on delivery that I became aware how truly serious things were. When the second midwife came in resuscitation gear was prepared on the table, but we were told that everything was being prepared to suction meconium out. We did not know that this was preparation for resuscitation of a nearly dead child.*"

Mr B continued:

"*There was never any talk of calling in an obstetrician.*

… There was never anything that remotely resembled a discussion about going to [the public hospital].

[Ms C] *made a statement like 'We might have to consider moving to* [the public hospital]*' but then she would say something else like 'We will listen for the foetal heart now' or something like that. The statement about* [the public hospital] *was part of a number of things being said. Things were happening quickly. No time was given for us to give a response, and the comment was never phrased as a question anyway.*

We didn't realise that the mortality rate for children two weeks overdue is doubled. We should have been told of our options before we chose to deliver at [the Maternity Unit]. *Anyway, the option to deliver at* [the public hospital] *should have been offered when the risks for* [Mrs A] *increased.*

…

I picked up in [Ms C's] *notes about* [Mrs A] *being preoccupied. It reads 'at twenty to one discussed transfer to* [the public hospital] *but contractions distracting* [Mrs A's] *thought'. If there was to be a discussion, I was standing right at the side of the bed. There was somebody in a position to make a decision, and I was never used.*"

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Information Gathered During Investigation *continued*

Ms C advised that when she referred to the public hospital at this stage she was really thinking out loud. Ms C advised:

> "*I accept that this might have seemed like a statement rather than a question as the situation was changing so fast and I almost immediately ruled the transfer out as it was just not in the best interests of* [Mrs A] *and Baby. This is why there was no fuller discussion with either* [Mrs A] *or* [Mr B]."

Ms C further stated:

> "[Mr B] *says he was looking for my lead and didn't get it but in fact he did. My lead was the decision to stay. On discovering the meconium and given the rapid labour I made a professional decision as a rural midwife of many years experience that the choice of transfer at that point was neither appropriate nor safe.*"

Mr B advised the Commissioner that he did not recollect telling Ms C that he did not want another brain injured child:

> "*... It* [the comment about not wanting another brain injured child] *was something that* [Ms C] *had said after the birth, which I found offensive. The comment was the beginning of the tide turning for us against* [Ms C]. *We realised the care she gave was not the best we were entitled to. The comment was said to justify stopping the resuscitation a few minutes before she had to.*
>
> *I would not say something like that. Even if I had said something like that,* [Ms C] *is acting firstly for* [Mrs A], *secondly for the baby, and me third. The key issue is that she stopped resuscitation without reference to us* <u>at that time</u>, *regardless of what was said prior. Both of us were available at that time to say 'stop' or 'keep going'.*"

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Information Gathered During Investigation *continued*

Mr B informed the Commissioner that Ms C knew he had a Down's Syndrome child because of discussions in the antenatal period:

> "*I met* [Mrs A] *when she was newly separated from her husband, and pregnant. I got to know* [Ms C] *through this pregnancy of* [Mrs A's]*, and I am open about my past. I told her of my separation and two children, one of who has Down's Syndrome,* […]*, who was born* [in] *1991. I met* [Ms C] *in 1994 and my separation and* […] *Down's Syndrome were still important issues to me at that time.*"

Ms C informed the Commissioner that the occasions Mr B had told her of his wishes with regard to not having another brain injured child were as follows:

> "*It came up a few times in our antenatal visits and he mentioned it again through the resuscitation time I think.*
>
> *I have a feeling that when I was bathing* [the baby] *with* [Mrs A]*, that* [Ms D, the assisting midwife] *had mentioned to me that just following the birth when* [Mr B] *was outside in the corridor with his Dad and* [Ms D] *went to talk to him, that he mentioned it to her again.*"

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Information Gathered During Investigation *continued*

Ms C advised the Commissioner that she received both the typed ultrasound report and the hand-written ultrasound report on Tuesday 14 October 1997. The typed scan report of 10 October 1997 stated:

> "*A single live intrauterine pregnancy is seen cephalic* [head presentation] *in presentation with spine to maternal left. The placenta presents anteriorly* [towards the front] *and contains calcification which indicates a mature placenta. Decreased liquor volume is noted and this is also consistent with post-maturity. BPD* [bi-parietal diameter] *9.4 cm equates to 37 weeks 2 days, femur length 7.8 cm is 40 weeks, abdominal circumference 35.4 cm equates to 38 weeks. These measurements give an estimated foetal weight of 3763 grams +/- 15 %. Limited foetal anatomy assessed today due to advanced gestational age but no obvious anomalies could be seen.*"

