Midwife, Ms C

A Report by the

Health and Disability Commissioner

(Case 15HDC00924)

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Executive summary

1. On 7 Month1[1] (at 21+5 weeks' gestation), Mrs A booked Ms C as her Lead Maternity Carer. Mrs A planned to give birth at the local hospital (Hospital 1). Ms C provided care to Mrs A antenatally and during her labour.

2. Antenatally, Ms C used palpation alone to assess the fetal size. There is no written care/birth plan in Mrs A's records, nor is there a record of a discussion about pain relief or the circumstances in which a transfer to Hospital 2 would take place.

3. At 2am on 7 Month5 (at 38+6 weeks' gestation), Mrs A started having mild contractions. At 10.30am, Mrs A met Ms C at Hospital 1. Ms C undertook an assessment and monitored Mrs A and her baby. At 1.20pm, Ms C recorded that the contractions had slowed. Shortly after 2.15pm, Mrs A returned home.

4. Following contact by Mrs A at 4.50pm, Ms C met Mrs A back at hospital at 5.45pm. At 6.34pm, Mrs A was 8–9cm dilated. Ms C told HDC that she would have discussed with Mrs A that she had made some progress, but would not have discussed the options of either transferring or consulting with a specialist at that time, as she was "quite happy with [Mrs A's] progress at that stage".

5. At 8.10pm, Mrs A was 9cm dilated. At 9.40pm, Ms C pushed the remaining cervix over the baby's head, and Mrs A experienced a spontaneous rupture of membranes at that time. At 9.55pm, Mrs A was pushing spontaneously with contractions. During the delivery, one of Baby A's shoulders became stuck, and delayed the delivery of her body. At 10.20pm, Baby A was birthed. Resuscitation was required, and Baby A was transferred to Hospital 3 by helicopter for further treatment.

6. Mrs A suffered a fourth degree perineal tear during the delivery, and was transferred to Hospital 3 by ambulance accompanied only by a friend and the ambulance driver.

Findings summary

7. Ms C failed to provide services to Mrs A with reasonable care and skill, in breach of Right 4(1)[2] of the Code of Health and Disability Services Consumers' Rights (the Code), in the following ways:

   a) Antenatally, Ms C failed to measure the fundal height and, instead, used palpation alone to assess the fetal size.

   b) Ms C failed to comply with the Referral Guidelines[3] by failing to recommend to Mrs A that a consultation with a specialist was warranted at 2.15pm and, instead, sent Mrs A home. Ms C also failed to comply with the Referral Guidelines at 6.34pm by not recommending to Mrs A that a consultation with a specialist was warranted at that time.

[1] Relevant months are referred to as Months 1-5 to protect privacy.
[2] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."
[3] Ministry of Health Referral Guidelines for Consultation with Obstetric and Medical Related Services.

c) Ms C failed to recognise that Mrs A's labour was not progressing normally.

d) During the delivery, Ms C did not try recommended manoeuvres to facilitate the delivery of the shoulders, other than repositioning and traction, and did not provide appropriate instructions to Ms B (core midwife at Hospital 1) or communicate effectively with her.

e) Ms C did not follow the *RANZCOG Guideline*, and did not monitor the fetal heart rate (FHR) every 15 to 30 minutes in the active phase of the first stage of labour, and did not auscultate the FHR after each contraction or every 5 minutes during the active second stage of labour. In addition, Ms C sent Mrs A home for a four-hour period without midwifery support at 2.15pm, knowing that the FHR would not be monitored during that period.

f) Ms C did not comply with the DHB's "Maternity Inter-hospital Transfers from [Hospital 1]" guideline, and did not make arrangements for Mrs A to be escorted in the ambulance by an appropriate practitioner.

8. In addition, by not providing Mrs A with adequate information about transfer to Hospital 2 should problems arise during labour, and not advising her of the recommendation in the Referral Guidelines that a specialist consultation was warranted at 2.15pm and 6.34pm, Ms C failed to provide Mrs A with essential information that a reasonable consumer in Mrs A's circumstances would expect to receive, and breached Right 6(1)[4] of the Code. It follows that Mrs A was not in a position to make informed choices about the delivery of her baby and, accordingly, Ms C also breached Right 7(1)[5] of the Code.

Recommendation summary

9. It is recommended that the Midwifery Council of New Zealand undertake a review of Ms C's competence should Ms C make an application to return to midwifery practice, and that Ms C provide a written apology to Mrs A.

10. Ms C has been referred to the Director of Proceedings for the purpose of deciding whether any proceedings should be taken.

Complaint and investigation

11. The Commissioner received a complaint from Mrs A about the services provided to her by Ms C. The following issue was identified for investigation:

The appropriateness of the care provided to Mrs A by Ms C in 2015.

[4] Right 6(1) of the Code states: "Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive …"
[5] Right 7(1) of the Code states: "Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise."

12. An investigation was commenced on 16 June 2016.

13. The parties directly involved in the investigation were:

Mrs A	Consumer/complainant
Ms C	Self-employed midwife/lead maternity carer

14. Information was also reviewed from:

Ms B	Core midwife (Hospital 1)
The District Health Board	

15. Independent expert advice was obtained from midwife Mary Wood (**Appendix A**).

Information gathered during investigation

Background

16. Mrs A, aged 29 years at the time of these events, had previously had a vaginal birth. Mrs A's first birth was a normal vaginal delivery following a prolonged labour. The baby weighed 3.5kg. She moved to New Zealand the next year and she became pregnant with her second child. Her estimated due date according to an ultrasound scan was 15 Month5.

17. Mrs A told HDC that as she had been in New Zealand for only a couple of months before getting pregnant, she was not sure how the maternity system worked. Mrs A said that she saw a general practitioner, who gave her the contact details of a community-based midwife, Ms C.[6] Mrs A said that she contacted Ms C because she did not know what other options were available to her.

Antenatal care

Booking

18. On 7 Month1 (21+5 weeks' gestation), Mrs A booked Ms C as her lead maternity carer (LMC). Ms C carried out a full assessment of Mrs A, including urinalysis (urine test), blood pressure, and fetal heart rate (FHR) monitoring, which were all normal. Ms C performed an abdominal palpation "using landmarks"[7] to assess fetal growth, and concluded that the uterus was measuring according to dates — indicating that fetal growth was normal.

19. Ms C told HDC that it is her usual practice to use landmarks to measure fetal growth, rather measuring the fundal height.[8] Ms C stated that this is the method she has always used, and she has learnt to "trust" her hands. Ms C also stated that fundal

[6] Ms C has been a registered midwife since 2007. At the time of these events, Ms C was a self-employed midwife working with other midwives as part of a group midwifery practice.
[7] The "landmarks" used are the symphysis pubis (the midline cartilaginous joint uniting the left and right pubic bones), umbilicus, and xiphisternum (the lowest part of the sternum).
[8] The distance between the pubic bone and the top of the uterus.

height measurements have been found to be less accurate in situations such as when a woman is overweight or obese. Ms C said that because Mrs A's body mass index (BMI) was 27.3,[9] she therefore chose "not to adopt fundal height measuring in this particular circumstance". Ms C told HDC that she would not have told Mrs A specifically that she had chosen to measure the fetal growth using landmarks rather than fundal height measurements.

Place of birth/care plan

20. Ms C told HDC that throughout Mrs A's antenatal period they discussed the "place of birth, when and how to contact the midwife when in labour, what to bring to the hospital, clothes for mother and baby, arranging hiring a car seat".

21. Mrs A recalls talking to Ms C about the place of birth. She said that some of her friends had delivered their babies at Hospital 2, and so she asked Ms C what would be best for her. Mrs A said that Ms C told her that there was no need for her to go to Hospital 2 unless she had complications. Mrs A said that she felt happy to have her baby at Hospital 1 (2.5 hours' drive from Hospital 2), but that "if there [was] any kind of complication" she wanted to be transferred to Hospital 2. Mr and Mrs A mistakenly understood that a helicopter and/or an ambulance would be "present" to transfer her to Hospital 2 if necessary.

22. Mrs A told HDC that Ms C told her that there would be an ambulance or helicopter available if there were any complications. Mrs A said she discussed the delivery with her husband, who said that, in that case, he was happy for it to be in Hospital 1. Mrs A said that she was aware that Hospital 1 was not staffed with obstetricians, but she was comfortable to deliver there because she would be able to be transferred if anything went wrong.

23. Mrs A said that Ms C never discussed with her the options for pain relief that were available at Hospital 1.

24. There is no written care/birth plan in Mrs A's records. In her maternity notes there is a reference on 7 Month1 to Mrs A being "very keen to have this baby at Hospital 1". On 23 Month4 and 31 Month4, there are references to "waterbirth". There is no record of a discussion about pain relief or the circumstances in which a transfer would take place, and the difficulties and challenges of transferring to Hospital 2, especially when labour was advanced or during adverse weather conditions.

Antenatal visits

25. Mrs A told HDC that Ms C did not discuss the baby's growth at her antenatal visits apart from saying that the baby was big. Mrs A said that she contacted Ms C about two weeks prior to the birth and said that she was having pain in her side, and was told to take Panadol. On 29 Month4, Mrs A contacted Ms C by text message advising that she had had a "little blood discharge yesterday [and a] bit 2day". Mrs A also included a comment that she was experiencing hip pain, but that it was "not like labour pain", and that she had some clear vaginal discharge.

[9] A BMI of 25 to 29.9 is considered overweight. A BMI of 30 or higher is considered obese.

26. Ms C responded advising that it was "ok", and told Mrs A: "You will know when it is labour pain. The discharge is probably increased vaginal discharge which is normal." Ms C followed up with Mrs A later that evening by telephone, asking if there was "any change at all?", to which Mrs A confirmed that there was no change.

27. On 31 Month4, Mrs A saw her back-up midwife who noted that Mrs A had experienced what may have been a "possible 'show'[10]" and some lower back pain. The back-up midwife carried out an assessment and documented her impression of a "well woman, well baby". The back-up midwife also documented that she had advised Mrs A to contact her midwife when she was in labour.

Labour — 7 Month5

28. At approximately 6.30am on 7 Month5 (38+6 weeks' gestation), Mrs A telephoned Ms C reporting that she had experienced "mild irregular" contractions since 2am that morning. It was agreed that Mrs A would stay at home until her contractions were closer together. Mrs A said that Ms C told her that it would take her about an hour to travel to the hospital.

29. At 9.14am Mrs A sent Ms C a text message stating: "Contractions [are about] 6 mins apart now pain is strong but last a minute." Ms C said that she rang Mrs A and arranged to meet her at Hospital 1 so that Ms C could undertake an assessment to decide whether Mrs A would stay at hospital or go home.

30. At 10.30am, Mrs A met Ms C at Hospital 1.

31. Ms C undertook an assessment, noting that on abdominal palpation the fetus was in a longitudinal lie, cephalic (head down), in a left occipito-anterior position,[11] which is the ideal position for delivery, with the head well engaged in the pelvis. The FHR was within normal limits at 142–155 beats per minute (bpm).[12] Ms C noted that on vaginal examination (VE) the cervix was anterior, fully effaced, and 6–7cm dilated, and the membranes were intact. Ms C noted that the "vertex[13] [was] confirmed at station –2 → –3[14]".

