

Midwife, Ms D

Midwife, Ms E

**A Report by the
Health and Disability Commissioner**

(Case 07HDC14036)



Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Overview

Mrs A's first baby was due in mid 2007. Mrs A had an uneventful pregnancy. Lead Maternity Carer (LMC) Ms D booked Mrs A for an induction delivery at a public hospital ten days after her due date. However, assessment by locum midwife Ms E indicated that Mrs A was in early labour and induction was not required. Ms E did not listen to the fetal heartbeat.

Mr and Mrs A returned to hospital the following morning but the fetal heart could not be heard and their baby had died. The family elected to proceed with a natural delivery and Baby A was delivered later that day. Ms D attended the delivery in conjunction with hospital staff.

The family became concerned about the level of professionalism and competence Ms D demonstrated during the day and requested that hospital staff manage the delivery. This report primarily considers the issue of whether mother and baby were adequately assessed by midwife Ms E, and whether LMC Ms D provided appropriate care during the delivery.

Complaint and investigation

On 6 August 2007, the Commissioner received a complaint from Mr and Mrs A about the services provided by midwives Ms D and Ms E. The following issues were identified for investigation:

Ms D

The appropriateness of the care midwife Ms D provided to Mrs A in relation to the labour and birth of Baby A.

The adequacy of the information and communication midwife Ms D provided to Mrs A in relation to the labour and birth of Baby A.

Ms E

The appropriateness and adequacy of the care midwife Ms E provided to Mrs A.

An investigation was commenced on 18 December 2007. The parties directly involved in the investigation were:

Mrs A	Consumer/complainant
Mr A	Complainant
Mr B	Mrs A's father/Witness
Mrs B	Mrs A's mother/Witness
Ms C	Mrs A's friend/Witness

Ms D	Provider/midwife
Ms E	Provider/midwife
Dr F	Provider/obstetric registrar
Ms H	Midwife
Ms I	Midwife
Dr J	Obstetric registrar
Ms K	DHB midwife

Independent expert advice was obtained from midwife Nimisha Waller.

Relevant information

Antenatal period

Mrs A had an uneventful pregnancy apart from an early bleed at seven weeks. Mrs A attended 13 antenatal appointments with Ms D. There was an isolated episode of transitional fetal tachycardia at 38 weeks. Ms D planned, in consultation with Mrs A, to proceed with a natural birth at a birthing centre.

Ms D said that at each antenatal visit Mrs A was routinely asked about fetal movement, and frequently “in the days before the delivery”. She was informed as part of her care plan at 36 weeks to be “quite aware” of fetal position and movement. An information brochure¹ that Mrs A was given requested that she contact her midwife urgently if there were fewer than 10 fetal movements daily. In contrast, Mr and Mrs A disagree that Ms D placed any emphasis on fetal movement in the antenatal period, and have no recollection of being asked about fetal movement in the days prior to the delivery.

Ms D’s communication style

Mrs A found Ms D to be “idiosyncratic” in her communications. Mrs A reported that the level of rapport that Ms D demonstrated was “terrible”, and she was overly focused on her own personal problems. On one occasion, Mrs A’s blood pressure was elevated after she had been walking her dogs. In response, Ms D embarked on an explanation about how she couldn’t walk her dogs because she had a bad leg, and about how her uncle had just died. However, Mrs A thought Ms D’s strange manner was “just one of those things” and did not consider obtaining a new midwife. Mrs A decided to ignore Ms D’s “quirks” and focus on the purpose of the visits.

Mrs A’s friend (and student nurse), Ms C, planned to be present at the birth to record events on video. Ms C said that the stories she heard from Mrs A made her concerned about Ms D’s professionalism. Ms C recalled that Mrs A told her about one consultation when Ms D took around five phone calls. Ms C suggested to Mrs A that

¹ Mrs A was provided with a six-page information booklet.

she should change midwives. However, Mrs A said that she would be “okay” and had great support around her.

Mr and Mrs B (Mr A’s parents) understood that Ms D always seemed to be telling Mrs A about crises she was experiencing.

Ms D explained that her practice is to ask about the well-being of her clients, and initiate conversation. She believes that the sharing of personal information (such as losing her dog, her father-in-law’s death, an injury to her leg, and her psoriasis) was appropriate in the context of developing a relationship with Mrs A. She kept any interruptions from phone calls to a minimum. She said:

“Had [Mrs A] given me any indication at any time that she did not wish to communicate at this more personal level, I would have respected her wishes.”

Ms D’s colleague, an independent midwife, commented that the sharing of personal information is a common occurrence in the context of midwifery care. Ms H, another of Ms D’s colleagues, expressed the view that, in her experience, Ms D is professional in antenatal situations.

Scan and assessment on Thursday

On Thursday, Mrs A was 41 weeks’ gestation² and underwent a scan which suggested that the size of her baby was in the upper limits of normal, with an estimated weight of 10.211oz (4589gm). The radiology report noted that there was good growth with normal liquor.³

Ms D assessed Mrs A after the scan. She recorded Mrs A’s temperature and blood pressure, listened to the fetal heart rate, and performed abdominal palpation. A cardiotocograph (CTG)⁴ reading was taken, detecting small contractions (2/10)⁵ which were not felt by Mrs A. Ms D decided that if labour had not established by Saturday evening, Mrs A should be induced at the public hospital. Mr and Mrs A commented that Ms D was initially going to book the induction for Monday, but they requested an earlier date.

Mr and Mrs A were concerned that the size of the baby should have been identified as a risk factor. However, Ms D commented that the fundal height⁶ did not show an abnormally large baby. She said:

² Gestation refers to the age of the fetus in the uterus. Delivery generally occurs at approximately 40 weeks’ gestation. A woman is considered post-mature at 41 weeks’ gestation and induction should be considered.

³ Liquor is the fluid surrounding the fetus in utero.

⁴ Used to record the fetal heart rate.

⁵ This is the ratio of contractions per minute, ie, two contractions every ten minutes.

⁶ The fundal height is a measure of the size of the uterus, used to assess fetal growth from the top of the pubic bone to the top of the uterus.

“There was no indication to treat this labour as other than normal or bring the induction date forward, and as it was we booked the earliest date that was available.”

Ms D said that although she was due for some time off she intended to manage Mrs A’s labour or induction “regardless”.

Progress until Saturday evening

Mrs A’s contractions increased in strength during Thursday and Friday and it was difficult for her to sleep. However, she commented that the contractions “were not really going anywhere”. Mr and Mrs A, and Mr A’s parents, felt that Ms D gave minimal support around this time, advising them not to contact her unless Mrs A was unable to talk and contractions were 3/10. Mr A commented that they became aware of reduced fetal movement, but they had been told this would occur because of the baby moving into position, and were not alerted to any concerns.

Mrs A contacted Ms D around midday on Friday and advised that the contractions were now noticeable but still only 2/10. Mrs A could talk easily, the baby was moving, there had been no show (mucous blood loss) and the membranes were intact.

Ms D contacted Mrs A on Friday evening (around 7pm) and was advised that the contractions had not developed further. Ms D advised Mrs A that this was not unusual, and she should try to get some rest before contractions recommenced. Fetal movement was present. During one of the phone calls on Friday evening, Mrs A passed on to Ms D that she had experienced mucous blood loss.

After midday on Saturday, Ms D spoke to Mrs A, who advised that contractions were stronger. It was agreed to continue with the plan to assess for induction at hospital that evening. Ms D advised Mrs A that she would arrange for another midwife to attend, as she had been called out to assist a colleague in the early hours of Saturday and she wanted to rest prior to the delivery.⁷ She also advised that, depending on progress, she might not start the induction herself the following day.

Mr and Mrs A advised that the baby was definitely moving before they went to the hospital. Mrs A was in the bath, and a video was taken showing the baby’s movement.

Assessment on Saturday

Independent midwife Ms E was in the hospital delivery suite on Saturday afternoon. Ms E is a member of a midwifery team. There are four midwives in this group, including Ms D and Ms E. Ms E was asked by Ms D to meet Mrs A at 6pm to decide whether she would need prostaglandins (prostins)⁸ for the induction. It seemed that Mrs A was now possibly in early labour after several days of irregular Braxton-Hicks⁹

⁷ In the early hours of [Saturday], Ms D was called to assist a colleague to complete a birth.