Dr F, an obstetrician and gynaecologist, provided written advice to Mrs A on 15 February 1998 at her request regarding the birth. He noted that standard practice dictated that when a pregnancy goes beyond 41 weeks the health professional's responsibility is to look for signs of post maturity. This would include contacting the radiology centre and following up the ultrasound scan results on the day the scan was done, referring on for specialist assessment given the abnormal findings of a mature placenta, doing an early rupture of membranes to look for meconium or the absence of amniotic fluid, and more regular monitoring of the baby's heartbeat. Dr F advised Mrs A that, in his opinion, "[t]*here were indications for delivery of the baby at that stage or, at the very least, another clinical assessment including a CTG and arrangements for another measurement of the amniotic fluid* [the waters] *two or three days later*".

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Information Gathered During Investigation *continued*

Following a perinatal meeting of the public hospital staff, the baby's birth was discussed and an obstetrician and gynaecologist from the public hospital indicated in a letter to Ms C dated 17 December 1997:

> "*The problem was an intrapartum stillbirth in a post mature baby and I note the ultrasound done on Friday showed decreased liquor volume but that is not actually measured, plus the comment that the placenta appears mature. My thoughts would be that these assessments are best done in MAFAU and the important matter of the assessment is the decision about what to do with regards to induction etc.*
>
> *I am not sure of the extent of monitoring during labour and I gather a CTG was not used in that situation and* [you] *had no opportunity to detect abnormality of the foetal heart. Clearly you are left in an impossible situation after rupture of membranes, thick meconium and difficulties hearing foetal heart and delivery occurring rapidly thereafter.*
>
> *In any future pregnancy we would suggest careful monitoring in late pregnancy and induction of labour around term ….*"

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Information Gathered During Investigation *continued*

On 20 October and 27 October 1997 Ms C visited Mr B and Mrs A at home to discuss the birth. Ms C advised the Commissioner:

> "*It seems that at this last meeting with* [Mrs A] *and* [Mr B] *that how I was feeling and the things that I* [was] *saying were badly misunderstood. This is not unusual when parents are grieving and I can see that my perceptions of that meeting and* [Mr B] *and* [Mrs A's] *may have been different. At this visit we were talking through what had happened. I wanted to ensure that they had all the information including my rationales for decisions and had lots of opportunity to ask questions. I mentioned that there was apparently a protocol requiring a minimum resuscitation period of 15 minutes, although I had been unaware of it at the time of* [the baby's] *birth. I later discovered that there was no such protocol and I had incorrectly been informed of this. I explained what factors influenced me in extubating* [the baby] *after 12 minutes. The most critical thing for me was the fact that it had been a total of at least 50 minutes since* [the baby] *had had a heartbeat and there had been no signs of life. I was also influenced by a conversation I had had with* [Mr B] *where he had said that he would not be able to cope with a brain damaged child as his firstborn had Down's Syndrome. (He was sufficiently concerned about this pregnancy for me to ask if Down's Syndrome markers could be picked up on the 30 April 97 scan.) We made all reasonable efforts to resuscitate* [the baby]. *We had the expertise to intubate her and had the right equipment. When I read the pathology report I recognised that no amount of resuscitation would have expanded those little lungs already filled with meconium by the time she was born.*

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Information Gathered During Investigation *continued*

The decision to stop resuscitation needs to be based on sound professional judgement. We knew that [the baby] *was stillborn and there was nothing we could do to change that. If there had been any signs of life then we would have summonsed a retrieval team and kept going until they arrived but I truly believe that* [the baby] *was already dead even before the birth. I felt at that the time our continuing efforts were futile. I am really sorry if* [Mrs A] *and* [Mr B] *feel that they were not referred to about the decision to discontinue resuscitation attempts. I believed that at the time they understood the futility of continuing and the total lack of response from* [the baby] *and accepted what we were doing.*"

Ms C also stated:

> "*I think it was the next day that I discussed with* [Mrs A] *and* [Mr B] *about the resuscitation.* [Mr B] *expressed surprise at the length of time we had resuscitated for as the baby had died prior to birth.*
>
> *If there were any signs of life I wouldn't have stopped at 15 minutes either and would have been getting the flying squad over.*
>
> *It had been a long time that this baby hadn't been getting any oxygen. She was stillborn.*"

Mr B advised the Commissioner:

> "[Ms C] *had photocopied a lot of material from the medical library which she said vindicated her decision for* [Mrs A] *to deliver at* [the Maternity Unit]. *I did not think that anything was wrong with her care at that time. I think I said to her I supported her level of care. Soon after that I faxed her to say to discontinue her visits. The letter was faxed to* [the Maternity Unit] *at* [Ms C] *on 10 Nov 1997.*

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Information Gathered During Investigation *continued*

The meeting of 27 October 1997 was like a 'recognisance mission' and to convince us she'd [Ms C] *done nothing wrong, yet at that time I hadn't thought she had done anything wrong. She seemed nervous, different to how she had been before.* [Ms C] *made a comment that she thought she might get into trouble over this with the College of Midwives. This was also the day she brought the photocopied material from the library, and the day she made the comment about* […]*, and justified her decision to allow* [Mrs A] *to deliver overdue at* [the Maternity Unit].

Two weeks had elapsed since the birth and we had heard a number of comments that the care [Ms C] *provided us was not good. To us, it was not obvious on the day of the delivery that there was anything wrong with her care ....*"

Ms C advised the Commissioner that she never intended her final meeting with the consumer and her husband to be a vindication of her practice. Ms C advised that the written information she had provided was for the purpose of assisting the consumer and her husband with their decision making about any future pregnancy.

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Information Gathered During Investigation *continued*

The post mortem findings were as follows:

"…

CLINICAL SUMMARY:
The mother is a healthy 33 year old woman who has had three previous normal births and three previous miscarriages prior to this pregnancy. The pregnancy had been normal and a routine ultrasound scan at 18 weeks gestation had shown no abnormality. The expected date of delivery was 28 September 1997. A scan was done at 41 weeks and six days gestation and this stated that the placenta showed calcification indicating a mature placenta and decreased liquor volume consistent with postmaturity. No obvious anomaly of the foetus was identified. Labour was established at 1930hrs on the 12th of October 1997 with a strong foetal heart heard from admission at 2100hrs. The foetal heart ranged from 130 – 150 beats per minute and was last heard at 0015hrs on the 13th of October 1997. The membranes were artificially ruptured at 0030hrs and there was associated thick meconium liquor. No foetal heart was heard at 0032hrs. At 0040hrs the mother had begun pushing. A stillborn infant was born at 0058hrs on the 13th of October 1997 and was not able to be resuscitated.

The postmortem was performed on the 13th of October 1997 at 1300hrs.

EXTERNAL EXAMINATION:
The body was that of a full term female.

…

RESPIRATORY SYSTEM:
The larynx, trachea and main bronchi were patent and contained meconium. The left and right lungs weighed 32g and 39g respectively. Both had scattered petechial haemorrhages on their pleural surfaces. They were of normal anatomy. The cut surfaces of both lungs showed meconium within some of the bronchioles.

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Opinion – Case 98HDC14872, continued

Information Gathered During Investigation *continued*

PLACENTA:
The placenta was circular in shape with a diameter of 180mm and a thickness of up to 25mm. Small areas of infarction making up an area approximately one tenth of the total area were present and measured up to 20mm in maximum dimension. A 520mm length of umbilical cord was inserted centrally and had three blood vessels. The membranes appeared to be stained by meconium.

…

HISTOLOGY:

Heart	*- No pathologic abnormality is seen.*
Lungs	*- The lungs are congested. Squames and meconium are seen within the alveolar spaces, bronchi and bronchioles consistent with antemortem foetal distress.*
Liver	*- There is congestion. Extra-medullary haematopoiesis is seen. There is no specific pathology.*
Kidneys	*- Cortical and medullary differentiation are seen. There is congestion along with focal interstitial haemorrhage.*
Spleen	*- There is congestion.*
Adrenals	*- There is medullary haemorrhage.*
Thyroid	*- There is congestion.*
Pancreas	*- Scattered chronic inflammatory cells are present but there is no specific pathology.*
Thymus	*- There is accelerated involution of Hassal's corpuscles suggestive of stress.*

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Opinion – Case 98HDC14872, continued

Information Gathered During Investigation *continued*

Uterus, ovaries and Fallopian tubes – The uterus, ovaries and Fallopian tubes appear normal

Brain - The brain stem, cerebellum and cerebral hemispheres show vascular congestion but are otherwise histologically unremarkable. There is no evidence of encephalitis or meningitis.

Placenta - The cord has three vessels. The membranes are stained by meconium but are otherwise normal. The small areas of infarction are confirmed and there is focal calcification. Elsewhere the villi appear well vascularised.