32. During an interview with HDC, Ms C said that while the abdominal and vaginal findings should "line up", they may not because sometimes the position of the baby can feel different depending on how you are assessing it, i.e., either by abdominal

[10] Towards the end of pregnancy, the cervix begins to ripen and soften, and some of the mucus plug may come away. The mucus plug is usually a clear or cloudy creamy white colour. It can be tinged with pink, red, or even brown. This is due to small blood vessels breaking when the cervix begins to thin and dilate. The blood can get caught in the mucus plug, and this is when it is also known as a "bloody show".

[11] The back of the baby's head facing forwards with the baby's back towards the mother's left side and the baby's face towards the right-hand side.

[12] Normal baseline FHR is 110–160bpm.

[13] The baby's head.

[14] "Station" is a term used to describe the descent of the baby into the pelvis. The station is measured in centimetres. An imaginary line is drawn between the two bones in the pelvis (known as ischial spines). This is the "zero" line, and when the baby reaches this line it is considered to be in "zero station". When the baby is above this imaginary line it is in a "minus" station. When the baby is below, it is in a "plus" station. Stations are measured from –5 at the pelvic inlet to +4 at the pelvic outlet.

palpation or by VE. She stated: "[O]bviously in this case it didn't [line up with what was felt abdominally] because –2 to –3 it's still saying from my understanding the head is engaged but maybe its not as well engaged as what it felt abdominally." Ms C's impression was that Mrs A was possibly in established labour, and her plan was for Mrs A to remain upright and mobilise.

33. The *RANZCOG Intrapartum Fetal Surveillance Clinical Guideline — Third Edition 2014* defines "Established (active) labour" as: "Regular painful contractions (contractions occurring every five minutes and persisting for 30 minutes or more) which may be associated with a show, ruptured membranes or cervical changes (full effacement, 4cm or more dilatation)." In addition, the Nice Guidelines Intrapartum Care Guidelines (updated 2017) define established first stage of labour as being when there are regular painful contractions and there is progressive cervical dilation from 4cm.

34. Mrs A recalls that following the VE Ms C told her that the baby was still quite high, and told her to walk around. The FHR was documented at 11.40am at 148bpm, and at 11.50am at 137bpm.

35. Labour continued during the morning. At 12.03pm, Ms C documented that Mrs A did not think her contractions were as strong or as regular as when she was at home. At 12.12pm, Ms C documented that contractions were still coming at a rate of "3–4 minutes??". The FHR was documented at 12.25pm as 145bpm, and at 12.38pm as 142bpm. At 1pm, Ms C documented that the contractions were now 1:5 but much more intense, and the FHR was documented at 137bpm.

36. At 1.20pm, Ms C noted that the frequency of the contractions appeared to have slowed.

37. The FHR was not documented between 12.38pm and 2.15pm. At 2.15pm, Ms C did a repeat VE, noting that the cervix was 6–7cm dilated, which was the "same as previous", and the vertex was at station –2 to –3. Ms C documented that her impression was "OP labour",[15] which is not an optimal position for delivery, and the plan was for Mrs A to return home. The FHR was documented at 146bpm.

38. In relation to what was discussed with Mrs A at that time, Ms C stated:

> "… I would have discussed … the progress of labour to date. The options available to her were consider transferring to [Hospital 2] via ambulance or return home to await labour contractions to become regular and strong again. [Mrs A] was adamant that she did not want to go to [Hospital 2] and my impression was that she was happy to return home to await labour. I would have discussed with her how her labour progressed to date, although unusual could still be considered to be within the normal range. … I did not feel at that stage there was any need to intervene, mother and baby were well, membranes were still intact. [Mrs A] was happy to go home."

[15] Occipital posterior position, which is where the back of the baby's head is against the mother's back.

39. Furthermore, Ms C told HDC that she would have discussed with Mrs A that the lack of progress was likely due to the position of the baby. Ms C said that she did not consider an obstruction of labour at that time, and did not discuss with Mrs A the option of consulting with a specialist.

40. Mrs A recalls that Ms C told her that her baby might not be in the right position. Mrs A also recalls her saying that the baby was big, but she never had a sense that there was anything wrong. Mrs A denies that she was given the option of transferring to Hospital 2 at that time, and said that if she had been told that she needed to go she would have been quite happy to do so, and that her husband was prepared to drive her if needed. Mrs A recalls that the only option she was given at that time was to return home. She said that the option of contacting an obstetrician was never discussed. Mrs A said that Ms C told her that she had "some appointments to do".

Return home

41. Mrs A then returned home. She recalls that her contractions continued to be irregular but were very strong. At 4.50pm, Mrs A sent a text message to Ms C advising that her contractions were "very strong" at about three minutes apart, and that some were a bit further apart. Mrs A's message continued: "[B]ut it's very strong I can't take it." Ms C responded that she would meet Mrs A back at hospital at 5.45pm. The FHR was not documented between 2.15pm and 6.20pm.

Return to Hospital 1 — 6pm

42. Mrs A arrived at hospital at around 6pm, at which time Ms C documented that Mrs A's contractions were now more regular and painful, with contractions 1:3 or 1:6. Ms C noted that Mrs A was looking "very uncomfortable" and was dropping to her knees during contractions.

43. Mrs A recalls that by around 6pm the contractions had become unbearable, and that she asked Ms C to help her, but Ms C just told her that she was "doing great". Mrs A recalls that the only pain relief she was offered was Entonox gas,[16] which did help while she was breathing it, but the pain came back as soon as she stopped.

44. At 6.20pm the FHR was documented at 137bpm. At 6.34pm, Ms C documented that Mrs A had requested a VE, which Ms C carried out, and recorded that the cervix was dilated to 8–9cm, the vertex was at station –2, and that bulging membranes were present. Ms C documented that she encouraged Mrs A to lie on her left side with a pillow between her legs. The FHR was 147bpm.

45. In a statement to HDC, Ms C said that she "would have" discussed with Mrs A the options available to her at that time, including transferring to Hospital 2 by ambulance or to return home to await labour to "establish/become more regular". Ms C stated:

> "As I understood from [Mrs A] at this time following discussion regarding progress she was adamant that she did not want to transfer to [Hospital 2] so consulting with the obstetric team at the base hospital would have potentially just caused concern for the obstetric team."

[16] Entonox is a brand name for nitrous oxide, which is an inhaled gas used as a pain medication.

46. However, in a later interview with HDC in relation to what she discussed with Mrs A at that time, Ms C said that she would have discussed that Mrs A had made some progress, but she would not have discussed the options of either transferring or consulting with a specialist at that time, as she was "quite happy with [Mrs A's] progress at that stage".

47. Mrs A told HDC that Ms C never discussed the options of transferring to Hospital 2 or consulting a specialist, and that, had those options been offered she would definitely have agreed to them at that time, as she was becoming concerned that there might be something wrong, and did not think that the labour should be taking so long.

48. There is no documentation relating to what Ms C discussed with Mrs A.

49. At 6.20pm, Hospital 1 core midwife Ms B received a text message from Ms C requesting that she attend as second midwife, as Ms C had a woman in labour who "[seemed] to be progressing well and [had] pushy urges". In a statement to HDC, Ms B explained that Hospital 1 is a small primary unit, and staff are on call unless there are in-patients. On the evening of 7 Month5, Ms B was on rostered night duty and, as there were no in-patients on the maternity unit, she was at home when she received Ms C's text message.

50. Ms B arrived at the hospital at approximately 6.45pm. She recalls that upon her arrival Ms C advised her that "[Mrs A] had taken a while to get fully established and that this was due to possible occipital posterior position". Ms B said that Ms C reported that Mrs A was 8–9cm dilated and her contractions were regular.

51. Ms B stated that she then assisted Mrs A's family members, who were waiting in the waiting room, and that she also advised the doctor in the Emergency Department that there was a woman in labour.

52. At 7.10pm the FHR was documented at 127bpm. At 7.35pm, Ms C noted that Mrs A was experiencing involuntary urges to push. At 7.50pm Ms C documented "??SROM[17]".

53. At 8.10pm, Ms C documented that Mrs A was requesting another VE, which Ms C carried out, noting that the cervix was 9cm dilated and that the membranes were still intact. Ms C documented that she tried to push the cervix over the baby's head, but it was too uncomfortable for Mrs A.

54. Mrs A continued to labour.[18] At 9.40pm, Ms C performed a VE, and this time pushed the remaining cervix over the baby's head. Ms C noted that Mrs A experienced a spontaneous rupture of membranes at that time, and that the liquor was draining clear. At 9.45pm Ms C performed another VE and recorded that the vertex was at station 0,

[17] Spontaneous rupture of membranes. This term describes the normal, spontaneous rupture of the membranes at full term.
[18] The FHR was documented at 8.20pm (158bpm), 8.43pm (138bpm) and 9.10pm (143bpm).

and that she felt the posterior fontanelle.[19] The FHR was documented at 137bpm. This was the last time Ms C documented the FHR during labour.

55. In her retrospective record, Ms B recorded that Ms C provided her with an update, and reported to her that Mrs A's membranes had ruptured. Ms B documented that the plan was for her to be called when assistance was required at the birth.

56. At 9.55pm Ms B was called into Mrs A's room. Mrs A was pushing spontaneously with contractions. Ms B told HDC that Mrs A was distressed with contractions, "but no more than any other woman in labour". Ms B checked the resuscitaire[20] in preparation for the delivery.

57. Mrs A recalls that she also requested an episiotomy[21] because she thought that it might help the baby come out, but Ms C told her: "[W]e don't do that over here." Mrs A also recalls that she was in a lot of pain at that stage, and that it was too painful to push.

58. During an interview with HDC, Ms C said that she does not recall Mrs A being distressed or that Mrs A requested an episiotomy. Ms C said that they had discussed an episiotomy antenatally, as it is standard practice in her home country for an episiotomy to be performed. Ms C said that she told Mrs A that an episiotomy would not be performed unless it was indicated. In Ms C's retrospective records, documented at 1.33am on 8 Month5, Ms C noted that Mrs A had requested that she "cut her to help her birth baby" but that at that stage there was "no need to undertake an episiotomy". Further to this, Ms C told HDC that she considered that the perineum was stretching "fine", and that there was no indication to perform an episiotomy.

59. At 10pm, Ms C documented that a "peep" of head was observed. In her retrospective record, Ms B documented that the head was "advancing with each push". Ms B told HDC: "At this point I had no concerns about how the vertex was advancing and its timing."

60. In Ms C's retrospective notes she documented that at 10.15pm the baby's head was birthed and some "turtling"[22] was noted. She documented that the head of the bed was lowered and Mrs A was placed in the McRobert's[23] position. Ms B said that at that time she pushed the emergency buzzer for assistance from the Emergency Department (ED).