⁸ Synthetic prostaglandins are used to induce childbirth.

⁹ Braxton-Hicks contractions are sporadic uterine contractions rather than established labour.

tightenings. Ms D advised that if early labour and regular contractions were indeed established, prostins might be contraindicated, as this could result in a hypertonic uterus. She also advised Ms E of the preference to proceed with a spontaneous birth at the birthing centre if possible.

The couple arrived at the hospital around 5pm on Saturday. Shortly after 6pm, Ms E conducted her assessment in a room at the delivery suite. A third-year midwifery student, Ms I, was also present. Mr and Mrs A commented:

“The new midwife had obviously not talked to [Ms D] and we had to explain the last few days over again. This lack of communication was apparent and again at this crucial time we should not have had to repeat our notes to the next care provider. We are not health professionals and how could we be sure we had covered all important factors.”

Ms E ascertained that contractions were around five minutes apart. As part of her assessment, she asked Mrs A to provide a history, which confirmed the information already provided by Ms D, including the preference to birth at the birthing centre if possible.

Mrs A recalled that Ms E felt the baby move during her abdominal examination. Ms E performed a vaginal examination but was unable to reach the cervix. She said that she noticed that there was no CTG machine present in the room. She and Ms I then left the room to obtain a sonicaid¹⁰ from the front desk to check the fetal heartbeat. (Mr and Mrs A commented that they were under the impression that Ms E left the room to obtain sleeping tablets.) Ms E saw the registrar on call, Dr F, and took the opportunity to consult him about the administration of prostins. Ms E stated:

“The Registrar then decided to meet with them personally and obtain information straight from them before he agreed that they could leave.”

Ms I commented:

“[The Registrar] ended up realising he knew [Mr and Mrs A] on a personal level, so he said he’d pop in and say ‘Hi’ and see how she was going. Whilst he was doing that, [Ms E] wrote in [Mrs A’s] notes and explained to me about avoiding prostaglandins when the uterus is already contracting. The registrar then came out to see us, and said he agreed with the assessment.”

Dr F attended Mrs A’s room and advised that if Mrs A was not in established labour she should return to hospital the following morning. Dr F documented that Mrs A had moderate contractions, was not for prostins, and could attend the birthing centre if labour developed.

¹⁰ A sonicaid is a hand-held device for listening to the fetal heartbeat. It does not produce a trace.

Mr and Mrs A recall that Dr F came to their room at the end of the assessment. They stated:

“[Dr F] stood in the doorway while we discussed the pregnancy casually. [Ms E] asked [Dr F] for his opinion, as the registrar, on the induction recommendation and [the birthing centre] option for the birth if it arrives overnight.”

The couple returned home with the intention of returning to the hospital at 8am on Sunday if there had been no further progress. The contractions continued through the night at regular intervals. Mrs A recalls that the sleeping tablets provided by Ms E had “no effect”.

Mr and Mrs A are very concerned that Ms D did not undertake the induction assessment herself. They state:

“We believe this was the biggest failure from our LMC. Due to the lack of urgency and no emphasis of the risk on the birth at this stage we lost our window of opportunity to save our daughter ... We believed that mother and daughter would not only have competent care but exceptional and thorough assistance. By placing our trust in our LMC we were sure that any problems would be resolved quickly and professionally.”

Comment from Ms E

Ms E did not detect any concerns about reduction of fetal movement. She said that her normal practice is to ask about fetal movement when listening to the fetal heart rate. Furthermore, Mrs A did not mention any concerns in this regard.

Ms E said that the couple were keen to return home as soon as possible to watch a rugby test with friends. In contrast, Mr and Mrs A dispute being anxious to return home to watch rugby as they wanted the baby to be delivered as soon as possible. Ms E was also attending to her own client’s induction that evening. This made her feel pressured for time during assessment.

Ms E recalled completing her documentation around 15 minutes after the couple had left hospital. She recorded:

“[Mr and Mrs A] arrived for assessment for Prostins — but reports she is contracting frequently since 1200hrs, 5 min[utes] apart. Strong on palpation. VE [vaginal examination]: unable to read cervix. Head station –3. Given temazepam. Discussed with Reg[istrar] to send home as she is having frequent strong contractions.”

Ms E said that she realised at the time of documenting her assessment that she had not listened to the fetal heartbeat, and discussed this with Ms I. Ms E stated:

“... [Ms I] asked whether we needed to have done a CTG, but I said that we would only have done a CTG prior to giving prostins. Instead, listening with the sonicaid for a minute should have been done.”

Ms E stated that she did not report back to Ms D that evening as she was very busy, and there were no apparent concerns. However, Ms D contacted Ms E at 7pm and noted “all well”.

Student midwife Ms I

Ms I recalled that Ms E contacted her the following morning after she found out that Mrs A’s baby had died. Ms I stated:

“Immediately [Ms E] realised what she didn’t do in the previous night’s assessment (listen to the fetal heart) and was very distraught for [Mr and Mrs A] for her mistake.”

Ms I commented that Ms E was preoccupied with her own client, who was being induced in the delivery suite, and that Mr and Mrs A were eager to return home.

Comment from Dr F

Dr F said that midwife Ms E contacted him only for specific advice about prostins. He was not made aware of any concerns about fetal welfare, and was “never formally consulted” about Mrs A. He saw Mrs A only because he knew Mr A socially.¹¹ Dr F stated:

“My discussions with them were brief and conversational rather than formal. The midwife was aware that I was only meeting the couple because of my social connection.”

Death of baby detected

Ms D did not attend the hospital on Sunday morning, and arranged for her colleague, midwife Ms H,¹² to start the induction. Ms D said that Mrs A had been informed that she might not be present initially. However, the couple say that they were surprised not to see Ms D when they arrived that morning. Mr and Mrs A stated:

“Although we were expecting to see [Ms D] a different midwife again met us. This midwife was once again ill-informed from the previous midwife and relied on us to explain what was discovered on the previous appointments.”

Ms H explained that Ms D had provided her with a thorough verbal briefing about Mrs A the previous evening, but she always obtains a full medical history herself as well. Ms H conducted her assessment but was unable to find a fetal heartbeat. Ms H

¹¹ Dr F further documented on [Sunday] that he visited the patient only as he knew her socially.

¹² Ms H is also a member of the midwifery team.

then sought a second opinion from the shift co-ordinator, midwife Ms K,¹³ who also could not locate a heartbeat.

Ms H documented that Mrs A had experienced reduced fetal movement over the last two days, with only one “kick” the previous night. Ms H asked Mrs A whether she had informed Ms D of this, and Mrs A confirmed that she had not. In response to my provisional opinion, Mr and Mrs A emphasised that they had not been alerted to any particular concerns about fetal movement, and the baby had been moving on Saturday evening.

Ms H also noted: “At 9.10 [Ms D] arrived to take over care from me. [Ms D] obviously distressed and has comforted [Mrs A] and her husband.”

Dr J was the registrar on call for that morning. Mrs A informed her that the baby had been “very quiet” for the last few days. Dr J confirmed that there was no fetal cardiac activity and that the baby had died. Ms H contacted Ms D and advised her of the fetal demise, while Ms K talked to Mr and Mrs A. Ms H recalled that Ms K informed Mrs A that hospital staff would be looking after her, and discussed the options for delivery — to continue with the induction as planned or to go home to take some time for themselves before planning the delivery. The couple elected to proceed with delivery that day. Dr J recalled that Mrs A and her family were happy for Ms D to remain involved with the delivery.

Ms H also contacted Ms E and advised her of the fetal demise. Ms E stated:

“When [Ms H] phoned me that morning to let me know that [Mrs A’s] baby had died, I asked who would be caring for [Mrs A]. She said that care had already been taken over by the team, but that [Ms D] was going in to see [Mrs A].”