SUMMARY OF FINDINGS:

1. *Stillborn female infant.*
2. *Organs of normal anatomy and position. No congenital defects identified.*
3. *The lungs show features of antemortem foetal distress.*
4. *The congestion and haemorrhage seen in a number of the organs are suggestive of hypoxia.*
5. *Focal placental infarction and meconium staining of membranes.*

FINAL COMMENT:

The cause of death was not able to be identified at postmortem but there are features consistent with antemortem foetal distress."

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Independent Advice to Commissioner

The Commissioner obtained the following advice from an independent midwife:

"***What is the standard of care,*** *which* [Ms C] *should have adhered to? Even now there is no precise standard of care generally acknowledged for the woman and foetus when the pregnancy has extended beyond 40 weeks. The evidence from good clinical studies does not exist. Some experts say that 38 weeks of gestation is the safest time to induce a labour which seems to many of us to be too early. Many experts say that 41 weeks is fine but then the foetus should be monitored carefully to 42 weeks. Few experts would consider allowing a pregnancy to continue for much beyond 42 weeks. This is the viewpoint that would have been current in 1997. Now there is even more emphasis on monitoring during the 42 week.*

The monitoring consists of –

- *recording of foetal movements by the woman i.e. there should be at least 10 foetal movements in 12 hours.*
- *a cardiotocograph should be done at 41 weeks or sooner if the foetal movements decrease. It should continue for at least 30 minutes and must demonstrate*
- *a) an increase in foetal heart rate with foetal movement*
- *b) a long-term variability or beat-to-beat variability of at least 10 beats per min.*
- *c) no change in foetal heart rate with uterine tightenings or contractions especially no decelerations*
- *d) a baseline foetal heart rate of between 120 and 160 beats per min.*
- *e) an ultrasound scan for liquor volume, foetal breathing movements, foetal movements and a Doppler of foetal blood flow is usually requested at about 10 days post term or sooner if any other sign of lack of well-being is present*
- *f) if the scan is satisfactory then a CTG should be done every 2 days*

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Independent Advice to Commissioner *continued*

- g) *if the scan showed decreased foetal well-being then a Specialist consultation should be sought and either an induction of labour or, in an extreme case, a Caesarean section would be done.*

Did* [Ms C] *monitor* [Mrs A's] *baby carefully enough? *In hindsight the answer is No.*

- *Foetal movements (Count-to-10) –* [Mrs A] *says she did this but I got the impression that she did it of her own volition rather than that* [Ms C] *asked her to. There is no record of it.*
- *A CTG was done at 41 weeks and said to be normal. The 10-minute trace, which is in the record, is of poor quality and too short. I accept the poor quality as being due to poor equipment but the duration should have been at least 30 minutes and have included at least 4 foetal movements. It does include 2 tightenings to which the foetus probably did not respond. This is a good sign.*
- *Scan for liquor volume was done and the result was ignored. At the very least* [Ms C] *should have repeated the CTG on the next day. She should also have wanted to speak to the sonographer. The scan report does not include any mention of foetal breathing movements, nor a measurement in centimetres of the deepest pool of liquor.*
- *Given that it was known that the liquor volume was reduced* [Ms C] *was very unwise not to rupture the membranes early in labour. At that point she does not seem to have recognised that this pregnancy was outside the limit of 'normal'. The thick meconium-stained liquor described at the time of membrane rupture is that which is seen when the liquor is severely reduced. An earlier ARM* [artificial rupture of the membranes] *would have given time for transfer to* [the public hospital]. *Meconium staining of the membranes was seen at Post Mortem and it is known that it takes some hours for this staining to develop. Whether transfer sooner would have altered the outcome is not known.*

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Independent Advice to Commissioner *continued*

Place of Birth

Care by a midwife in a small maternity unit is quite appropriate for a multiparous [has delivered more than one baby] *woman when there are no apparent problems and the pregnancy has not exceeded 42 weeks. I find the complaint by* [Mrs A] *that she lacked the information to enable her to decide on the place of birth to be a fair complaint. She certainly did not appreciate the significance of the reduced liquor volume* <u>*but nor did the midwife.*</u>