61. Ms C told HDC that Mrs A was then encouraged to push "as hard as possible". In her retrospective record, Ms B documented that Ms C then noted that the umbilical cord

[19] The posterior fontanelle is triangle-shaped with an open area covered by a tough membrane, where the two parietal bones adjoin the occipital bone.
[20] Baby resuscitation table.
[21] An episiotomy is a surgical cut in the muscular area between the vagina and the anus (the area called the perineum) made just before delivery to enlarge the vaginal opening.
[22] Where the fetal head is delivered but then retracts against the perineum.
[23] An obstetrical manoeuvre used to assist in childbirth. It involves hyperflexing the mother's legs tightly to her abdomen. It is effective because of the increased mobility at the sacroiliac joint, allowing rotation of the pelvis and facilitating the release of the fetal shoulder.

was around the baby's neck, and easily slipped it over the baby's head. Ms C told HDC that she is unsure whether suprapubic pressure[24] was applied by Ms B at that point. Ms C said that normally the primary midwife (Ms C) would direct the assisting midwife (Ms B) if suprapubic pressure was required, but stated that because Ms B is a very experienced midwife, there was no discussion between them about what to do. However, in her retrospective record (documented at 5.45am on 8 Month5), Ms B documented: "[U]nable to perform [suprapubic] pressure as unable to determine position of back/anterior shoulder. Decision made to roll [Mrs A] onto all fours."

62. Ms B told HDC that she would always use the all-fours position in a situation where the McRobert's position and suprapubic pressure were unsuccessful. Ms B said that there was no discussion about using internal manoeuvres prior to rolling Mrs A onto all fours. Ms B also stated that she "cannot recall with accuracy, at this point, any discussion with [Ms C] around [the] decision for [the] all fours position".

63. Ms B said that at that time she noted that assistance from ED had not yet arrived, so she left the room briefly to advise the ED nurse that they had a shoulder dystocia[25] and required assistance. Ms B said that by the time she returned, Mrs A was on all fours.

64. Ms C stated that when the McRobert's manoeuvre was unsuccessful, she did not attempt any internal manoeuvres, and immediately turned Mrs A onto all fours. Ms C said that there was no discussion with Ms B about what she (Ms C) should do at that time.

65. Ms C stated that in "hindsight" there were a number of other techniques she could have tried, but that it was a "highly charged situation", and this was the first shoulder dystocia she had ever experienced.

66. Ms C said that she then applied "gentle traction", and Baby A was born at 10.20pm. Baby A's birth weight was 4,870 grams.[26] The cord was clamped, but no cord gases were taken. Ms B immediately took Baby A to the resuscitaire, where resuscitation was commenced by two ED doctors.

67. Baby A's Apgar scores[27] were 2 at 1 minute and 3 at 5 minutes. At 10.25pm, Ms C was asked to call the Neonatal Retrieval Team at Hospital 3 to request assistance. Baby A required ongoing resuscitation and support, and the decision was made to transfer her to Hospital 3 for specialist care.

[24] Suprapubic pressure is the attempt to manually dislodge the anterior shoulder from behind the symphysis pubis during a shoulder dystocia. It is performed by making a fist, placing it just above the maternal pubic bone, and pushing the fetal shoulder in one direction or the other.
[25] Shoulder dystocia is when the baby's head has been born but one of the shoulders becomes stuck behind the mother's pubic bone, delaying the birth of the baby's body. It is diagnosed when the shoulders fail to deliver shortly after the head. Shoulder dystocia is an obstetric emergency.
[26] A large baby for gestational age.
[27] The Apgar scale is determined by evaluating the newborn baby on five criteria on a scale from zero to two, then summing up the five values. The resulting Apgar score ranges from zero to 10, with 10 being the most reassuring.

Ongoing care of Mrs A

68. Ms C remained with Mrs A in the immediate postnatal period. Syntocinon[28] was administered, and the placenta was delivered at 10.26pm.

69. At 10.49pm, Ms C noted that Mrs A was experiencing moderate to heavy bleeding, and that the uterus was firm and deviated to the right. Mrs A continued to experience heavy bleeding. At 11.38pm, Mrs A's blood pressure was recorded as 132/79mmHg, and her pulse was 94bpm. Syntometrine[29] was given intramuscularly. Ms C estimated that the blood loss was 400–500ml. At that time, Ms C also recorded in the maternity notes that Mrs A had a second or third degree perineal tear,[30] which was not bleeding, and that she recommended transfer to Hospital 3 for suturing. Ms C told HDC that she was unable to repair the tear herself because it was beyond her expertise.

70. At 2.15am Ms C recorded in the maternity notes that Mrs A was "back down to postnatal". Ms C made no further clinical records.

71. Ms C said that she acted as a go-between, providing Mrs A with regular updates about Baby A's status. Ms C stated that Mrs A had a lot of support people with her. One of the ED doctors went to the maternity unit to speak to Baby A's family, and explained that when Baby A was sufficiently stable, the Retrieval Team would take her to the neonatal unit at Hospital 3.

72. Mrs A recalls that a male doctor spoke to her about Baby A, and told her that the baby needed to be transferred to another hospital, but she did not know which one. She recalls that Ms C told her later that she (Mrs A) needed to go to Hospital 3, but does not recall any discussion about how she would be transferred. Mrs A said that initially she thought that she would have to travel to Hospital 3 by car, but the male doctor later said that she could go by ambulance.

73. Ms C said that initially there was a plan for Baby A to be transferred to Hospital 3 by helicopter, and she discussed with Mrs A the possibility of transferring her as well in the helicopter. However, when this option was changed due to the weather, the decision was made that Mrs A would be transferred by ambulance.

74. Ms C said that there was not enough space in the ambulance for her to accompany Mrs A, and that the paramedic was happy for Mrs A to be transferred unaccompanied. Ms C told HDC that there was a driver and a paramedic accompanying Mrs A, and Mrs A's friend was in the ambulance, and "therefore [Mrs A] did not require a midwife escort".

[28] Syntocinon contains oxytocin, which is a naturally occurring hormone. It is given after the birth of the baby to stimulate the womb to contract. This helps the placenta to separate from the womb and be pushed out, speeds up delivery of the placenta, and reduces the risk of heavy bleeding.
[29] Syntometrine is administered to help to deliver the placenta and to prevent or control heavy bleeding following the delivery of the placenta.
[30] A second degree perineal tear is a tear affecting the muscle of the perineum (the area between the vaginal opening and the anus) as well as the skin. A third degree tear is a tear that extends downwards from the vaginal wall and perineum to the anal sphincter (the muscle that controls the anus).

75. In contrast, Mrs A told HDC that only the ambulance driver and her friend accompanied her, and she recalls feeling concerned about what would happen should she start to bleed. Mrs A said that there was never any discussion about Ms C accompanying her to Hospital 3.

76. Ms C also told HDC:

> "If the paramedics had not agreed that they were happy to transport [Mrs A] I would then have gone or requested another midwifery colleague accompany [Mrs A] as at this point I would have been unable to provide safe effective midwifery care for the three and a half to four hour ambulance journey."

77. The DHB's "Maternity Inter-hospital Transfers from Hospital 1" guideline states that the LMC retains clinical responsibility for the woman's care until formally transferred to a specialist. In the DHB's Investigation report, it noted: "[T]he patient could have been at jeopardy and therefore seriously compromised. Transfer with the accompaniment of a midwife is therefore a practice recommendation."

78. Mrs A's fourth degree perineal tear[31] was repaired at Hospital 3. She said that she has been left with ongoing urinary and bowel incontinence. She stated that Ms C did not discuss the delivery with her following Baby A's birth. Mrs A recalls that Ms C visited her at Hospital 3, but said that at that time she (Mrs A) was not in a fit state to discuss the events during the labour. Mrs A changed midwives and received no further care from Ms C.

79. Baby A has recovered well, although it is still unclear whether she will have any ongoing effects from the events during and following her birth.

Midwifery Council of New Zealand

80. On 12 April 2016, the Midwifery Council of New Zealand notified HDC that it had made an order for interim suspension of Ms C's practising certificate on the grounds that its concerns about Ms C's competence were so serious that they constituted reasonable grounds for believing that she posed a risk of serious harm to the public by practising below the required standards of competence.

Responses to provisional report

81. Mrs A was given an opportunity to comment on the "information gathered" section of the provisional report, and provided comments to HDC. Mrs A told HDC that she has suffered from severe depression and incontinence issues following this event. She described the day of Baby A's delivery as being a nightmare for her.

82. Ms C was given an opportunity to comment on the provisional report. She advised that she does not have any comments to make.

[31] A tear that extends from the vaginal wall to the anus.

Relevant standards

The New Zealand College of Midwives consensus statement (22 February 2012) Assessment of fetal wellbeing during pregnancy (NZCOM consensus statement)

83. The consensus statement provides:

> "• From 24 weeks gestation it is recommended that the fundal-symphysis height should be measured and recorded in centimetres at each antenatal appointment, preferably by the same person. Midwives using NZ Customised Growth Charts should be conversant with their conditions and limitations. If there is a decision to use a customised growth chart it is commenced beyond 24 weeks gestation …"

Referral Guidelines

84. The guidelines for consultation with obstetric and medical related services (Referral Guidelines) provide guidelines for circumstances in which an LMC must recommend a consultation with a specialist or the transfer of clinical responsibility to a specialist. The Referral Guidelines previously appended to the section 88 Maternity Services Notice 2002 are to be used in conjunction with the Primary Maternity Services Notice 2007. The Referral Guidelines require that the woman is informed that a consultation is warranted in certain circumstances. Under "Consultation", the Guidelines state:

> "The LMC must recommend to the woman (or parent(s) in the case of the baby) that a consultation with a specialist is warranted given that her pregnancy, labour, birth or puerperium (or the baby) is or maybe affected by the condition. Where a consultation occurs, the decision regarding ongoing care, advice to the LMC on management, and any recommendation to subsequently transfer care must involve three-way conversation between the specialist, the LMC and the woman. This should include discussion of any need for and timing of specialist review."

85. Under the conditions and referral categories code 5021 prolonged and first stage of labour states: "> 2 cm in 4 hours for nullipara and primipara. Slowing in progress in labour of second and subsequent labours. Take into consideration descent and rotation of fetal head, and changes in strength, duration and frequency of contractions."

86. The referral category in 5021 is "Consultation".

RANZCOG Intrapartum Fetal Surveillance Clinical Guideline

87. The *RANZCOG Intrapartum Fetal Surveillance Clinical Guideline — Third Edition 2014* (the *RANZCOG Guideline*)[32] provides that, where there are no risk factors and a CTG is not required, the FHR should still be monitored by intermittent auscultation every 15 to 30 minutes in the active phase of the first stage of labour and after each contraction, or at least every five minutes in the active second stage of labour.

[32] Endorsed by the New Zealand College of Midwives.

Midwives Handbook for Practice

88. The New Zealand College of Midwives (NZCOM) *Midwives Handbook for Practice 2008: Standards of Practice* provides:

> "Standard Two
>
> The midwife upholds each woman's right to free and informed choice and consent throughout the childbirth experience.
>
> …
>
> Standard Six
>
> Midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk."
>
> **Competency Two**
> The midwife applies comprehensive theoretical and scientific knowledge with the affective and technical skills needed to provide effective and safe midwifery care.
>
> …
>
> 2.3 assess the health and well-being of the woman and her baby throughout pregnancy, recognising any condition which necessitates consultation with referral to another midwife, medical practitioner or other health professional."

Opinion: Ms C — breach

89. In this case I am highly critical of aspects of the care provided by Ms C to Mrs A antenatally, during labour, and postnatally, as set out below.