Ms D arrived at the hospital shortly after birth options had been discussed. Ms H stated:

“When [Ms D] came into the delivery suite I informed her that [Ms K] had told the [couple] their options and that she has said that their induction was now under hospital care (secondary care).”

Ms H recalled that when Ms D entered Mrs A’s room, Mr A said that “everything had been explained by [Ms K]” and he did not want Ms D to explain it again.

Ms K commented that Ms D seemed shocked but assured her that she “wanted and needed” to care for Mrs A. Ms K offered to support Ms D wherever she could. Ms K, Ms D and Dr J discussed the best way of managing the induction.

¹³ Ms K is an employee of the District Health Board. She is responsible for the coordination of the delivery suite, overseeing the care of tertiary care patients, and helping and supporting LMC midwives and their clients in the delivery suite.

Responsibility for midwifery care during delivery

The District Health Board (the DHB) maintains that clinical responsibility for Mrs A's labour and delivery care was not formally handed over to hospital staff on Sunday. The midwife leader for the DHB advised that "[i]t is common practice in this delivery unit for LMCs to maintain clinical responsibility for the labour and birth of women who have experienced an IUFD (intrauterine fetal death), with the support of the DHB medical and midwifery staff, should the midwife and the woman wish to do this". There was no documentation of formal transfer of care to the hospital team at any stage of the labour. The DHB's "Intrauterine fetal death (IUFD)/Stillbirth" policy states:

"If the maternal condition requires ongoing specialist care then 'transfer to secondary care' **may** be recommended. This transfer of care will be done in consultation with the woman, her lead maternity carer (LMC) and the consultant obstetrician. Continuity of care will be encouraged whenever it is clinically appropriate."

The midwife leader noted that "most LMCs will choose the option to remain clinically responsible for the care and engage with the medical and midwifery staff for advice and support as required".

Ms K and Dr J said that they supported Ms D throughout the day. Ms K said that she remained in close communication with Ms D and that Ms D assured her that progress was normal after each examination Ms D conducted. Ms K was not made aware of any concerns about the progress of labour (or about Ms D herself). Dr J examined Mrs A and ruptured the membranes. She performed clinical assessments on Mrs A and frequently checked on the progress of labour.

In contrast, Ms D understood that the care had been handed over to the DHB staff before she arrived, and that she attended in a support capacity only. Ms D documented that she "arrived to support [Mrs A]". Ms D was told by Ms H that the care had been handed over to the secondary team. Ms D stated:

"When I initially arrived I was told by [Ms H] that care had been handed to the Secondary care team. I told [Mr and Mrs A] that I was willing to stay and give them my support. Had this uncertainty been mentioned during the labour I would have repeated that care had been handed to staff *before* I arrived. I did not document this as it was stated by [Ms K] (in the presence of [Ms H]) to [Mr and Mrs A], *before* I arrived. I therefore did not realize that I was responsible for documenting this in the notes."

Ms D acknowledged, however, that she remained involved in Mrs A's clinical care:

"Because [the] delivery suite was very busy I did assist hospital staff that day by caring for [Mrs A's] comfort measures. The registrar was always called

when a decision or procedure had to be made. I was asked to document by [Ms K] as she did not have the information to complete the paperwork.

...

I was never told of any concerns during the labour by the family or staff [not] that they believed me to be in charge, and wished care to be taken over by the staff.”

Ms H also thought that the DHB staff had taken over care of Mrs A. (Ms H did not remain present for the delivery.) Ms H noted that Dr J ruptured the membranes and checked on the progress of labour, a task that is normally undertaken by the LMC.

Ms E commented that, in her experience, there is often confusion around when care has been handed over to the hospital team, and emphasised that the decision to hand over care is shared with hospital staff. Furthermore, even when care has been handed over, there is often a shared care situation due to the availability of hospital staff. In this situation, no core staff member was allocated to Mrs A, so Ms D continued to provide whatever support and assistance she thought necessary.

Mrs A recalled that Ms D came into the room and asked whether she wanted another midwife. Mrs A said no, as she did not think it would make any particular difference. Mrs A was then rather surprised when Ms D asked if she “hated her”. (Ms D disputes making this comment.) Mrs A said that she thought that Ms D remained in charge of her care. Mr A (and his parents) also thought this to be the case.

Comment from Mrs A and support group

Mrs A said that Ms D kept making inappropriate light-hearted comments, which “sunk like a stone”. For example, Ms D commented that Mrs A’s blood test would show how much wine she had been drinking. (Ms D disputes making this comment.) She continued to make inappropriate comments throughout day. There was a particular incident when Ms D told Mrs A to “cuddle” the teddy bear from the SANDS (Stillbirth and Newborn Death Support) basket provided by the DHB instead of her baby, which was very upsetting. Ms D was very emotional at times and was crying during the actual delivery. Ms D also gave Mrs A some tablets for milk suppression but did not explain what they were for other than to say “they would help with milk”. Mrs A was not informed that the tablets would suppress her milk.

Mr A said that they were not confident in Ms D’s ability to deliver the baby, and she could not communicate under pressure. He also felt that Ms D became very emotional and distressed at the time of the delivery. In his view, she should have had sufficient training to cope with the situation and provide support, and he was concerned that she did not control the situation. In particular, Ms D did not give clear instructions, she did not know where to locate hospital equipment, and she attempted to adjust intravenous fluids after hospital staff had already done so.

Ms C stated that it was very obvious that this was Ms D’s first stillborn delivery as she clearly had no idea what she was doing. Ms D made lots of unprofessional comments,

some in an attempt to alleviate stress, which “did not help”. Ms C also recalled the comment about the blood test showing alcohol, and said that Mrs A was very upset after the incident with the SANDS basket. Ms C said that the relationship with Ms D deteriorated as the day went on. She kept making insensitive “bloopers” throughout the day. When it came time for the delivery, she made it known to the DHB staff that the family did not want Ms D to deliver the baby. It was then clarified that Ms D was present only for support, and that hospital staff would deliver the baby. Ms D was very emotional during the actual delivery, and was crying and “blubbing” when the baby was born. Ms C thought this was very unprofessional. It seemed that it was “all about her” throughout the process, even the delivery. After the delivery, Ms D said that she was going to give up midwifery practice, which was a particularly unprofessional comment.

Mrs B recalled that Ms D was quite stressed and gave the impression that “she did not know what she was doing”. She made “a lot” of inappropriate comments. At the end of the delivery Ms D informed Mrs A that this was the first time this had happened to her and said, “Oh well, I don’t know whether you have been on drugs or not.” Mrs A was also very upset by Ms H’s comments later that day. Mrs B said that Ms H saw them in the hospital café and discussed the fact that the cord had been wrapped around the baby’s neck. Mrs A found the tone of this conversation “very upsetting and inappropriate”.

Ms H has no recollection of meeting Mrs A or making any such comments.

Mr B felt that Ms D did not demonstrate competence or engender their confidence. She made “silly, insensitive” comments. Eventually, he expressed concern to the DHB staff about her behaviour. He understands that Ms C complained separately.

Request for transfer of care

Dr J was approached by Ms C around 7pm and advised that the family had little confidence in Ms D. At that stage, Ms K agreed to deliver the baby and took over Mrs A’s care. Ms K said:

“When [Ms D] came back into the room I could sense some disagreement between her and [Mrs A’s] relatives. I kept charge of the delivery and [Ms D] agreed to stay in the background. She was clearly very emotional.”

Ms D commented:

“If staff were aware of [Ms C’s request] I feel I should have been approached, and they should have documented handover of care if they felt I was clinically responsible at this stage, and there had been a request for me not to be.”

Ms D remained in the room and documented in the medical record. Baby A was delivered stillborn at 9.15pm. Ms K said that after delivery Ms D was “overwhelmed and in tears”.

The post-mortem report revealed an anatomically normal baby. There was evidence to suggest that the umbilical cord had been compressed, causing death.