Monitoring Choices

[Ms C] *states that a CTG was done early on admission on Sunday 12th October. There is neither a copy of this in the Pregnancy and Birth Record nor a mention of it in the case notes. I would very much like to have seen it. This baby was already stressed and this CTG should have shown it. This is a particularly important CTG and should be used to guide future actions. It can certainly be difficult to get a woman in labour to keep still for monitoring but all women have the well-being of their baby at heart and, in my experience, will keep still if the problems are properly presented. I am surprised to read, 'I listened over a period of minutes before a contraction came …' in* [Ms C's] *letter. The case notes say that* [Mrs A] *was contracting every 3 minutes. The important time for listening is immediately after a contraction.* [Ms C] *seems to have listened frequently but was unfortunate to miss ever hearing a reduction in the foetal heart rate. I cannot believe that when there was thick meconium present (*[Ms C's] *notes) and where the membranes were meconium stained (PM report) that the foetal heart showed no alteration in rate before it stopped. The final stage of demise does happen very quickly but there are changes in the CTG well before that. A foetus who dies suddenly and without warning does not pass meconium.*

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Independent Advice to Commissioner *continued*

Conclusions

[Ms C] *did not recognise the importance of the reduced liquor seen on the ultrasound scan and so, following the guidelines of the College of Midwives, did not give* [Mrs A] *care consistent with her needs. I also feel that she was very unlucky.*"

The Commissioner requested that the independent midwife advisor make additional comments in response to new information supplied by Ms C. The advisor made the following additional comments:

"*The* [following] *description of the assessment of foetal wellbeing is the assessment used today. It is not quite perfect. Rarely a baby is discovered to be distressed when a CTG within the past 2-3 days has been normal. We now tend to do CTGs every 2 days but this would not have been the case in 1997:*

Re: Monitoring of foetal heart rate

When the foetus is overdue it has been the practice for at least 12 years to check the wellbeing of the baby by using the cardiotocograph (CTG). Depending on the general impression of the health of the mother and foetus a CTG will be done at between 7 and 10 days overdue. This is a separate check from the ultrasound scan. The points taken into consideration are that –
1/ there must be at least a 20-minute period of foetal wakefulness
2/ during this period there should be at least 4 foetal movements
3/ there must be an acceleration of the foetal heart rate with the foetal movements
4/ and at least 2 of these accelerations must be of at least 15 beats per minute from the baseline
5/ at least 1 Braxton Hicks contraction should be seen
6/ during this contraction there should not be any slowing of the foetal heart rate
7/ measures should be taken to wake a sleeping baby and the usual measure is to give the mother a drink of ice-cold water
8/ no baby may sleep for more than one hour without more thought being given to what the next step should be.

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Independent Advice to Commissioner *continued*

If any of these criteria are not met then further investigation and consultation is required. This would usually take the form of an ultrasound scan, which particularly looks at 4 items. These are
a) The depth of the largest pool of amniotic fluid
b) Foetal breathing movements should be present
c) Foetal body movements should be present (as for CTG)
d) The Doppler must be normal. (This measures the pressure needed to push the foetal blood through the placenta.)
Each one of these items is scored on a 0, 1, 2 basis and together are thought to give a reasonably good indication of the health of the placenta. A baby with a score of 8 is quite OK. The lower the score the more need there is to take action."

The advisor also stated:

"*Ultrasound*
'Slightly decreased liquor' is <u>*not*</u> *normal though it may be fairly common in the post-mature where the placenta is not functioning quite as well as it did. It is regarded as a warning sign that things are starting to go amiss.*
The communications, or lack thereof, between the ultrasound scanning agency and independent practitioners (both medical and midwifery) can be a problem. I have no quarrel with [Ms C] *asking* [Mrs A] *what the result of the scan was but I do believe that* [Ms C], *hearing that the liquor was reduced, should have contacted* [the radiology centre]. *It has been known that an ultrasonographer has tried to allay the patient's anxiety by downplaying the results and saying 'slightly reduced' when they really mean 'significantly reduced'. At times the sonographer is in a difficult position because it is not really their job nor their training to interpret the results to the patient.*

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Independent Advice to Commissioner *continued*

CTG
I agree with [Ms C] *that on very rare occasions a baby may die suddenly from unknown causes during labour. This may have happened to* [the baby] *but the only way to prove this would have been to have a continuous CTG trace which would not have been possible (restless woman) or reasonable (assumed to be normal labour). However the meconium staining of the cord and membranes does indicate that this baby had been distressed for many hours if not days. ...*

Foetal Movements
I have little further comment to make except to say that, as a general principle, one argues from a stronger standpoint if there are records such as a 'kick chart'. This would not only show the number of foetal movements per day but also show whether the time at which the tenth movement was reached was getting later each day.