Standard of care

Antenatal care

90. Mrs A became pregnant with her second child shortly after she moved to New Zealand. Mrs A booked Ms C as her LMC when she was at 21+5 weeks' gestation. Ms C assessed Mrs A during her pregnancy by way of abdominal palpation using landmarks to assess fetal growth, and concluded that the fetal growth was normal.

91. Ms C's usual practice is to use landmarks to measure fetal growth, rather than measuring the fundal height. She stated that fundal height measurements are less accurate if the woman is overweight or obese. Mrs A's BMI was 27.3. My expert midwifery advisor, Mary Wood, advised that, at that BMI, Mrs A was in the overweight range but she was not obese. Ms Wood advised that measurement of fundal height has been shown to be more accurate than palpation alone for detecting that babies are either small or large for gestational age. She stated:

> "Recording fundal height on customised fetal growth charts is likely to improve detection rates for babies small and large for gestational age."

92. The New Zealand College of Midwives consensus statement "Assessment of Fetal Wellbeing During Pregnancy 2012" states:

> "There is emerging evidence that the use of individualised fetal growth charts (which incorporate fundal–symphysis height measurements) may both reassure a woman that her baby is growing well and alert the midwife and the woman to possible concerns regarding the baby's growth.
>
> Plotting fundal–symphysis height measurements using a tape measure on a customised growth chart may alert midwives that a baby's growth is above or below normal parameters for that baby. A growth scan and more frequent assessments may be indicated at this point."

93. The consensus statement recommends that from 24 weeks' gestation the fundal–symphysis height should be measured and recorded in centimetres at each antenatal appointment, preferably by the same person. The consensus statement adds:

> "[T]here is no evidence to support:
>
> - Assessment using abdominal palpations/inspection alone
> - Assessment using fundal/symphysis height measurement alone."

94. Ms Wood noted that Baby A's birth weight was 4,870 grams when she was delivered at 38 weeks and six days' gestation. Ms Wood said that this would be considered a very large baby for gestational age, and noted that Baby A's birth weight plotted significantly above the 100th percentile. Ms Wood advised that "risk factors for LGA (large for gestational age) babies include prolonged vaginal delivery time [and] difficult birth, especially shoulder dystocia".

95. I accept Ms Wood's advice that fundal height measurements would have been a more accurate gauge of Baby A's growth than palpation alone, and I note that fundal height measurements is the recommended practice for assessment of fetal growth. Ms C was aware that Mrs A was having a big baby and, as such, should have been mindful of the need to assess the size of the baby reliably, given the risk factors. I note Ms Wood's advice that the choice not to use fundal height measurement to assess the ongoing growth of Mrs A's baby was a moderate departure from the accepted standard of care.

96. The Referral Guidelines state that if the baby's estimated weight on a customised growth chart is over the 90th percentile, consultation with a specialist is required. However, although Ms C told Mrs A that her baby was big, Ms C did not utilise a customised growth chart, and was not able to assess the estimated weight percentile.

97. In a previous decision[33] I reiterated the importance of obtaining the information necessary to comply with the Referral Guidelines. In that case I stated:

[33] See 15HDC00673, available at www.hdc.org.nz.

> "[A] slowing of fundal height was identified, but without further objective measures such as plotting the measurements on a GROW chart or an ultrasound growth scan, Ms X was unable to comply with the Referral Guidelines, which in these circumstances provide that, where there is possible [intrauterine growth restriction] or [small for gestational age], the midwife must recommend that a consultation with a specialist is warranted."

98. In my view, similar criticisms apply in this case. At the very least, once Ms C assessed Mrs A's baby as being "big", she should have measured the height of the fundus and plotted the growth on a customised growth chart at that time. This may then have alerted her that a consultation was required. In my view, Ms C's failure to use fundal height measurement to assess the ongoing growth of Mrs A's baby was poor midwifery care.

Labour

99. On 7 Month5 Mrs A telephoned Ms C at 6.30am to report that she had been experiencing contractions since 2am that morning. At 9.15am Mrs A contacted Ms C again because the contractions were six minutes apart and lasting up to a minute.

100. Mrs A was admitted to Hospital 1 at 10.30am, at which time Ms C conducted an assessment including abdominal palpations, VE, and the usual recordings of blood pressure, urine, and pulse. The VE found that Mrs A's cervix was anterior, fully effaced, and 6–7cm dilated, but the fetal head was high at station –2 to –3. Mrs A's membranes were intact.

101. Ms C thought that Mrs A was in established labour at that time. By 11.30am Mrs A's contractions were stronger and coming every three minutes. Ms C was preparing for the imminent birth.

102. Over the next two hours and 45 minutes the labour continued, but the contractions became erratic and less frequent, coming only every five minutes. By 1.30pm the contractions were one every 10–15 minutes and, at 2.15pm, Ms C examined Mrs A again to check her progress. Ms Wood advised that the VE at that time was appropriate midwifery management.

103. The VE showed that there had been no progress since the examination at 10.30am. Ms C decided that Mrs A should go home and wait for the contractions to accelerate again. Ms Wood noted:

> "There does not appear to be any consideration given to the possibility that this was a non-progressive labour, nor to consult with an obstetrician."

104. Ms Wood stated that her interpretation of the notes at this time was that Mrs A was in established labour, but not progressing, and her labour was no longer within the range of a normal labour. I am critical that Ms C failed to recognise that Mrs A's labour was not progressing normally.

105. Ms Wood advised:

> "I would regard this action, and suggesting [Mrs A] go home at this point, rather than considering a consultation with the obstetric service, as a moderate departure from accepted standard practice and I believe it would be regarded as such by midwifery peers."

106. The Referral Guidelines state that the LMC must recommend to the woman that a consultation with a specialist is warranted in the following circumstances:

> "> 2cm in 4 hours for nullipara and primipara. Slowing in the progress of labour for second and subsequent labours. Take into consideration descent and rotation of fetal head, and changes in strength, duration and frequency of contractions."

107. In my view, the Referral Guidelines required Ms C to recommend to Mrs A that a specialist consultation was warranted at 2.15pm. It was even more obvious by 6.34pm when Mrs A returned to the hospital that her labour was not progressing normally. Again, I consider that the Referral Guidelines required that Ms C recommend to Mrs A that a specialist consultation was also warranted at 6.34pm. Ms Wood stated:

> "I would consider [Ms C's] actions in not consulting the obstetric service at the base hospital, when it was apparent that this was a labour that was not following a normal pathway, was a moderate departure from [an] acceptable standard of midwifery care."

108. I accept that advice and am very critical of this failure. I am particularly concerned by Ms C's lack of action because Mrs A was approximately two and a half hours' travel by road from the nearest base hospital. I note Ms Woods' comments that the more progress Mrs A made in her labour, the greater was the likelihood of dealing with a birth in the ambulance. In my view, Ms C should have commenced the consultation process early in order to minimise that risk. I also note that there is no documentation in the clinical notes that reflects this concern, or any consideration regarding consultation or transfer during the labour.

Delivery

109. Mrs A began having involuntary pushing urges with contractions at 7.35pm. At 8.10pm she was found to be 9cm dilated. During the VE, Ms C attempted to push the remaining cervix away but was unsuccessful. Ms C examined Mrs A again at 9.40pm and, at that time, was able to push the remaining lip of cervix back over the baby's head, and Mrs A's waters broke.

110. Baby A's head was birthed at approximately 10.15pm, and Ms C recognised that the head was "turtling", which is a sign of a potential shoulder dystocia.

111. Ms C placed Mrs A in the McRobert's position and encouraged her to push as hard as she could. There is no mention in the notes that Ms C attempted other manoeuvres, such as suprapubic pressure, to try to dislodge the anterior shoulder, or any interior manoeuvres to try to rotate the baby or deliver the posterior arm by axillary traction. As the McRobert's position was unsuccessful, Mrs A was placed in an all-fours position, and Ms C delivered Baby A by applying traction to the baby's head.

112. Ms Wood advised that there are concerns with encouraging a woman in the McRobert's position to push as hard as she can. Ms Woods stated:

> "One of the problems of asking the woman to push in this fashion without using suprapubic pressure is that it can further impact the anterior shoulder against the pubic bone."

113. Ms Woods advised:

> It is my opinion that the management of this shoulder dystocia emergency did not meet the standards expected of midwifery practice, as there were no manoeuvres tried to facilitate the delivery of the shoulders other than repositioning and traction. I consider that in this situation it would be viewed as a mild departure from expected standards by midwifery peers."

114. The core midwife providing second midwife support at Hospital 1 that night, Ms B, stated that she was unable to attempt suprapubic pressure because she could not determine which side the baby's back was on. Ms C had documented that the baby's back was on the left earlier in the labour and, despite the stress of the moment, I consider that Ms C should have communicated better with Ms B. Ms B said that there was no discussion about using internal manoeuvres, and Ms C agreed that there was no discussion between her and Ms B during the emergency.

115. I accept that this was a stressful emergency situation, but am critical that Ms C did not try recommended manoeuvres to facilitate the delivery of the shoulders, other than repositioning and traction, and did not provide appropriate instructions to Ms B or communicate effectively with her. Ms C was leading the procedure, and maintained overall responsibility for Mrs A's care.

FHR monitoring during labour and delivery

116. As noted above, Mrs A was in established (active) labour from approximately 10.30am. Ms C recorded the FHR at the following times: 10.30am, 11.40am, 11.50am, 12.25pm, 12.38pm, 1pm, 2.15pm, 6.20pm, 6.34pm, 7.10pm, 8.20pm, 8.43pm, 9.10pm, and 9.40pm. Baby A was born at 10.20pm. There is no record of FHR auscultation in the second stage of labour and, on four occasions, the FHR was not auscultated for over an hour in the first stage, and not checked for four hours between 2.15pm and 6.20pm when Mrs A was sent home.

117. The *RANZCOG Guideline* recommends that the FHR should be monitored by intermittent auscultation every 15 to 30 minutes in the active phase of the first stage of labour and after each contraction, or every 5 minutes in the second stage which, according to the *RANZCOG Guideline*, is the minimum fetal assessment required for any woman during the active second stage of labour.

118. Adequate FHR monitoring is essential to establish the continued well-being of the baby. I am highly critical that Ms C did not follow the *RANZCOG Guideline* and did not monitor the FHR every 15 to 30 minutes in the active phase of the first stage of labour, and did not record any auscultation of the FHR after Mrs A was assessed as being in the active second stage of labour. Ms C's actions in sending Mrs A home for

a four-hour period without midwifery support at 2.15pm, knowing that the FHR would not be monitored during that period, was seriously suboptimal.

Transfer to Hospital 3

119. Ms C remained with Mrs A following Baby A's birth. Ms C administered Syntocinon, and the placenta was delivered at 10.26pm. At 10.48pm Ms C noted that Mrs A was experiencing moderate to heavy bleeding, which was noted at 11.26pm to be continuing.

120. At 11.38pm Ms C noted that Mrs A had suffered a second or third degree perineal tear, and recommended that Mrs A be transferred to Hospital 3 for suturing as it was beyond her expertise. Ms Woods advised that referring the repair of the tear was appropriate. The decision was made that Mrs A would be transferred by ambulance.