Comment from Ms D

Ms D believes that she provided appropriate care during the delivery. It was not her intention to be disrespectful at any stage, and she apologises if she caused any distress. She believes that she adequately explained the purpose of the milk suppression tablets and was competent in the care that she provided. She stated:

“In my mind I had thought to convey that she might like to put her essence upon the bear, so that it would be something that she had handled, and it could be placed with [Baby A] if she wished.”

Ms D states that, in hindsight, it may have been best if she had not undertaken the support role as the hospital staff are “sometimes better able” to distance themselves from the emotions of the family. She stated:

“Regarding my show of tears at the final delivery of [Baby A], this was the only time I joined the family in their grief. I was not emotional at any other point in time. I still continued to attend to [Mrs A’s] comfort and it did not affect my performance.

...

While I may have also shared their sadness and cried with them all, I do not consider this to be unprofessional, but caring and human. I was not overcome with emotion and I was able to continue to assist by writing the notes, weighing [Baby A], and other cares.”

Nonetheless, Ms D accepts that she was not effective in her communications with Mrs A and her family.

Comment from Ms E

Ms E accepts responsibility for failing to undertake a full assessment of Mrs A. She states:

“Once again I would like to add that we have all been extremely saddened for [Mr and Mrs A], for the loss of their stillborn daughter [Baby A]. I accept that my role in not completing the full assessment leaves many questions unanswered regarding [Baby A’s] state of wellbeing that evening, and whether or not this loss could have been prevented.”

Ms E added:

“I have worked alongside [Ms D] at many births, and I have never seen her behave in an insensitive manner, or make insensitive comments. I have always trusted her completely with caring for my clients.”

Comment from the DHB

The DHB held informal meetings with Ms D and Ms E in August 2007 to consider whether there were any deficiencies in the primary/secondary interface and whether the midwives' access agreements with the DHB should be reviewed (no records were kept of these meetings). As a result of these meetings, the DHB were satisfied that both midwives had carefully reviewed their practice. It was therefore considered unnecessary to give consideration to suspension of their access agreements. The DHB also advised Mr and Mrs A that consideration would be given to reviewing the induction policy to make it "absolutely obvious" that CTG monitoring should be performed if a baby is being assessed for induction.

Independent advice to Commissioner

Expert advice was obtained from midwife Nimisha Waller, who was asked to comment on the standard of care provided to Mrs A by Ms E and Ms D. See Appendix 1 and Appendix 2 for Ms Waller's reports.

Responses to provisional opinion

I received responses to my provisional opinion from Ms E, Ms D and Ms H. The midwives were particularly concerned about the issue of handover of care, and submitted that Mrs A's care had been taken over by hospital staff before Ms D arrived (when Ms H was present). The family was also provided with the opportunity to comment on the information gathered. The responses from the midwives and the family have been incorporated into the body of this report.

Factual findings and expert advice

The death of Baby A was a tragic event that was profoundly traumatic for Mr and Mrs A, and for those involved with her care. The cause of Baby A's death appears to have been compression of the umbilical cord — an event that is not predictable. It remains unknown whether Ms E would have detected any signs of fetal distress had she completed her assessment on Saturday evening. This report does not determine the cause of Baby A's death (an issue that is not for the Commissioner to determine), but whether the care provided was of an appropriate standard.

Clinical care during antenatal period

The antenatal care provided to Mrs A by Ms D was not specifically under investigation. My expert midwifery advisor, Ms Nimisha Waller, considers that the birth-plan and antenatal care provided by Ms D were reasonable. The scan on Thursday showed that while the baby was in the upper half of the normal range for size, the size was not a particular risk factor and there was no specific requirement to consult with secondary services.

Mr and Mrs A have expressed concern that Ms D was not present at key moments, such as the assessment on Saturday and the induction the following day. Ms Waller commented:

“[Ms D] did ensure that she as LMC or another midwife from her group was available to provide phone advice and assessments for [Mrs A]. Therefore she did co-ordinate [Mrs A’s] care from [Thursday] to the morning of the [Sunday]. To maintain safety of the woman and her family, and to prevent burnout, the LMC on her own is unable to provide care for 24 hours a day, 7 days a week. The midwives often work in groups so they are able to provide cover for each other. The women should be informed by the LMC about how she and her group practise. It appears that this was the case in this instance. [Mrs A] was apparently verbally informed of how the group practised at the first introductory visit and the information was also reiterated in the group’s brochure. This is reasonable/appropriate care.”

Assessment by Midwife Ms E on Saturday

Ms E has acknowledged that she did not complete her assessment of Mrs A on Saturday but became distracted after discussion with obstetric registrar Dr F. She was also under time pressure due to managing another woman in active labour in the delivery suite, and believed the couple wanted to leave. Ms E stated:

“I will always regret that I did not disregard those pressures, and have learned that regardless of the circumstances a full assessment must be prioritised in order to confirm the wellbeing of the baby. I acknowledge that the full assessment was my responsibility.”

Mrs A did not mention any decline in fetal movement to Ms E, and Ms E did not ask. Ms E said that her usual practice is to ask about fetal movements when she is checking fetal heart rate, which in this case she failed to do. Mrs A recalled that the baby was moving shortly before attending the hospital and during the assessment. However, it does seem that there may have been some reduction in fetal movement around this time, as noted by Ms H the following morning.

Ms Waller considers that there would be “divided opinion” about undertaking a CTG recording, given the lack of concern and recent CTG on Thursday. However, Ms Waller acknowledged that Ms E did not complete her assessment by not checking the fetal heartbeat or fetal movement. Ms Waller noted that the New Zealand College of

Midwives' "Second decision point in labour" states that the baby's well-being should be assessed, including the heartbeat. Ms Waller stated:

"It is not possible to say with certainty that asking about fetal movements or auscultating the fetal heart rate would have prevented the loss [Mr and Mrs A] have suffered. However, it would have helped to reassure them that the practitioners had not been complacent."

Responsibility for care during delivery

There is a conflict of opinion on whether Ms D remained clinically responsible for Mrs A's maternity care on Sunday. This is relevant to the issue of whether Ms D met the professional standards expected of a midwife in this situation.

Ms D, Ms H and Ms E informed me that Mrs A's care was transferred to the DHB staff before Ms D arrived, and that Ms K had stated that "[Mrs A's] induction was now under Hospital care". Ms H heard Ms D attempting to discuss options with Mrs A, but Mr A said that they had already had their options explained by Ms K. Because Ms D understood that care had been transferred before she arrived, and this had been explained to Mrs A, she did not document the transfer of care. Ms D understood that she was present in a support capacity only, and clinical decisions were deferred to the registrar, Dr J. Ms D maintains that she carried out clinical duties only because the delivery unit was shortstaffed.

In contrast, the DHB advised me that Ms D maintained clinical responsibility for the delivery with the support of midwifery and medical staff. This occurred in accordance with the DHB policy to ensure continuity of care. Ms K recalls offering to take over, and Ms D refused, saying she wanted to continue caring for Mrs A. Ms D then proceeded to carry out clinical assessments, and there is no record of care being handed over.

Mrs A's recollection was that Ms D asked her whether she wanted another midwife, and she said no. It appeared to Mr and Mrs A that Ms D was acting in a clinical role, rather than a support role, during Mrs A's labour until they requested that the DHB staff take over for the actual delivery.

There are certain events that may occur during an episode of maternity care where it is appropriate to consider referring the woman (or the parents in the case of a baby) to a specialist. Intrauterine death is one of those events. As a result, the Ministry of Health has developed Guidelines for Consultation with Obstetric and Related Specialist Medical Services (the Referral Guidelines).¹⁴

The Referral Guidelines classify intrauterine death (Code 4010) as a level 3 referral,¹⁵ which means that the LMC must recommend to the woman that the responsibility for

¹⁴ Issued under the Section 88 Primary Maternity Services Notice 2007.

¹⁵ The Level 3 guidelines for consultation with obstetric and related specialist medical services, state:

her care be transferred to a specialist given that her labour and birth may be affected by the outcome. Ms Waller noted:

“The decision regarding ongoing clinical roles/responsibilities must involve a three way discussion between the specialist, the LMC and the woman concerned. In most circumstances the specialist will assume ongoing responsibility and the role of the primary practitioner (LMC) will be agreed between those involved. This should include discussion about timing of transfer back to the LMC.”