Re transfer to Base Hospital
It was correct for [Ms C] *and* [Ms D] *to attempt to resuscitate* [the baby] *rather than transfer a woman who was obviously going to deliver her baby before she could possibly arrive there. Trying to resuscitate a very flat baby in the ambulance with no assistance would have reduced the chances of success even further.*

Timing of Rupturing of Membranes
... There is a possible risk of prolapse of the umbilical cord if the membranes are ruptured when the foetal head has not entered the maternal pelvis. Nevertheless had it been done earlier and thick meconium seen there would probably have been time for a transfer. I understand that this statement will be seen as being 'a medical approach' but I rather think of it as a safe option.

... I do believe that had [Mrs A] *been treated as a 'high risk' woman, because of the post-maturity, the outcome may have been different but it is not practicable to treat all post-mature women this way. The women would complain.*"

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Opinion – Case 98HDC14872, continued

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.*

RIGHT 6
Right to be Fully Informed

2) *Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent.*

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Opinion – Case 98HDC14872, continued

Opinion: Breach Midwife, Ms C

In my opinion midwife, Ms C, breached Right 4(1) and Right 6(2) of the Code of Health and Disability Services Consumers' Rights as follows:

Right 4(1)

In my opinion Ms C did not provide maternity services to the consumer, Mrs A, with reasonable care and skill, and accordingly breached Right 4(1) of the Code.

Antenatal period

In my opinion Ms C did not monitor Mrs A and her baby closely enough as the pregnancy went post-term.

My midwifery advisor stated that few experts would allow the pregnancy to continue beyond 42 weeks and that there needs to be particular emphasis on monitoring during the 42nd week. Such monitoring consists of the recording of foetal movements by the woman. A cardiotocograph should be done at between seven and ten days overdue, depending on the general impression of the health of the mother and foetus, and it should continue for at least 30 minutes. An ultrasound should be requested at 10 days post-term or if any other sign of lack of foetal well-being is present.

Ms C arranged a CTG at 41 weeks, two days into the pregnancy on 7 October 1997. The CTG trace included in the records is approximately 10 to 13 minutes long and my advisor comments that the trace is of poor quality. The trace shows two tightenings. My advisor informs me that the trace ought to have included at least four foetal movements and should have continued for a minimum of 20 minutes of foetal wakefulness. My advisor stated that this has been accepted practice for the last 12 years.

Ultrasound scan

In my opinion Ms C did not provide Mrs A with maternity services with reasonable care and skill and breached Right 4(1) when she failed to organise an ultrasound at 10 days post-term.

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Opinion: Breach Midwife, Ms C *continued*

My advisor has informed me that an ultrasound scan for liquor volume, foetal breathing movements, foetal movements and a Doppler of foetal blood flow is usually requested at about 10 days post-term or sooner if there are any signs of a lack of well-being.

Ms C made no attempt to organise an ultrasound as Mrs A was nearing 10 days overdue. Mrs A had an ultrasound on 10 October 1997 when she was 12 days overdue, after she called Ms C requesting the scan.

Scan results and subsequent management

An ultrasound was organised for 10 October 1997. Ms C called Mrs A that evening to ask her what the results were. Mrs A advised me that she told Ms C that the radiologist said that there was decreased liquor and that the baby was small. Ms C disputed that Mrs A advised the baby was small but did not dispute she was advised of decreased liquor. Ms C should have attempted to contact the sonographer following this conversation with Mrs A. In my opinion a midwife should not rely on a consumer to relay results conveyed to her by another provider, but should seek that information directly from the other provider. A consumer may not be able to remember all the relevant information and may not appreciate the significance of that information. My advisor also informs me that it is not unknown for an ultrasonographer to downplay abnormal results when speaking with a consumer in order to allay their fears. I do not accept that Ms C was not responsible for checking the results with the radiology centre. In my opinion, checking with the source for the results is particularly important in a situation such as this, where Mrs A was overdue, and the risks for both mother and child increased as the pregnancy lengthened.

My advisor said that given what she had been told, at the very least, Ms C should have repeated the CTG the next day. Ms C did not undertake a CTG trace on Mrs A on the following day.

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Opinion: Breach Midwife, Ms C *continued*

My advisor also disputed Ms C's belief that a finding of slightly decreased liquor is normal. My advisor accepted that "*slightly decreased liquor*" may be fairly common in the post-mature foetus where the placenta is not functioning as well as it did. However, the advisor stated that a finding of slightly reduced liquor is a warning sign for potential problems. My advisor informed me that the results from the scan provided valuable information indicating that the baby was post-mature and should have prompted Ms C to monitor Mrs A's baby more frequently than she did.