121. I accept Mrs A's evidence that she travelled to Hospital 3 in an ambulance with only the driver and her friend accompanying her. Ms Wood advised that in those circumstances it would have been appropriate for Ms C to accompany Mrs A during the transfer to Hospital 3. However, Ms Wood noted that Ms C would have been tired and past the point of being able to provide safe, effective, midwifery care for a further two and a half hours during the ambulance transfer.

122. With regard to Mrs A travelling with only the ambulance driver and her friend, Ms Wood advised:

> "Given [Mrs A's] risk factors for PPH [post-partum haemorrhage], the injury she had sustained during the birth and the fact that she had already had a significant blood loss, I consider this inappropriate."

123. Ms Wood stated that she believes Mrs A should have been escorted by a midwife or a nurse if a paramedic was not available.

124. I note that the DHB's "Maternity Inter-hospital Transfers from Hospital 1" guideline states that the LMC retains clinical responsibility for the woman's care until formally transferred to a specialist.

125. In my view, Ms C was responsible for Mrs A's care until her care was formally transferred to the obstetric team at Hospital 3. The trip to Hospital 3 was long, and Mrs A was at risk for PPH. Ms C should have made appropriate arrangements if she was unable to accompany Mrs A. Ms C failed to do so, and I consider that this was seriously suboptimal midwifery care.

Conclusion

126. Ms C failed to provide services to Mrs A with reasonable care and skill in the following ways:

a) Antenatally, Ms C failed to measure the fundal height and, instead, used palpation alone to assess the fetal size.

b) Ms C failed to comply with the Referral Guidelines by failing to recommend to Mrs A that a consultation with a specialist was warranted given that her labour,

birth (or the baby) might be affected by the delay in labour at 2.15pm and, instead, sent Mrs A home. Ms C also failed to comply with the Referral Guidelines at 6.34pm by not recommending to Mrs A that a consultation with a specialist was warranted at that time.

c) Ms C failed to recognise that Mrs A's labour was not progressing normally.

d) During the delivery, Ms C did not try recommended manoeuvres to facilitate the delivery of the shoulders, other than repositioning and traction, and did not provide appropriate instructions to Ms B or communicate with her effectively.

e) Ms C did not follow the *RANZCOG Guideline*, and did not monitor the FHR every 15 to 30 minutes in the active phase of the first stage of labour, and did not auscultate the FHR after each contraction or every 5 minutes during the active second stage of labour. In addition, Ms C sent Mrs A home for a four-hour period without midwifery support at 2.15pm, knowing that the FHR would not be monitored during that period.

f) Ms C did not comply with the DHB's "Maternity Inter-hospital Transfers from Hospital 1" guideline, and did not make arrangements for Mrs A to be escorted in the ambulance by an appropriate practitioner.

127. These failings are very poor midwifery care, and I find that Ms C breached Right 4(1) of the Code.

Informed consent — breach

128. I am critical about Ms C's provision of information and communication with Mrs A at various points during the time she was providing care.

Lack of information provided antenatally

129. I accept that Ms C talked to Mrs A about where she would give birth. Mrs A said that Ms C told her that there was no need for her to go to Hospital 2 unless she had complications. Mrs A was happy to have her baby in Hospital 1, but wanted to be transferred to Hospital 2 if there were any complications. Mrs A was aware that Hospital 1 was not staffed with obstetricians, but she mistakenly understood that an ambulance or helicopter would be "present" if she required transfer to Hospital 2.

130. Mrs A said that Ms C did not discuss with her what options for pain relief were available at Hospital 1. In my view, Ms C should have had ongoing discussions with Mrs A about matters such the facilities available at Hospital 1, the pain relief available, the circumstances in which a transfer would take place, and the difficulties and challenges of transferring to Hospital 2, especially when labour was advanced or during adverse weather conditions. These conversations should have been recorded in a care plan provided to Mrs A.

131. I am critical about the minimal information provided to Mrs A, and the lack of a documented care plan to which Mrs A could have referred. I am also concerned that Mrs A appeared to be of the understanding that an ambulance or helicopter would be "present" if she required transfer to Hospital 2.

Lack of information about consultation and transfer

132. Ms C told HDC that she would have discussed the options available to Mrs A during labour, including transferring her to Hospital 2 by ambulance. However, Ms C stated that as she understood that Mrs A did not want to transfer to Hospital 2, she (Ms C) considered that consulting with the obstetric team at the base hospital would have just caused concern for the obstetric team. However, Ms C later said that she would not have discussed with Mrs A the options of transferring or consulting with the specialist because she (Ms C) was "quite happy with [Mrs A's] progress at that stage [at 6.34pm]".

133. Mrs A said that Ms C never discussed the options of transferring to Hospital 2 or consulting a specialist. Mrs A stated that if she had been offered the options of consulting a specialist or transferring, she would definitely have agreed, because she was becoming concerned that there was something wrong, and did not think that the labour should be taking so long.

134. There is no documentation of what Ms C discussed with Mrs A. In light of that, and given Ms C's and Mrs A's evidence, I find that Ms C did not discuss the possibility of consulting a specialist or transferring to Hospital 2 during Mrs A's labour. This is despite the fact that the Referral Guidelines provide that in the case of a prolonged first stage of labour, the LMC must recommend to the woman that a consultation with a specialist is warranted given that her labour, birth (or the baby) is, or may be, affected by the condition.

135. In my view, that was essential information that Mrs A had the right to receive at 2.15pm and at 6.34pm, and did not. By not discussing the Referral Guidelines recommendation with Mrs A, Ms C did not ensure that Mrs A was at the centre of decision-making, and denied Mrs A the opportunity to make an informed decision about her ongoing care and treatment.

Conclusion

136. I consider that Ms C should have discussed with Mrs A antenatally the specific circumstances and travel issues regarding a transfer to Hospital 2 should problems arise during labour. Additionally, given the requirements of the Referral Guidelines, Ms C should have had a thorough conversation with Mrs A at around 2.15pm, and certainly by 6.34pm, recommending that a consultation with a specialist was warranted, and discussing the possibility of a transfer to Hospital 2.

137. By not providing Mrs A with adequate information about transfer in labour, and not advising her of the recommendation in the Referral Guidelines, Ms C failed to provide Mrs A with essential information that a reasonable consumer in Mrs A's circumstances would expect to receive, and breached Right 6(1) of the Code. It follows that Mrs A was not in a position to make informed choices about the delivery of her baby. Accordingly, I find that Ms C also breached Right 7(1) of the Code.

Recommendations

138. I recommend that:

a) The Midwifery Council of New Zealand undertake a review of Ms C's competence should Ms C make an application to return to midwifery practice.

b) Ms C provide a written apology to Mrs A, within three weeks of the date of this report. The apology is to be sent to HDC, for forwarding to Mrs A.

Follow-up actions

139. Ms C will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994, for the purpose of deciding whether any proceedings should be taken.

140. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Midwifery Council of New Zealand and the DHB, and they will be advised of Ms C's name.

141. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the New Zealand College of Midwives, and the Royal New Zealand College of Obstetricians and Gynaecologists, and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

142. I note that on 1 February 2016, the Midwifery Council issued a statement to all midwives reminding them that working in partnership with women means that they use the Referral Guidelines as an integral component of care. The Council advised that a campaign to communicate clearly with midwives about safe and professional practice, which will include use of the Referral Guidelines, was to be a priority in 2016. I intend to engage in communication with the Midwifery Council about the progress it has made with the campaign.

Addendum

143. The Director of Proceedings decided to institute HRRT proceedings. The Director filed proceedings by consent against Ms C in the Human Rights Review Tribunal. The Tribunal issued a declaration that Ms C breached Rights 4(1), 6(1), and 7(1) of the Code in relation to the care she provided to Mrs A

Appendix A: Independent midwifery advice to the Commissioner

The following expert advice was provided by midwife Mary Wood:

"***Ref: 15HDC000924***

My name is Mary Wood. After completing a diploma in Comprehensive Nursing at Carrington Polytechnic (now Unitec) in 1989 I completed a diploma in midwifery at AUT in 1990. I then completed a Bachelor of Health Science Midwifery at AUT in 2001. I worked as a midwife in the delivery unit of North Shore Hospital from Jan 1991 until September 1991, after which I began working as an independent midwife on the North Shore in Auckland. I worked as a full time self employed midwife on the North Shore until 2013. In April 2013 I began working part time as an Associate Clinical Charge Midwife in the birthing suite of North Shore Hospital, where I am responsible for the management of the labour ward, co-ordinating, teaching and supporting staff and responding to emergency situations. Currently I combine a part time self employed caseload with my part time work at the hospital. As a self employed midwife, I work with four other charge midwives from WDHB who also take a small caseload. I provide midwifery care for women throughout pregnancy, from positive pregnancy test through until six weeks after the birth of the baby, delivering either at home or North Shore hospital. I provide midwifery care for women in low, moderate and high risk pregnancies.

I have read and agree to follow the HDC 'Guidelines for Independent Advisors' and I have no conflicting interests either profession or personal in this case.

I have reviewed the documentation provided by the HDC including:

1. A background summary of the events relating to the complaint
2. [Mrs A's] complaint dated […]
3. [Ms C's] response to the complaint, dated […]
4. [Mrs A's] midwifery notes
5. Relevant information from [the DHB], including copy of SAC report and relevant policies and procedures
6. [Mrs A's] Clinical records
7. [Baby A's] DHB clinical records

1. You have asked me to comment generally on the standard of midwifery care provided to [Mrs A], and include comment on the care provided by [Ms C], as well as the care provided by hospital midwife [Ms B] where appropriate. You have also asked me to provide advice on the following:

2. The adequacy and appropriateness of the antenatal care and management provided by [Ms C].

[Mrs A] had [a previous miscarriage], and a [previous vaginal birth at term]. She booked with [Ms C] relatively late in the pregnancy, at 21/5 weeks. She appeared to have no risk factors at this stage, her BMI/weight (27.3) was in the overweight

but not obese range, her blood pressure was normal, and it is documented that her father is diabetic, although it does not specify type 1 or type 2. [Ms C] has documented a thorough and comprehensive booking history, and discussion about her on going care, including an HbA1c blood test (which was normal) in order to check her recent blood sugar levels, I am assuming this was in light of her father's diabetes.

[Ms C] saw [Mrs A] at 26 weeks, and again at 29/5 weeks, when her 28 week blood test was discussed. [Ms C] has documented that she offered testing for diabetes at this time (Polycose /GTT) but [Mrs A] declined to be tested, and consented only for a follow up HbA1c blood test, which was normal. The antenatal visits continued at 2 weekly intervals until around 35 weeks, and then weekly visits until 38/6 days, when [Mrs A] presented in labour.

The antenatal assessments included assessment of fetal growth by way of comparison to 'anatomical landmarks' rather than by fundal height measurement. 'Landmark guided fundal height assessment is well-established practice, and is included in possibly every midwifery text.' The 'landmarks' used are the symphysis pubis, umbilicus and xiphisternum. The growth of the fundus is expected to approximate a defined pattern in relation to the landmarks. Pairman, et al 2010 page 452. However, measurement of fundal height has been shown to be more accurate for detecting SGA/LGA babies than palpation alone. Recording fundal height measurements on customised fetal growth charts is likely to improve detection rates for babies small and large for gestational age. (Pairman et al. 2010 page 453).