The DHB has noted that, at its delivery unit, it is common practice for the LMC midwife to maintain clinical responsibility for the labour and delivery when intrauterine death has occurred. However, hospital staff may also provide assistance.

Although the Section 88 Primary Maternity Services Notice 2007 states that the LMC must recommend referral to a specialist when an intrauterine death occurs, this does not automatically mean that handover will occur. I accept that there may be a variety of acceptable practices where the LMC and hospital staff “share care” in certain scenarios. However, at the very minimum, there must be a three-way discussion between the LMC, the specialist, and the woman as to how the situation is going to be managed, and who is responsible for which aspects of the woman’s care. This discussion and the outcome should then be documented. The Referral Guidelines make it clear that it is the LMC who leads this process by recommending the initial referral.

There is no documentation in the medical records indicating formal transfer of care before or after Ms D’s arrival at the hospital, *or* after the family requested that the DHB staff take over the care. Ms Waller considered that the clinical record showed “confusion” around the role Ms D undertook. Ms Waller noted that Standard 7 of the New Zealand College of Midwives’ *Midwives Handbook for Practice*¹⁶ requires the midwife to clarify any issues of responsibility. Ms Waller commented:

“The clarity of the roles and responsibilities were not addressed subsequently when [Ms K took] over the birth of [Baby A]. It appears that at this time the relationship between [Ms D] and [Mrs A’s] family/friend had deteriorated for them to ask a [DHB] midwife to help birth [Baby A] and [Ms D] was visibly upset. This was the time [Ms D] needed to formally hand over the care to [the

“The Lead Maternity Carer **must recommend** to the woman (or parents in the case of the baby) **that the responsibility for her care be transferred** to a specialist given that her pregnancy, labour, birth or puerperium (or the baby) is or may be affected by the condition. *The decision regarding ongoing clinical roles must involve a three way discussion between the specialist, the Lead Maternity Carer and the woman concerned.* In most circumstances the specialist will assume ongoing responsibility and the role of the primary practitioner will be agreed between those involved. This should include discussion about timing of transfer back to the primary practitioner.”

¹⁶ See Appendix 3.

DHB] staff. She could have then concentrated on her role as a support person. As a support person [Ms D] would not have been responsible for any clinical input or documentation.

...

Lack of clarity can be viewed with moderate disapproval as it impacts on the care of the woman and her family as well as on midwife's contractual agreement with the MOH. It raises issues regarding the midwife's accountability to the woman as well as to the midwifery profession."

Ms Waller's view was that Ms D continued to provide clinical midwifery care to Mrs A, rather than undertaking the role of the support person. She stated:

"I acknowledge that [Ms D] did this with the best intention that is to support her [DHB] colleague, [Ms K], but it resulted in causing ambiguity regarding provision of midwifery care to [Mrs A] and her family."

I am conscious that when Ms D arrived at the delivery unit, she was facing a very difficult situation. While she was concerned for Mrs A's welfare, she was also dealing with her own shock as this was the first intrauterine death she had managed as LMC. It is therefore not surprising that she was very distressed. However, the focus in such situations must be on the mother, and ensuring that everyone involved is clear about their roles.

The key message here is that, when an unexpected event occurs, it is important for the woman to have a clear idea about her options for delivering her baby, and who will be looking after her during this time. The three-way discussion should involve the specialist, the LMC, and the woman and a plan developed. If the care remains with the midwife, it should be documented that referral has been considered, and there should be clarity around the support role of the hospital staff. If the care is transferred, there should be a discussion with the woman about whether she wants the midwife to remain in a support role. This is an intensely personal time for a woman as she deals with the shock and grief of losing her baby and, in some cases, she may not want her LMC to remain as support. The LMC must therefore be sensitive to any cues that her presence would not be beneficial, and respect the woman's choices.

On balance, I consider that it was not clear who was taking overall responsibility for Mrs A's care during her labour. As Ms Waller has noted, it was Ms D's role to take leadership on this issue, to clarify and document any issues of responsibility.

Conduct of Ms D during delivery

The family group (including Mrs A's friend, Ms C) felt that Ms D was over-emotional and made numerous inappropriate comments during the labour and delivery. In contrast, Ms D disputes that this occurred.

Ms Waller noted that it is important to ensure that communication with families is appropriate at all times. She stated:

“What may be appropriate for one woman and her family may not be for the other.

...

Practitioners do often show their emotion and the woman and her family often appreciate such empathy. However, emotion should not undermine the professionalism of the practitioner.”

Opinion: Breach — Ms D

1. Overall, I consider that Ms D provided appropriate midwifery care during the antenatal period. In response to my provisional opinion, Mr and Mrs A queried whether Baby A’s size at birth (9.35 lb) was a factor that should have been taken into account in the final days of Mrs A’s pregnancy. However, I note that this was a low-risk pregnancy and Ms D had arranged for a scan a few days before the birth. I do not consider that the size of the baby was a factor that increased the risk.

In response to my provisional opinion, Mr and Mrs A raised concerns about the level of information they received about monitoring fetal movements in the last weeks of pregnancy. It is not disputed that they received a booklet on fetal movements but they believe that the issue should have been given more significance. Clearly it is of concern that Mr and Mrs A were not aware of the significance of fetal movements. However, I am satisfied that Ms D took reasonable steps to provide information to them.

2. It is difficult to pass judgement on the level of professionalism that Ms D demonstrated during the antenatal period. However, it seems clear that the extent that she divulged personal details made Mrs A uncomfortable. I emphasise that the onus was not, as Ms D suggests, on Mrs A to set the boundaries for appropriate communication. However, there is insufficient information to determine that Ms D breached the Code in this regard.
3. Clearly, it is important to maintain good continuity of care. However, a crucial component of the practice of independent midwifery is the use of back-up support when necessary. Ms D was entitled to exercise her judgement that Mrs A needed to rest before the delivery. This decision, and the reasons for it, were appropriately explained to Mrs A. Overall, I consider that Ms D provided appropriate continuity of care during the antenatal period.

4. The ambiguity around whether Ms D remained responsible for the care of Mrs A was not satisfactory. DHB staff certainly had input into Mrs A's care. However, I agree with Ms Waller that Ms D continued to provide clinical midwifery care and there was confusion about who was taking overall responsibility. The *Midwives Handbook for Practice* and the Primary Maternity Services Notice make it clear that the onus for ensuring correct lines of clinical responsibility is on the LMC. These standards were not met. Accordingly, I consider that Ms D breached Right 4(2) of the Code¹⁷ in this regard.
5. I am faced with differing accounts of the interaction between the family group and Ms D on Sunday. However, the information suggests that, on balance, Ms D mishandled her communications with the family on several occasions during the day, to the extent that the family lost confidence in her ability to manage the delivery. Her apparent lack of composure also seems to have contributed to this loss of confidence. While I acknowledge Ms Waller's comment that many midwives will show their emotion, it is important that the midwife's primary focus is on the needs of the mother in this situation. Ms D has acknowledged that she did not communicate effectively with the family on the day of the delivery. In my view, Ms D breached Right 5(2) of the Code by failing to take reasonable steps to provide an environment that enabled effective communication.

Opinion: Breach — Ms E

1. As she has acknowledged, Ms E did not complete her assessment on Saturday. The checking of the fetal heartbeat was an important observation that needed to be done to ensure there were no signs of fetal distress. Another important observation that should have been performed was the check for fetal movement. It is not sufficient to place sole responsibility on the mother to report reduction in fetal movement, particularly given the tendency for reduction in movement as labour develops. It appears that Ms E intended to check the fetal heartbeat but became distracted after her conversation with Dr F. There were several factors causing Ms E to feel pressured for time. However, Ms E was required to undertake a thorough assessment according to the relevant professional standards. Accordingly, I consider that Ms E breached Right 4(2) of the Code.

¹⁷ See Appendix 3 for relevant Code Rights.