In my opinion Ms C did not monitor Mrs A's pregnancy sufficiently during the period after the ultrasound scan until labour began and breached Right 4(1) of the Code.

Labour

CTG monitoring
It is disputed whether Ms C undertook a CTG trace on Mrs A on arrival at the Maternity Unit on 12 October 1997. The consumer's husband, Mr B, and Mrs A denied that a CTG took place. Ms C advised me that the CTG she used was hand-held and I note that Mr B and Mrs A confirm that a 'hand-held monitor was used on arrival'. Ms C advised that this was the CTG monitoring that occurred, and that the CTG monitor was only on for about three minutes. Ms C has been unable to produce a copy of this trace. Ms C's progress notes do not contain any reference to CTG monitoring.

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Opinion: Breach Midwife, Ms C ***continued***

My advisor states that the CTG on arrival at a hospital with labour pains is a particularly important CTG and should be used to guide future actions. The advisor states that the baby was already stressed and a CTG should have shown it. My advisor went on to say that it can be difficult to get a woman in labour to stay still for monitoring but in the advisor's experience all women have the welfare of the baby at heart and will keep still if the problems are properly explained to them. In my advisor's opinion, a continuous CTG would not have been possible, or reasonable in the circumstances. However, even if it was accepted that a CTG trace of three minutes duration did take place, this was not a sufficient length of time. In failing to conduct an adequate CTG scan on Mrs A's arrival at the hospital, Ms C did not provide maternity services with reasonable care and skill and breached Right 4(1) of the Code.

Foetal heart rate monitoring
The progress notes record that the foetal heart was monitored at five points during labour at 9.15pm, 10.30pm, 11.00pm, 11.15pm and 12.15am (no range was recorded at 11.15pm). Ms C advised me that she monitored the foetal heart rate more often than she recorded it. Mr B and Mrs A disputed that this was the case. Mrs A stated that she was in the bath from 9.25pm until 11.15pm. During the time she was in the bath she stated that she remembered being monitored only once. She stated that she remembered this incident clearly as she has to lift herself up so that the portable monitor could be placed on her stomach. Ms C stated:

> "*My case notes do not completely reflect my commitment to detecting abnormalities in the baby's well-being as the entries of the foetal heart rate are not recorded half hourly.*"

I accept that Ms C did not monitor the heart rate as often as was desirable during labour. My midwifery advisor states that on rare occasions a baby may die suddenly during labour. However, in this case the advisor considered that this would have been unlikely because of the meconium staining of the cord and membranes which indicated that the baby had been in distress for hours if not days.

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Opinion: Breach Midwife, Ms C *continued*

The advisor stated that:

> "*I cannot believe that when there was thick meconium present (*[Ms C's] *notes) and where the membranes were meconium stained (PM report) that the foetal heart showed no alteration in rate before it stopped.*"

If Ms C had monitored the foetal heart-rate more frequently she perhaps could have heard that the foetus was in distress before the heart stopped beating.

It is my opinion, Ms C failed to conduct foetal heart rate monitoring with reasonable care and skill and accordingly breached Right 4(1) of the Code.

Earlier ARM
The membranes were ruptured at 12.30am, thick meconium was found and no foetal heart-rate was subsequently heard. My advisor informed me that Ms C should have ruptured the membranes earlier in Mrs A's labour as the pregnancy was outside normal limits, given the ultrasound findings of reduced liquor. Had Ms C done so, a transfer to the public hospital would have been feasible, as delivery would not have been imminent at the time the meconium was detected. Ms C stated that it was not her practice to rupture the membranes without clinical reason to do so and that an early rupture of her membranes can compress the cord, and interrupt the oxygen supply to the baby. My advisor acknowledged this risk, but stated had the membranes been ruptured earlier there would probably been time for a transfer once the meconium was discovered. My midwifery advisor characterised this as "*a safe option*". I consider that in failing to perform an earlier ARM Ms C failed to provide services with reasonable care and skill and breached Right 4(1) of the Code.

Right 6(2)

In my opinion, Ms C did not provide the information Mrs A needed to receive about management of her post-term pregnancy, nor did she satisfy herself that Mrs A understood all the implications of her decisions.

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Opinion: Breach Midwife, Ms C *continued*

Ms C advised the Commissioner that she did not inform Mrs A that at 41 weeks plus gestation that "*it was my normal practice to suggest an appointment with the Maternal and Foetal Assessment Unit (MAFAU)*" since "*we both thought labour was imminent we did not discuss this specifically*". In my opinion, Mrs A would have expected to be advised of the usual practice of her midwife when making decisions about the care she wished to receive.