Nice Guidelines 1.10 Fetal Growth and Well Being 2014

1.10.1 Symphysis-fundal height should be measured and recorded at each antenatal appointment from 24 weeks.

NZCOM Consensus Statement

Assessment of fetal wellbeing during pregnancy 2012

There is emerging evidence that the use of individualised fetal growth charts (which incorporate fundal–symphysis height measurements) may both reassure a woman that her baby is growing well and alert the midwife and the woman to possible concerns regarding the baby's growth

Plotting fundal–symphysis height measurements using a tape measure on a customised growth chart may alert midwives that a baby's growth is above or below normal parameters for that baby. A growth scan and more frequent assessments may be indicated at this point.

Recommendations:

From 24 weeks gestation it is recommended that the fundal–symphysis height should be measured and recorded in centimetres at each antenatal appointment, preferably by the same person. Midwives using NZ customised Growth Charts should be conversant with their conditions and limitations. If there is a decision to

use a customised growth chart is it commenced beyond 24 weeks gestation: www. gestation.net

There is no evidence to support:

- *Assessment using abdominal palpation/inspection alone*
- *Assessment using fundal–symphysis height measurement alone*

NZCOM Midwives Handbook for Practice:

Competency Two

'The midwife applies comprehensive theoretical and scientific knowledge with the affective and technical skill needed to provide effective and safe midwifery care'

The Midwife:

2.3 assesses the health and well-being of the woman and her baby throughout pregnancy, recognising any condition which necessitates consultation with or referral to another midwife, medical practitioner or other health professional:

The Standards of Midwifery Practice:

Standard Six:

Midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk

- *The midwife identifies deviations from the normal, and after discussion with the woman, consults and refers as appropriate.*

[Mrs A's] baby's birth weight was documented to be 4870 at 38 weeks and 6 days. This would be considered a very large for gestational age (LGA) baby for her. 'LGA babies have birthweights greater than the 90th percentile for their gestational age, meaning that they weigh more than 90% of all babies for the same gestational age. In New Zealand, the definition in pregnancy is uterine size measuring greater than 4 weeks (4 cm) than expected or greater than the 90th percentile on customised centile charts, or a neonate that weighs more that 4.5 kg.' [Baby A's] birth weight plots significantly above the 100th centile. Risk factors for LGA babies include prolonged vaginal delivery time, difficult birth, especially shoulder dystocia. Pairman et al 2010 page 998–999.

It is not clear whether fundal height measurement would have indicated an LGA baby in this case, as both [Ms C] and [her back up midwife] have both documented that the fundus was equal to dates on clinical examination. However it would be my expectation that given [Mrs A's] size, fundal height measurement would have been a more accurate gauge than palpation alone, and it is the recommended practice standard for assessment of fetal growth. [Ms C's] reason for not using fundal height measurement appears to be based on [Mrs A's] BMI of 27.3. This however, would not have classified [Mrs A] as obese, but rather in the overweight range. Auckland DHB recommends that fundal height measurement is inaccurate if the woman is greater than 100 kg. *'A BMI measurement at which*

fundal height measurement is unreliable is difficult to prescribe, as it depends on distribution of maternal fat and also height. A plan for growth scans is recommended for women with BMI over 35. (NZMFM SGA Guideline 2014).' Although this guideline is primarily for the detection of SGA (small gestational age) babies, this description of the effectiveness of fundal height measurement in obese women would be accurate in my experience. [Mrs A] was not obese. It is my opinion that the choice not to use fundal height measurement to assess the ongoing growth of [Mrs A's] baby was a moderate departure from expected standard of care.

3. **The Adequacy and appropriateness of [Ms C's] assessment and management of [Mrs A] between 10.30am and 2.15pm**
4. **The appropriateness of the decision to allow [Mrs A] to go home following her assessment at 2.15pm when she noted no progress. Please advise on any application of the Ministry of Health Referral Guidelines.**

[Mrs A] phoned [Ms C] at 6.30am on the 7th [Month5], to report that she had been experiencing mild contractions since 2.00am that morning. At 9.15am she contacted [Ms C] again as the contractions were now 6 mins apart and lasting up to a minute. [Mrs A] was admitted to [Hospital 1] at 10.30am. At that time [Ms C] records a thorough assessment including abdominal palpation, vaginal examination and the usual recordings of BP, Urine, Pulse. No temperature was documented as having been recorded at this time.

The palpation records cephalic presentation with the fetal head well engaged into the maternal pelvis. The vaginal examination records that the cervix was anterior, fully effaced, 6–7cms dilated, but the fetal head was high, (station –2 to –3). This finding is somewhat at odds with the abdominal palpation finding. The membranes were intact. [Ms C] records that she believes [Mrs A] to be in established labour at that time.

By 11.30am, the contractions are recorded as being stronger and coming every three mins. [Mrs A] was mobilising to help the progress of the labour and [Ms C] was preparing for the imminent birth (bringing uterotonics into the room in preparation for the delivery of the placenta). For the next 2 hours 45 mins, the labour continued but the contractions became somewhat erratic, stronger but coming only every 5 mins. By 1.30pm the contractions appeared to have spaced to 1 in 10 to 15 mins and at 2.15pm [Ms C] examined [Mrs A] again to check her progress. It is common to see a woman's contractions become erratic and sometimes space out for a time when she is coming into the second stage of labour. The vaginal examination at this time was appropriate midwifery management.

The examination revealed that there appeared to have been no progress since the examination at 10.30am. [Ms C's] thinking at this time was that the baby was in an OP (posterior) position, and the plan was for [Mrs A] to go home to wait for the contractions to accelerate again. [Ms C] writes in her [response to the complaint] that she now felt that this was still the latent phase of labour. There

does not appear to be any consideration given to the possibility that this was a non-progressive labour, nor to consultation with an obstetrician. [Mrs A] went home at that time.

The latent phase of labour is the term used to describe the early stages of labour when the cervix softens and shortens. The length of this stage of a woman's labour can vary greatly, and there is no consensus in the literature about what constitutes the length of a normal latent phase (Pairman et al 2010 page 488). Established labour is generally considered to be measured from when the cervix has dilated to 3 to 4cms and has finished effacing (thinning out), and the contractions have become more regular in strength and duration. However it has been my experience that the point at which a woman can be said to be in 'established labour' can vary significantly. It has certainly been my experience that in some multiparous women, the cervix will efface and dilate at the same time, and the cervix may be 6 or 7cms dilated by the time it has fully thinned out. However, from this point the labour would normally escalate and progress steadily, and very often rapidly.

[Mrs A] described her contractions as being strong and regular when she first came into the hospital at 10.30am, and the clinical notes record that they progressively became stronger and closer together, to the point that the midwife was preparing for the birth. By 1.00pm, the clinical notes describe the contractions as much more intense but had slowed somewhat to 1 in 5 and by 1.20pm the contractions had slowed significantly to 1 in 10 to 15 mins apart. The second vaginal examination done at 2.15pm, four hours after the initial examination, which is normal practice for assessing the progress of labour, found that there was no change in the cervix or descent of the fetal head.

It is my opinion that in this situation, rather than sending [Mrs A] home, consultation with the obstetric team at the local base hospital should have been considered at this point. Whatever the reason for the stalled progress, (OP position) my interpretation of the notes would indicate that [Mrs A] was in established labour, but was not progressing. As such, her labour was no longer within the range of normal labour. I would regard this action, in suggesting [Mrs A] go home at this point, rather than considering a consultation with the obstetric service, as a moderate departure from an expected standard of practice and I believe that it would be regarded as such by midwifery peers.

Section 88 Referral Guidelines.

Code 5021 Prolonged first stage of labour: Slowing in the progress of labour for second and subsequent labours. Take into consideration descent and rotation of fetal head, and changes in strength, duration and frequency of contractions. (requires consultation)

NZCOM Handbook for Practice

The third decision point in labour

If the woman or the midwife feels that progress is not being made, mother and baby should be reassessed regularly for factors that may indicate additional care should be considered.

Competency Two

2.6

The midwife identifies factors in the woman or her baby during labour and birth which indicate the necessity for consultation with, or referral to, another midwife or a specialist medical practitioner

Code of ethics

Responsibilities to the woman

j) Midwives have a responsibility to ensure that no action or omission on their part places the woman at risk.

5. The adequacy and appropriateness of [Ms C's] management following [Mrs A's] return to hospital between 6.10pm and 9.40pm. Please advise on any application of the Ministry of Health Referral Guidelines.

In her complaint [Mrs A] describes a birth plan conversation she had with [Ms C] during the pregnancy regarding transferring to [Hospital 2] should her labour not progress 'in a timely manner'. I have detailed the times of examinations and findings below. It is my opinion that [Mrs A] was in established labour when she was admitted at 10.30am. As such, the progress of this labour was well outside what would be expected, particularly in a multiparous woman.

Timeline from clinical notes:

0200 onset of contractions

1030 admission to [Hospital 1] 6–7 cm dilated

1415 VE 6–7 cm dilated discharged home

1834 VE — 8–9 cm dilated

2010 VE — 9 cm dilated

2140 VE — remaining cx pushed away

2155 Pushing

2115 Fetal head birthed

2120 Baby delivered Shoulder dystocia

It is my opinion that in keeping with the Section 88 Referral Guidelines, consultation with an obstetrician should have occurred if not after the examination at 2.15pm, then certainly by 6.34pm when it seemed clear that that the labour was not progressing normally. I would consider [Ms C's] actions, in not consulting the obstetric service at the base hospital, when it was seemed apparent that this was a labour that was not following a normal pathway, was a moderate departure from acceptable standard of midwifery care. In my opinion this would have been

especially relevant in light of the fact that they were in a remote rural setting, 2½ hours from the nearest base hospital. In her [response to the complaint] [Ms C] discusses her decision making regarding the place of birth for the women she cares for, and identifies some of the factors she considers given the remote rural location, such as 'is the labour progressing normally'. She also discusses the limitations and difficulties when a transfer is needed, such as the availability of the ambulance and the ambulance staffing. I agree with her concern about the dangers of dealing with a difficult birth in the back of an ambulance with limited support available. In this situation, the more progress [Mrs A] made in her labour, albeit apparently very slowly, the greater the likelihood of having just such a situation arise during the ambulance transfer. There is no documentation in the clinical notes that reflects this concern or any consideration regarding consultation or transfer, during the labour.

It is my opinion that earlier recognition of the apparent lack of progress in this labour, and consideration of the need for transfer or at least consultation, was warranted by the time of the third vaginal examination at the latest, in this situation. It does not appear from the clinical notes that any consideration was given to the possibility that this labour was not progressing normally until [Mrs A] was actually pushing. I believe the failure to recognise the warning signs that were present earlier in this situation, would be considered a moderate departure from accepted standards of midwifery care.

6. The adequacy and appropriateness of the management of delivery, including the management of the shoulder dystocia once it was identified.