Other comment

Dr F

Dr F was a social acquaintance of the family. Dr F was specifically requested by Ms E to provide his view of whether prostins should be administered. Primary responsibility for Mrs A's assessment lay with Ms E. However, Dr F's involvement was more than merely social. He was consulted by Ms E for advice, and noted his advice on the clinical record. It appears that it was only once Dr F realised that he knew Mr and Mrs A that he categorised the interaction as being purely social. Ideally, Dr F would have taken some further steps to ensure that Mrs A was more thoroughly assessed.

Ms H

Mrs B was concerned that when Ms H saw her in the café later on Sunday, she discussed the fact that the cord had been wrapped around the baby's neck in an "upsetting and inappropriate" way. Ms H does not recall any such conversation and did not attend the hospital café that day. However, I note the comments of my expert:

"Such comments, if they were made and were made in inappropriate settings, have the potential to cause further distress and are better left for discussion during follow-up/case reviews."

I also note that, optimally, it would have been helpful if Ms H had documented her discussion with Ms K. This could potentially have assisted in clarifying whether or not a decision had been made to transfer Mrs A's midwifery care.

Availability of the DHB staff

I note Ms E's view that independent midwives will often provide a degree of "shared care" due to the limited availability of hospital staff. I endorse Ms Waller's view that any difficulties around transfer of care should be carefully documented *and* brought to the attention of the DHB.

Actions taken

Ms D

Ms D has reflected on her practice and now ensures that "any care given from my backup is conducted in the manner I would have". She undertook a New Zealand College of Midwives midwifery standards review in December 2007 in relation to this matter. No changes to her practice were recommended following the standards review.

Ms E

Ms E advised me that she no longer provides assessments for other clients in the delivery suite while managing her own patient in active labour. She is now more vigilant in requesting that clients contact her immediately if they become aware of reduced fetal movement.

Recommendations

I recommend that Ms D:

- apologise to Mr and Mrs A for her breaches of the Code. The apology is to be sent to this Office and will be forwarded to Mr and Mrs A;
- ensure that, in future, she appropriately negotiates and documents the transfer of care;
- reflect on how her communication style was perceived.

I recommend that Ms E:

- apologise to Mr and Mrs A for her breach of the Code. The apology is to be sent to this Office and will be forwarded to Mr and Mrs A.

The DHB

- I request that the DHB report on any review of the induction policy.
-

Follow-up actions

- A copy of this report will be sent to the Midwifery Council of New Zealand.
- 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, the Maternity Services Consumer Council, and SANDS New Zealand (Stillbirth and Newborn Death Support).
- A copy of this report, with details identifying the parties removed except the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix 1

Independent advice to Commissioner

The following expert advice was obtained from midwife Nimisha Waller:

“I have been asked to provide an opinion to the Commissioner on case number 07/14036, and that I have read and agree to follow the Commissioner’s guidelines for Independent Advisors.

My qualifications are RN (includes General and Obstetrics), RM, ADM, Dip Ed (UK) and Master in Midwifery (VUW, 2006). I have been a midwife for 24 years, the last 12 years in New Zealand. I have worked in community and hospital tertiary settings as well as in education both here and in the UK. I am currently a Senior Lecturer in Midwifery at Auckland University of Technology, Midwifery Co-ordinator of the NZCOM Auckland Midwifery Resource Centre and take a small caseload of women as a Lead Maternity Carer. My caseload includes women who reside in the City, in semi rural areas and occasionally in rural areas.

...

[Background information has been deleted here for the purpose of brevity.]

My response to the advice required is as follows:

- 1. In my professional opinion, were the services provided by both midwives to [Mrs A] appropriate?***

[Ms D]

[Ms D] provided care to [Mrs A] from [when] [Mrs A] was 6 weeks’ pregnant. In total there are 13 contacts documented on the Antenatal Summary Record and one appointment [that Mrs A] did not attend. Fetal movements were discussed from 25 weeks’ gestation and have been documented with a tick suggesting that these were reasonable. The last documentation on Antenatal Summary Record is at [39+ weeks’ gestation]. The midwifery notes have the documentation of [Mrs A] being seen on the [Thursday] and phone call discussions that occurred on the [Friday and Saturday]. The blood test, the swabs, the urine tests and the scans that were undertaken in this pregnancy are appropriate.

The birth plan formulated by [Ms D] and the antenatal care provided by [Ms D] are reasonable.

On [Thursday] at 1030hrs [Mrs A] was seen for postdates (41 weeks of gestation). [Mrs A] was apparently having 2 contractions in 10 minutes

however these were mild and were not palpable by [Ms D] or felt by [Mrs A]. The fetal heart rate had a baseline of 150bpm with accelerations to 165bpm, variability of 10bpm and there were no decelerations. From the documentation it is not clear whether the interpretation of fetal heart rate was undertaken with a hand held Doppler or as a cardiotocograph trace (CTG). However, in a letter to the Health & Disability Commissioner on 23rd October 2007 [Ms D] states that a CTG was performed at 10.30am. This CTG is enclosed in the file. There is no maternal pulse charted in the clinical records or the CTG. This would not have affected the plan of care that was made but best practice is to take maternal pulse at the commencement of the CTG and record this on the CTG — this helps to provide clarity that the tracing is of the baby's heart rate and not maternal. [Ms D] further states that neither undertaking a CTG nor a scan at 41 weeks' gestation are part of a protocol but her practice is to recommend both and perform another CTG at day 10 overdue (41 weeks and 3 days). The [DHB] protocol/guideline regarding management in prolonged pregnancy is not in the file sent.

Following an abdominal palpation, a vaginal examination found the cervix to be posterior, thick, with internal os closed. The presenting part was cephalic (head) and was 3cm above the ischial spines (-3). The fetal heart rate is documented as 145bpm following a vaginal examination and there was no presence of a 'show'. [Mrs A] had an ultrasound that day that showed a normal liquor volume and the measurements and estimated fetal weight were in the upper half of the normal range for the term infant. When these measurements were plotted on the graphs they lie between 50th and 95th per centiles (page 00107). The conclusion was that there was good growth, normal amount of liquor and Doppler examination showed a normal wave form.

Just over 24 hours later ([Friday]) [Ms D] was paged at 1240hrs by [Mrs A]. The documentation states that the contractions were mild, there were 2 contractions in 10 minutes and the baby was moving. There was no blood loss (show) or evidence of ruptured membranes. A plan was made to call [Mrs A] at 1900hrs if [Ms D] had not heard from her.

At 1900hrs [Ms D] phoned [Mrs A]. The contractions at this stage had stopped. On questioning, [Mrs A] informed [Ms D] that fetal movements were present and there was no mucous blood loss (show) or evidence of ruptured membranes. A plan was made for [Mrs A] to rest before the contractions recommenced.

On [Saturday] (no time is documented) [Ms D] was paged by [Mrs A] as the contractions were stronger. There was no show or evidence of ruptured membranes. The fetal movements were present. [Ms D] contacted [Mrs A] as soon as she had completed a care for a woman in labour as the message said to call when [Ms D] was available and no urgency communicated through the

paging service. A plan was made for [Ms E] to assess [Mrs A] later on delivery suite.

[Ms D] contacted [Ms E] at 1900hrs to check the outcome of her assessment of [Mrs A]. It appears that [Ms D] was informed that all was well with [Mrs A]. [Ms D] did not ask directly whether a CTG had been undertaken when [Ms E] assessed [Mrs A]. [Ms D] could have directly asked the outcome of the CTG particularly if it had been discussed between [Ms E] and herself that CTG was necessary. However, being informed that all was well would have reassured [Ms D] that a CTG had been undertaken.

The issue here is did [Mrs A] receive Continuity of Care from [Ms D] (LMC) from [Thursday to Sunday morning]?

The Primary Maternity Services Notice (MOH, 2002 & 2007) under DA6 General responsibilities of the LMC state ‘The LMC or a backup LMC will be available 24 hours a day, 7 days a week to provide phone advice to the woman and community or hospital based assessment for urgent problems, other than acute emergencies.’ Under DA7 Continuity of care it states ‘From the time of registration of a woman, the LMC is responsible for coordinating for the woman all of the modules of lead maternity care in order to achieve continuity of care.’