Ms C stated that she rang Mrs A the next day (Wed 8 October 1997) and "*everything had settled down*". In my opinion, this was another opportunity for Ms C to inform Mrs A of the induction options available and the risks associated with each choice, as well as her professional recommendations. When it became apparent that labour had ceased on 8 October 1997, Ms C still did not provide any information to Mrs A about the option of a referral to MAFAU.

I do not accept Ms C's comment that Mrs A chose artificial rupture of membranes at the Maternity Unit rather than an induction at the public hospital. Mrs A was not adequately informed to make this choice, as the options were not offered to her.

In failing to supply the information distinguishing the option of a referral to MAFAU for a full induction and the option of ARM at the Maternity Unit, Ms C did not provide Mrs A with the information she needed to make an informed choice about the management of her post-term pregnancy.

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Opinion: Breach Midwife, Ms C *continued*

Ms C advised me that Mrs A "*... rang on Friday when she was 41 weeks and 5 days gestation and said that although she didn't feel ready to have the baby she thought a scan would help her make up her mind whether an induction or intervention was warranted*". In my opinion, this indicates that Mrs A was seeking information from Ms C in order to make an informed choice. Ms C failed to respond to this request from Mrs A. Mrs A clearly indicated in this statement that she was prepared to undergo intervention or an earlier delivery if it appeared that her baby's safety was at risk. Mrs A informed me that she requested a scan as in a previous post-term pregnancy the obstetrician had organised this for her at this point in the pregnancy and because she was concerned that the baby's movements had decreased. Ms C informed me that Mrs A had not mentioned that movements had decreased.

Ms C did not explain to Mrs A that slightly decreased liquor was a sign of post-maturity and that, as the duration of her pregnancy increased, so too did the risks to her and her baby. If Mrs A had this information presented to her at the conclusion of the scan it is possible that she may have chosen to be induced at the public women's hospital or to have her delivery at that facility.

Mrs A also stated that she was not given information about the types of monitoring available, why monitoring was important, particularly in view of the fact that she was overdue, and was not given the choice of how frequent the monitoring was to be. Ms C did not explain to Mrs A the importance of increased monitoring as her pregnancy moved past its due date, and she did not discuss with Mrs A the necessity for an ultrasound scan, nor of the importance of increased CTG monitoring. Ms C stopped monitoring the fetal heartrate on arrival as Mrs A wanted to move. As my advisor pointed out, women in labour are willing to tolerate extensive monitoring if the welfare of their baby is at stake. If Ms C had discussed the importance of monitoring during labour, particularly with a post-term labour, I consider it would have been likely that Mrs A would have indicated that she wished for frequent monitoring during labour, despite any discomfort she may have felt.

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Opinion – Case 98HDC14872, continued

Opinion: Breach Midwife, Ms C ***continued***

In my opinion, Ms C failed to provide information which Mrs A needed to receive in order to make an informed choice and give informed consent, and therefore breached Right 6(2) of the Code.

Opinion: Insufficient Evidence to Form an Opinion

CTG

Midwife, Ms C, arranged a CTG at 41 weeks, two days into the pregnancy on 7 October 1997 (nine days overdue). The CTG trace included in the records is approximately 10 to 13 minutes long and my advisor comments that the trace is of poor quality. The trace shows two tightenings. My advisor informs me that the trace ought to have included at least four foetal movements, and should have continued for a minimum of 20 minutes of foetal wakefulness. My advisor stated that this has been accepted practice for the last 12 years. Ms C drew my attention to the possibility that the trace appears to have been torn off while foetal heart monitoring was still in progress.

In view of this, I am therefore unable to conclude that Ms C undertook the CTG monitoring on 7 October 1997 with reasonable care and skill.

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Midwife, Ms C

Opinion – Case 98HDC14872, continued

Actions

I recommend that midwife, Ms C, takes the following action:

Apologises in writing to the consumer's husband, Mr B, and the consumer, Mrs A, for her breaches of the Code in relation to the treatment Mrs A received. This apology is to be sent to the Commissioner and I will forward it to Mr B and Mrs A.

Other Actions

- A copy of this report will be sent to the Nursing Council of New Zealand.
- A copy of this opinion will be sent to the New Zealand College of Midwives with a request that the College undertake a review of midwife, Ms C's, competence to practise midwifery.

I will refer this matter to the Director of Proceedings in accordance with section 45(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any actions should be taken.

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