The notes describe [Mrs A] having some involuntary pushing urges with contractions at 7.35pm. At 8.10pm she requested a vaginal examination to check progress and was found to be 9cm dilated at that time. During this examination [Ms C] attempted to push the remaining cervix away to facilitate the second stage of labour, but she was unsuccessful at that time. [Mrs A] was then encouraged to use entonox through the contractions, and she experienced more involuntary pushing urges at 8.30pm. [Ms C] again examined [Mrs A] at 9.40pm and was at that time able to push the remaining lip of cervix back over the baby's head, at which point the waters broke. At 9.45pm a further vaginal examination revealed that the baby was in an OA position (the posterior fontanelle was felt at the 12 o'clock position which indicates that the baby was facing backward) and the head was at station 0 (the bottom of the maternal pelvis). The notes describe [Mrs A] pushing well at 10.00pm, and the fetal head was beginning to come onto view. Second midwife [Ms B] was present at this time. From this point the notes are written in retrospect, which I would expect, as the midwives present would have been busy dealing with the events as they unfolded.

The baby's head birthed at approximately 10.15pm and at that time [Ms C] recognised signs of potential shoulder dystocia as the baby's head was 'turtling', which is a term which describes the head pulling tightly back into the woman's perineum and vulva. [Ms C] placed [Mrs A] into the McRoberts position and encouraged [Mrs A] to push 'as hard as she could'. The 'McRoberts Manoeuver'

has the woman flat on her back with her knees drawn up to her breasts as far as possible (knees to nipples). This position maximises the pelvic outlet dimensions and is normally the first intervention used in dealing with a shoulder dystocia emergency. There is no mention in the notes of trying other manoeuvres such as suprapubic pressure to try to dislodge the anterior shoulder, nor any internal manoeuvers to try to rotate the baby or deliver the posterior arm by axillary traction. [Mrs A] was then placed in an all fours position and the baby was delivered by traction being applied to the baby's head.

Shoulder dystocia is a serious and feared complication of birth that places the baby's life at risk as well as increasing the incidence of significant injury for the woman. 'Shoulder dystocia is best defined as a birth in which additional manoeuvres are required to deliver the fetal shoulders after normal gentle downward traction has failed' (Pairman et al 2010 page 917). The majority of shoulder dystocia cases occur in women with no risk factors, and therefore can be unpredictable and in the main, unpreventable. It is believed to occur in 0.58% to 0.7% of vaginal births, although there is a wide variance in the reported incidence (Auckland DHB Shoulder Dystocia document May 2012, Ansel et al 2011). 'In cases of shoulder dystocia resulting in infant morbidity, only 16% had identified risk factors' (Canterbury DHB Maternity Guidelines Group 2015 page 1). Risk factors that have been identified include fetal macrosomia, (although around 50% of shoulder dystocia cases arise with infants that weigh less than 4000gm) and prolonged labour.

In practice, midwives and doctors tend to refer to shoulder dystocia as being mild, moderate or severe, depending on the level of intervention required to successfully facilitate the birth of the baby's shoulders. 'True shoulder dystocia occurs when there is disproportion between the bisacromial diameter of the fetus and the anteroposterior diameter of the pelvic inlet. The anterior shoulder is impacted behind the symphysis pubis' (Pairman et al 2010 page 918).

Midwives attend yearly emergency refresher days, where there is the opportunity to practice the skills needed for dealing with emergencies such as shoulder dystocia. Management of a shoulder dystocia is guided by a systematic set of actions or manoeuvres such as the described by the HELPERR Mnemonic:

Call for help

Maternal repositioning (McRoberts)

Suprapubic pressure (to dislodge the anterior shoulder)

Consider Episiotomy *(although shoulder dystocia is considered a bony problem rather than a soft tissue problem so the use of episiotomy is debatable.)*

Internal Manoeuvres

- Deliver Posterior Arm (Axillary traction)
- Internal rotational manoeuvres

Move into all fours position

McRoberts is normally the first option of choice in hospital, together with suprapubic pressure to try to dislodge the anterior shoulder from above the brim of the pelvis. Other measures are used in any order, depending on the midwife or doctor, and this will often depend on their previous experience and what they have found to have worked best in other such situations. The All Fours position (Gaskin Manoeuver) has been reported to be successful in as much as 83% of cases (Pairman et al 2010 page 923) and many midwives prefer this management. The Axillary Traction technique described by Ansell (Irving) et al, Midwifery 2011 has been identified as an effective technique that can be used in any circumstance, and is both simple to perform and easy to remember. This technique involves the midwife/doctor sliding the hand into the vagina behind the baby, grasping the posterior shoulder by circling the thumb and first finger around the axilla with the second finger on top of the baby's upper arm, and delivering the posterior arm by applying traction to follow the curve of the sacrum. The posterior shoulder and arm are delivered first.

This manoeuvre is being widely used in Auckland at this time, and I note, is included in the Canterbury DHB Shoulder Dystocia Maternity Guidelines document. This method allows for significant traction to be used to deliver the posterior shoulder without causing harm to the baby, as the traction is applied through the axilla rather than against the fetal structures, which happens when strong traction is applied to the fetal head or humerus (Ansell et al, 2011 page 7). The aim is to deliver the baby without significant delay in order to avoid hypoxia, possible neurological damage, or death, while avoiding injury to the baby from excessive traction, such as brachial plexus palsy, clavicle fracture or humeral fracture.

The retrospective clinical notes describe [Mrs A] being put into McRoberts position and being encouraged to push as hard as she could. One of the problems with asking the woman to push in this fashion without using suprapubic pressure is that it can further impact the anterior shoulder against the pubic bone. When this did not achieve the delivery of the shoulders and there did not appear to be any restitution of the baby's head, which would have signalled the descent of the shoulders into the pelvis, [Mrs A] was moved to all fours position and the baby was delivered by way of maternal effort and 'gentle traction' after a delay of an estimated 5 minutes. No internal manoeuvres were attempted and it is documented in the Serious Adverse Event Report that suprapubic pressure was not able to be applied with the McRoberts manoeuvre. I could only find reference to this in the retrospective clinical notes written by [Ms B], 'unable to perform suprapubic pressure as unable to determine position of back/anterior shoulder'. [Ms C] has made no reference to this although she had documented earlier that the baby was in an LOA position, which would indicate that the baby's back was on [Mrs A's] left side.

[Baby A] was born in very poor condition, with 1 minute apgar score of 2, 5 minute apgar score of 3, spontaneous breathing at 5 mins and maintaining O2 saturations of 90 to 95% with high flow O2 at 15 mins. Apgars of 8 were documented at 57 mins of age. Resuscitation was commenced immediately after

the birth and then management of the resuscitation was taken over by the medical staff available at [Hospital 1]. Baby was subsequently transferred via Air ambulance to [Hospital 3] for continuing treatment for a Hypoxic Brain injury and Brachial Plexus injury (Erb's palsy).

A severe shoulder dystocia is a frightening complication that all midwives and doctors who attend births are likely to have to deal with at some stage. The best outcomes in my experience, result from quick action and a calm methodical approach to management, starting with early recognition or anticipation of an impending dystocia, getting help, keeping the woman involved as it is easy for her to panic, and systematically working through the manoeuvres required to achieve the birth. This was [Ms C's] first experience of shoulder dystocia and it was severe. [Mrs A] describes the birth from her perspective as 'a real struggle' to get the shoulders delivered. [Ms C] describes using McRoberts and then Hands and Knees position and describes using mild traction to the baby's head to deliver the baby. Given the time it took to achieve the birth of the shoulders (5–6 minutes) and the injury to the baby (Brachial Plexus injury and neurological injury) I would question that the amount of traction that was applied to the baby's head in order to facilitate the birth was as described.

It is my opinion that the management of this shoulder dystocia emergency did not meet the standards expected of midwifery practice, as there were no manoeuvres tried to facilitate the delivery of the shoulders other than repositioning and traction. I consider that in this situation, it would be viewed as a mild departure from expected standard by midwifery peers.

NZCOM Midwives Handbook for Practice

Competency Two: 'The midwife applies comprehensive theoretical and scientific knowledge with the affective and technical skill needed to provide effective and safe midwifery care'

Performance Criteria:

2.8 the midwife recognised and responds to any indication of difficulty and any emergency situation with timely and appropriate intervention, referral and resources

Midwifery Standards of Practice: Standard Six

The midwife:

** Demonstrates competency to act effectively in any maternity emergency situation*

7. The adequacy and appropriateness of the management of [Mrs A] following the delivery of her baby, including the management of the 400–500 ml blood loss and the perineal tear.

Following the birth of baby A, the cord was clamped and cut immediately as it was clear that the baby needed immediate resuscitation. [Mrs A] was at risk of PPH because of her prolonged labour and the shoulder dystocia. Pairman et al

2010 page 952. She was given syntocinon 10 IU intramuscularly into her right thigh and the placenta was delivered by controlled cord traction. Her blood loss was described as moderate to heavy at 10.48pm. At 11.26pm syntometrine was administered intramuscularly as [Mrs A] was continuing to 'bleed quite heavily' (clinical notes). Her blood loss was estimated as 400–500 mls. Given the description of the blood loss as being moderately and quite heavy, I believe weighing the blood loss would have been preferable as estimations of blood loss have been demonstrated to be highly inaccurate. At 11.38pm her blood pressure and pulse was measured, and found to be within normal limits, which would support the estimation of blood loss as being within normal limits. In NZ post partum haemorrhage is considered to be a blood loss of greater than 500 ml. At 2.15am [Mrs A] was able to get up to the toilet and pass urine, after which her fundus is documented to be around 2 cm above her umbilicus. [Ms C] had examined [Mrs A's] perineum and found her to have a '?? second or third degree laceration', which would need repair by an obstetrician. [Ms C] documented that the laceration was not bleeding at the time she undertook this examination.

[Ms C's] management of [Mrs A's] blood loss was within the standards of practice expected of a midwife. [Mrs A's] blood loss, whilst being heavy, was not at the level of being defined as a post partum haemorrhage, although she was at risk of this given the complications of the labour and birth and the extensive laceration she sustained. She appropriately administered syntometrine when [Mrs A's] blood loss appeared to be heavier than normal. While she did not recognise the 4th degree laceration, she did check that it was not actively bleeding at that time and she did recognise that it was beyond her expertise to attempt to repair it and referred appropriately. It is my opinion that the management of the blood loss and perineal laceration was within the standards expected.

8. The appropriateness of the decision to allow [Mrs A] to be transferred to [Hospital 3] unaccompanied.

There are no other comments recorded in the clinical notes after this time, pertaining to plans or discussions around [Mrs A's] transfer to [Hospital 3], however [Ms C] notes in her letter that there was a discussion between the practitioners present about [Mrs A] being transported to [Hospital 3] by private car as she appeared to be stable at that time. I am unable to find any documentation regarding the time that [Mrs A] was actually transferred, but there is a comment in the Adverse Event Report that suggests that it was 8 hours after the birth. Given the extent of the injury to her perineum and the long and difficult labour, transfer in a private car in my opinion would have been inappropriate, especially given the fact that this would have been a 2½ hour journey. Transfer to [Hospital 3] was arranged via ambulance and [Ms C] has stated in her letter that as an ambulance officer and paramedic were to accompany her she did not require a midwife escort. Risk factors for primary post partum haemorrhage (PPH) which is defined as blood loss greater than 500 ml occurring in the first 24 hours after delivery, include macrosomic baby, prolonged labour and genital trauma. (Pairman et al 2010 page 952–954).