[Ms D] did ensure that she as an LMC or another midwife from her group was available to provide phone advice and assessments for [Mrs A]. Therefore she did co-ordinate [Mrs A’s] care from [Thursday] to [Sunday morning]. To maintain safety of the woman and her family and to prevent burnout the LMC on her own is unable to provide care for 24 hours a day, 7 days a week. The midwives often work in groups so they are able to provide cover for each other. The women should be informed by the LMC about how she and her group practise. It appears that this was the case in this instance. [Mrs A] was apparently verbally informed of how the group practised at the first introductory visit and the information was also reiterated in the group’s brochure. This is reasonable/appropriate care.

As the outcome was not what was expected [Mr and Mrs A] are likely to feel that [Ms D] was not there to provide care during crucial moments. In hindsight it is easy to see the crucial moments when the care from an LMC may have been appropriate. However, one cannot say with certainty that the outcome would have been different.

Within the file there is an issue raised by [Mr and Mrs A] that [Ms D] discussed a lot of personal issues at the antenatal visits. The main focus in the antenatal visit is very much on the woman, and her and her baby’s well being. How much of that main focus was not present in [Mrs A’s] antenatal visits is difficult to comment on as such conversations are not documented.

Please see question 7 regarding appropriateness of care relating to the estimated size of the baby and question 8 in relation to care provided by [Ms D] before and during delivery.

[Ms E]

As [Ms D] had been on the birthing suite on [Saturday] for another birth she had asked [Ms E] to see [Mrs A] and assess her for prostins and an overnight stay in hospital later that evening at 6pm. [Ms E] had stated to [Ms D] that prostins would be contraindicated if [Mrs A] was in early labour. [Ms E] was aware that [Ms D] had done postdates CTG and a scan on [Mrs A] and there were no concerns. Prior to leaving the birthing suite [Ms D] had informed [Ms E] that [Mrs A] would now meet her at 5pm.

[Mrs A] and her partner were waiting on [the ward] and did not meet up with [Ms E] till 1820hrs. [Ms E] discussed the frequency of contractions and asked if she could do a vaginal examination to see whether [Mrs A's] cervix was dilating. An abdominal palpation was undertaken to determine the baby's position prior to a vaginal examination. A vaginal examination was then performed but [Ms E] was unable to reach the cervix. [Ms E] was aware that she needed to auscultate [listen to] the baby's heart rate and went to get the hospital sonicaid. However, at the front desk (presumably of the birthing suite/delivery suite) [Ms E] saw the Registrar and decided to take the opportunity to have a consult with him about [Mrs A's] assessment.

[Ms E's] own woman being in active labour, [Mrs A] and her partner wanting to leave as the rugby game was starting shortly and the registrar deciding to meet [Mrs A] and her partner to obtain information prior to giving consent for them to leave distracted [Ms E] from completing her full assessment. [Ms E] has stated that she did not ask about fetal movements or auscultate the fetal heart rate at this assessment. As [Ms E] has stated not completing the full assessment leaves many questions unanswered in relation to [Baby A's] well-being at that time.

Not completing the full assessment would be viewed with mild to moderate disapproval by [Ms E's] peers. Generally it would be viewed with moderate disapproval. As [Ms E] herself has stated she needed to slow the proceedings down as she was responsible for conducting a full assessment at that time. My reason for stating mild disapproval is that there was pressure on [Ms E] to assess [Mrs A] quickly, sonicaid was not in the room and she had a woman in established labour. In such circumstances it is understandable to get distracted. It is true that [Mrs A] did have a responsibility to alert the midwives of the change or absence of baby's movements however, it is my understanding that most women do not provide this information unless they are directly asked the question. [Mrs A] has also stated that she had heard from her friends and family that the baby's movements tend to slow down as the date of birth approaches. This would have reassured her that the baby's movements were

satisfactory and would not have volunteered the information unless directly asked by [Ms E].

[Mrs A] has informed that apparently [Ms E] did feel [the] baby move during the abdominal palpation. Presence of fetal movements has not been documented in the clinical records by [Ms E]. Asking about fetal movements would have been reasonable as it would have provided a bit more information about baby's well being even if the fetal heart rate had not been auscultated. However, to get a complete picture about fetal well-being both assessments (asking about fetal movements and heart rate auscultation) needed to be undertaken. Asking about fetal movements may have alerted [Ms E] to auscultate the fetal heart rate or even undertake a CTG if there had been a mention of the fetal movements being less than normal.

It is not possible to say with certainty that asking about fetal movements or auscultating the fetal heart rate would have prevented the loss [Mr and Mrs A] have suffered. However, it would have helped to reassure them that the practitioners had not been complacent.

The NZCOM (2005) standard of practice of relevance is:

1. Standard Five, criteria 8 'considers the safety of the woman and baby in planning and prescribing of care' — the incompleteness of full assessment leaves many questions unanswered in relation to [Baby A's] well being.

The NZCOM (2005) decision points identify those times when there ought to be an assessment during pregnancy and childbirth. The decision point of relevance for midwifery care in labour is:

2. The second decision point in labour — when the woman wants intermittent support from midwife — under 'from examination' assess baby's well-being, including heart rate.

The NZCOM (2005) Code of Ethics under Responsibilities to the Woman state 'Midwives have the responsibility to ensure that no action or omission on their part places the woman at risk.'

1. What standards apply in this case?

See response in Question 1.

2. Were the standards compiled with?

See response in Question 1.

In relation to [Ms E]

- 2. Please comment on the adequacy of [Ms E's] assessment of [Mrs A] on [Thursday], including whether she should have checked the fetal heart rate.*

See response in Question 1 under [Ms E].

- 3. Should [Ms E] have taken any other steps to ensure the health of the baby?*

[Ms E] could have undertaken a CTG however, she had been informed that afternoon by [Ms D] that the postdates CTG and scan had been done and there were no concerns. This CTG was done two days prior to [Ms E] seeing [Mrs A] (on [Thursday]) so undertaking another CTG as [Mrs A] had continued to be in latent phase of labour could have been considered. [Mrs A] was 41+2 weeks pregnant and her pregnancy had been normal. There is no protocol/guideline from [the] DHB in the file sent of the monitoring that should occur when the pregnancy is prolonged (postdates). There would be divided opinion regarding undertaking another CTG. Some practitioners would feel that a CTG should have been undertaken by [Ms E] as [Mrs A] was greater than 41 weeks pregnant and being induced the next day (so can be considered to be high risk). Other practitioners would consider that this was still a normal pregnancy and a normal latent phase of labour and not undertaking another CTG would be reasonable.

The registrar who saw [Mrs A] and her partner to get information prior to allowing them to leave also did not inquire whether a CTG had been undertaken or request a CTG.

Practitioners who would consider that a CTG should have been undertaken would view this departure with moderate disapproval.

The NZCOM (2005) standard of practice of relevance is:

- Standard Five, criteria 8 ‘considers the safety of the woman and baby in planning and prescribing of care’ — not undertaking a CTG can be seen as not considering the safety of the baby when planning care.

In relation to [Ms D]

- 1. Please comment generally on the adequacy on the antenatal care provided, including whether [Ms D] formulated an appropriate delivery plan*

See response in Question 1.

2. Please comment on whether the estimated size of the baby created any particular risks.

The definition that is used for a baby that is large for gestational age is when the measurements taken by ultrasound are greater than 95th per centile by customised centile charts, or baby's weight at birth being greater than 4.5kg if customised centiles are not available.

The baby's weight was 4180gms and in the pregnancy and delivery record of [the DHB] the baby has been classed as Large for Dates (LFD). The MOH (2007) referral guidelines state large for dates to be when the uterine size is greater than 4 weeks of expected gestation or abdominal circumference or estimated fetal weight being greater than 90th percentile (Code 4013).