Guidelines for Consultation with Obstetric and Related Medical Services

4.5 Page 16

Clinical responsibility during transport

Until care is formally transferred to a specialist, the LMC retains clinical responsibility for care. This means that paramedics or ambulance crew must take clinical direction from the LMC when they are responding to an obstetric emergency.

If the LMC cannot provide a clinical escort during transport, clinical responsibility is transferred to the crew for the period of transport only. This clinical responsibility will normally be considered to have been transferred when the woman arrives at [the DHB] facility.

[Ms C] has not made comment on why she did not accompany [Mrs A] during the transfer to [Hospital 3]. In most circumstances I believe it would have been appropriate for her to have done so, as although [Mrs A] appeared to be stable, she was still at risk of haemorrhage. However if [Mrs A] was not transferred until around 6am, [Ms C] would have been very tired herself, and past the point of being capable of providing safe effective midwifery care for a further 2 1/2hours during the ambulance transfer. The Paramedic was apparently happy to take responsibility for the care of [Mrs A] ([the DHB's] SAE report page 16). It is my opinion that in this situation, it was appropriate for [Ms C] to hand over the responsibility for the care of [Mrs A] to the Paramedic for the duration of the transfer to [Hospital 3].

9. The adequacy of [Ms C's] documentation

The documentation up to the point of the birth is thorough and follows the story of the labour and birth in a comprehensive way. It was understandable that the notes around the birth itself and the shoulder dystocia were made in retrospect, as the attention of the two midwives would have been completely taken up in dealing with the emergency as it unfolded. In a hospital setting there are normally many more pairs of hands available to help and someone is often available to scribe during the event. The retrospective notes document that the placenta was delivered by CCT at 10.26pm. It is noted that the retrospective notes describing the events of the birth were written at 0133h, but the contemporaneous notes appear begin again at 2348h, with a note regarding [Mrs A's] blood loss and fundus. There is a further note made at 2300h, 2326h and 2338h. At 0215h it is documented that [Mrs A] has been up to the toilet and has passed urine, that her fundus is central and sitting 2 cm above her umbilicus. This is the final comment made in the notes I have reviewed regarding [Mrs A's] well being or the midwifery care being provided.

If [Mrs A] was transferred at around 0600h then there is a significant amount of time when her well being and care have not been documented. It is my opinion that the documentation following the birth is inadequate and does not meet the standard expected. Given that apparent lack of any documentation describing the

care provided to [Mrs A] after 2.15am I would regard this as a moderate departure from the acceptable standard of care.

NZCOM Midwives Handbook for Practice: Competency Two.

Performance Criteria

2.16 the midwife provides accurate and timely written progress notes and relevant documented evidence of all decisions made and midwifery care offered and provided:

Standards of Midwifery Practice: Standard Seven.

The midwife clearly documents her decisions and professional actions

10. Any other comment you wish to make

I have no further comments at this time.

Mary Wood

References:

Auckland DHB Shoulder Dystocia Management and Flowchart
May 2012.doc

Midwifery Preparation for Practice (Second Ed): Pairman, Sally. Tracy, Sally. Thorogood, Carol. Pincombe, Jan 2010
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Nice Guidelines 1.10 Fetal Growth and Well Being 2014
New Zealand College of Midwives (INC) Consensus Statement: **Assessment of fetal wellbeing during pregnancy** 2012

New Zealand College of Midwives (INC)
Documentation and Record Keeping Practice Guidance
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New Zealand College of Midwives Handbook for Practice

NZ Maternal Fetal Medicine SGA Guideline 2014
Section 88 Referral Guidelines for Consultation with Obstetric and Related Medical Services

Shoulder Dystocia: A qualitative exploration of what works. Midwifery (2011) Ansell (Irving), L, et al, Doi:10.1016/j.midw.2011.05.007

Canterbury District Health Board:
Shoulder Dystocia / Maternity Guidelines/Christchurch Women's Hospital.

July 2015 Maternity Guidelines Group
NZ Maternal Fetal Medicine SGA Guideline 2014"

Further expert advice

Further advice was obtained on 1 December 2016:

> "You had asked me to review the further documentation you have forwarded to me and requested that I review the new information provided and consider whether I would wish to amend or add to my original advice.
>
> In particular you have asked if I consider there has been a departure from accepted professional standards, and to comment on
>
> 1. how significant a departure I consider it is: and
> 2. how the care provided would be viewed by midwifery peers.
> 3. The appropriateness and adequacy of the care provided by hospital midwife, [Ms B], particularly in relation to her involvement in the management of the shoulder dystocia.
> 4. Any recommendations for improvement that may help to prevent a similar occurrence in the future.
> 5. Any additional comment I wish to make.
>
> I have read the further documentation, including:
>
> 1. Copy of [Ms C's] response to the complaint, dated […]
> 2. Copy of [Ms C's] letter of 12 July 2016
> 3. Copy of transcript of interview with [Ms C] on 24 August 2016
> 4. Copy of transcript of interview with [Mrs A] on 16th August 2016
> 5. Copy of letter from [Ms B], dated 14th July 2016
> 6. [Mrs A's] midwifery notes
> 7. Relevant information from [the DHB], including copy of SAC report and relevant policies and procedures
> 8. [Mrs A's] [DHB] clinical records
> 9. Baby A's [DHB] clinical records
> 10. [Mrs A's] complaint dated […]
>
> I have nothing further to add to my initial report regarding the antenatal care provided by [Ms C] to [Mrs A].
>
> I note from the documentation that there are conflicting descriptions given by [Mrs A] and [Ms C] regarding any discussion about the possibility of transfer after the vaginal examinations undertaken at 2.15pm and 6.34pm. [Ms C] states in her letter of 12 July 2016 that she would have discussed the progress of labour to date and the options available to [Mrs A], to either transfer or to return home. She recalls that [Mrs A] was adamant that she did not want to transfer to [Hospital 2]. She states in her interview with HDC that she would have discussed the lack of progress in her labour as being attributed to the baby's position and therefore was not concerned about any delayed progress of the labour. As such she would not have considered consultation with a specialist at the time. It is my opinion that regardless of the possible reason for the delayed progress in this labour, consideration of consultation was warranted, given the situation.
>
> [Mrs A] has stated that at no time was any option for transfer discussed, and that the only option offered to her was to return home. She also states that the option of

consultation with a specialist obstetrician was never discussed with her. She is clear that she would have been happy to transfer and in fact her husband was prepared to drive her if necessary.

There is no documentation reflecting any discussion between [Mrs A] and [Ms C] about the possibility of transfer, nor consideration of consultation with an obstetrician in the clinical notes.

If no discussion took place between [Ms C] and [Mrs A] regarding the possibility of consultation or transfer, given the apparent slow progress of [Mrs A's] labour, I believe this would be regarded as a moderate departure from expected standards of midwifery care. It seems clear from [Ms C's] letter and the interview transcript that she did recognize the lack of progress in this labour but attributed it to the position of the baby, in that she felt that the baby was in an OP position (facing forward rather than facing backward), which is a known cause of delayed progress in labour. She describes her belief that the progress, albeit slow, was still within the normal parameters one would expect in a multiparous woman in labour. [Mrs A] considered herself to be in labour when she was admitted to [Hospital 1] at 10.30 am, at which time she was 6–7cm dilated and fully effaced. She was not fully dilated until 09.40pm. It is my opinion that this is very slow progress regardless of the reason, and outside what would be considered normal by midwifery peers. I have not changed my opinion that this would be considered a moderate departure from acceptable care standards.

The appropriateness and adequacy of the care provided by hospital midwife, [Ms B], particularly in relation to her involvement in the management of the shoulder dystocia.

[Ms B] was the core midwife who was on call to provide second midwife support at [Hospital 1] that night. After being notified by [Ms C] that she had a woman in labour in the unit, she arrived at the hospital at around 6.45pm. She was called into the birthing room at 9.55pm at which time [Mrs A] was fully dilated and actively pushing. The shoulder dystocia was recognized very quickly once the baby's head was delivered and [Mrs A] was immediately placed in McRoberts position. [Mrs A] was encouraged to 'push as hard as she could' while [Ms C] applied traction to the baby's head.

[Ms B] had pushed the emergency bell to summon help from the Emergency department but the buzzer didn't sound in the ED. After attempts to deliver the baby with [Mrs A] in McRoberts were unsuccessful, [Ms B] briefly left the room to summon help in person. In her statement of 14th July 2016 [Ms B] said that when she returned to the room she helped [Ms C] and [Mrs A's] birth partners maneuver [Mrs A] onto all fours (Gaskin Maneuver) and after further traction was applied the baby was born. In her interview with HDC [Ms B] stated that when she returned to the room [Mrs A] was already on her hands and knees.

[Ms B] in her statement of 14th July 2016 has commented on the appropriateness of using the Gaskin Maneuver to successfully resolve the shoulder dystocia. I agree with her comments regarding the use of this manoeuvre. However in this

situation [Mrs A] was already in McRoberts, and instructing her to 'push as hard as she could' while applying downward traction to the baby's head but without the added action of suprapubic pressure increased the risk of further impacting the anterior shoulder against the pubic bone, and as such, increased the risk of contributing to a brachial plexus injury. [Ms B] was unable to determine which side the baby's back was on and explained that this was the reason she was unable to try suprapubic pressure. However [Ms C] had documented that the baby's back was on the left earlier during the labour. I can appreciate that given the tension and pressure of the moment she may have forgotten to share this information with [Ms B], but I consider that better communication between [Ms C] and [Ms B] would have been helpful in more effectively managing the emergency. [Ms B] has commented that there was no discussion that she can recall about using internal manoeuvres nor Gaskin. [Ms C] has also stated that there was no discussion between her and [Ms B] during the emergency.

I agree with [Ms B]'s] comment that using the Gaskin manoeuvre in itself, was not a deviance from standard practice, and many midwives do prefer this manoeuvre over other manoeuvres they may be less familiar with using. However, I am concerned that the overall management of this situation could have been more effective and that the use of McRoberts and traction without suprapubic pressure had the potential to further entrap the baby's left shoulder. Immediate use of Gaskin for example, when it became apparent that suprapubic pressure was not possible, rather than proceeding with applying traction to the baby's head, would have been a more appropriate action given the circumstances, if internal manoeuvres such as posterior axillary traction was not considered.

I do appreciate how stressful and difficult a serious shoulder dystocia is and how quickly events unfold. I do applaud the fact that the midwives involved did use an alternative option when the manoeuvre they were trying did not affect the birth of the baby. I have given this a great deal of consideration however, and I do still regard the management of this emergency as a mild departure from acceptable care standards.

[Mrs A's] transfer to [Hospital 3]

At the time of writing my original report, the documentation I reviewed indicated that [Mrs A] transferred in an ambulance in the company of an ambulance driver and paramedic. I therefore was of the opinion that a midwifery escort was not required. However it now has become evident that in fact she transferred with only an ambulance officer. Given her risk factors for PPH, the injury she had sustained during the birth and the fact that she had already had a significant blood loss, I consider this inappropriate. While I do not consider that [Ms C] should have accompanied [Mrs A] given the time she had been awake and her exhaustion, I do believe she should have been escorted by a midwife, nurse if a paramedic was unavailable. It is unclear to me from the documentation, who was responsible for the decision to transfer [Mrs A] in the company of a sole ambulance driver."