[Mrs A's] polycose result was 5.7mmol/l [in] April 2007 and as this is classed as a normal result her baby was not large due to diabetes in pregnancy. The scan on [Thursday] shows the baby to be well grown with cephalic presentation (head presenting) and normal liquor. The measurements from the scan and estimated fetal weight charted on graphs are between 50th and 95th percentiles. Estimated fetal weights are not always accurate and the plan usually is to await established labour and see how labour progresses unless the baby is considered to be greater than 95 percentiles by customised centile charts or large due to diabetes in pregnancy. Caesarean section is usually considered if there is a presence of fetal distress or failure to progress in first or second stage of labour. [Mrs A's] height in the clinical records is charted as 176cm and weight at booking was 70kg which indicate that she would have baby of reasonable size. It is reasonable for [Ms D] not to have consulted with the secondary services regarding the estimated fetal weight in this instance. As the scan was done at 41 weeks for prolonged pregnancy the plan would have been to await established labour or have induction of labour at 41 weeks and 3 days (3 days later) as planned.

3. Did [Ms D] provide [Mrs A] with an appropriate level of support before and during delivery? (Please also outline what is expected of a midwife in these situations in terms of care and support.)

The MOH (2007) Referral guidelines state Intrauterine death (Code 4010) as a Level 3 referral. This means that the LMC must recommend to the woman that the responsibility for her care be transferred to a specialist given that her labour and birth may be affected by the outcome. The decision regarding ongoing clinical roles/responsibilities must involve a three way discussion between the specialist, the LMC and the woman concerned. In most circumstances the specialist will assume ongoing responsibility and the role of the primary practitioner (LMC) will be agreed between those involved. This should include discussion about timing of transfer back to the LMC.

Within the clinical records there is no documentation of a formal handover by [Ms D] to [the DHB] staff. [The] Midwife Leader at [the] DHB also states that there was no documentation of formal transfer of care to hospital team at any stage throughout the labour. From the records it appears that there is confusion regarding the role [Ms D] took on arrival to the delivery suite.

From [Ms D's] response to the Commissioner it appears that [Ms D] provided support for [Mrs A] during delivery. [Ms D] informs that she was told on her arrival to the delivery suite on [Sunday] that care had been taken over and that [Mr and Mrs A] had been seen by the Registrar and Delivery Unit Co-ordinator. On entering the room [Ms D] asked [Mrs A] if she wanted her to stay with her during the day. [Mrs A] agreed for [Ms D] to stay. At this point [Ms D] needed to discuss with [Mrs A] her role in her care. [Ms D] also needed to discuss with [the DHB] staff her role in [Mrs A's] labour care. From [Ms K's] response to the Commissioner it appears that [Ms K] asked if [Ms D] was okay and whether she wanted to continue with her care for [Mrs A]. [Ms D] said she wanted to and needed to care for [Mrs A]. [Dr J's] response to the Commissioner also mentions that [Ms D] was called once the scan confirmed that there was no heartbeat and [Mrs A] and her family were happy for [Ms D] to be involved in the care and labour. Though [Ms D] may have felt that care was taken over, this was not what [the DHB] staff felt had occurred and [Ms D] continued to assist with clinical care/input as delivery suite was very busy and wished to support the family.

The clarity of the roles and responsibilities were not addressed subsequently when [Ms K] took over the birth of [Baby A]. It appears that at this time the relationship between [Ms D] and [Mrs A's] family/friend had deteriorated for them to ask a [DHB] midwife to help birth [Baby A] and [Ms D] was visibly upset. This was the time [Ms D] needed to formally hand over the care to [the DHB] staff. She could have then concentrated on her role as a support person. As a support person [Ms D] would not have been responsible for any clinical input or documentation.

When [Ms D] was continuing to provide midwifery care she was expected as a midwife in this situation in terms of care and support to do the following:

- Clearly document in the clinical records her decision to continue to provide midwifery care following the discussion with [Mrs A] and her family and [the DHB] staff but the clinical responsibility of care would be transferred to the DHB obstetric specialist
- Continue regular assessment on [Mrs A] such as general state and how she is coping, vital signs
- Discussion on vaginal examinations and who would be undertaking these
- Continue to support pain relief choices/ manage epidural anaesthesia

- Assessing contractions and managing Syntocinon infusion/Intravenous infusions
- Encourage [Mrs A] to drink and remain hydrated
- Continue to support [Mrs A] and her family, provide information regarding ongoing care in first, second and third stage of labour
- Providing information regarding birth of [Baby A] and aspects of birth plan that can still remain in place as discussed during the antenatal period
- Explaining what the baby may look like at birth
- Support services including providing [Mrs A] with information from SANDS
- Procedures that may occur following the birth of the baby to [Mrs A], to the baby and the placenta
- Discussion of ongoing support in the first 24 hours following birth of the baby and subsequent care
- Documentation.

[Ms D] says that she provided support as epidural anaesthesia was being organised, sited and when it required further management during the course of [Mrs A's] labour. [Ms D] did a vaginal examination following consent when [Mrs A] felt bowel pressure to check if she was ready to have her baby. Following the examination the plan in discussion with [Dr J] was to allow the baby's head to descend for pushing and the sensation to push was strong. [Ms D] states that as the Delivery Suite Co-ordinator was there to deliver [Baby A] she quietly encouraged and comforted [Mrs A] and held her hand. Following the birth of [Baby A] [Ms D] appeared to support [Mrs A] and left later to give them some private grieving time.

[Ms D] returned when [Baby A] was being bathed to remove the epidural catheter, discuss the medication for milk suppression as well as check [Mrs A] to ensure her uterus was well contracted and her bleeding per vagina normal. [Ms D] left the remainder of the care for the Delivery Suite Co-ordinator at 2230hrs so she could complete the paperwork. [Ms D] and [Ms H] left at 2330hrs after saying goodbye to [Mr A].

[Ms D] apparently initiated the request that [Mr and Mrs A] and family stay in delivery suite overnight with [Baby A], rather than being separated if [Mrs A] was upstairs on the ward.

The [clinical record] reflects the care provided by [Ms D]. From the documentation it appears that [Ms D] was providing midwifery care and was not solely there as a support person. The documentation does not reflect the

full discussion regarding milk suppression medication — often practitioners don't tend to document such discussion in full when they need to. [Ms D] was also documenting labour care on the partogram. The intrauterine death/stillbirth checklist shows the information that [Ms D] provided to [Mrs A] and her family. There is no documentation of the time when [Ms D] handed over the care to [the DHB] staff following the birth of [Baby A].

[Ms D] contacted [Mr and Mrs A] the following day once they had returned home. As [Mr and Mrs A] wanted some time with [Baby A], a plan was made to contact them for a postnatal visit [the next day]. A suggestion was also made to [Mrs A] that a new postnatal midwife could be arranged if she so wished. At the time [Mrs A] did not feel this was necessary. The following morning [Ms D] was paged by [Mrs A] to inform her that she would prefer a fresh start to the postnatal period. Another midwife from another group was arranged by [Ms D] to provide postnatal care for [Mrs A]. This is reasonable.

The NZCOM (2005) standard of practice of relevance is:

- Standard Seven, criteria 7 'In situations where another dimension of care is needed, ensures negotiation take place with other care providers to clarify who has the responsibility for the care' — responses given are conflicting and not clear whether [Ms D] was providing midwifery care or was there as a support.

Lack of clarity can be viewed with moderate disapproval as it impacts on the care of the woman and her family as well as on midwife's contractual agreement with the MOH. It raises issues regarding the midwife's accountability to the woman as well as to the midwifery profession.

4. Please comment on the decision to induce, and whether the proposed induction was appropriately scheduled.

In the file sent there is no protocol or guideline from [the DHB] regarding induction of labour. The decision to induce is not within the midwifery scope of practice. However, some protocols/guidelines do allow the midwives to make a decision regarding induction of labour from 41 weeks and 3 days' gestation if the induction is just for prolonged pregnancy without any other risk factors. If this is the case in [the] (DHB) protocol then it was reasonable for [Ms D] to have booked induction of labour for [Mrs A] when she was 41 weeks and 3 days. [Ms D] reports that [Mr and Mrs A] were offered the option of either having the induction of labour at 41 weeks and 3 days or at 42 weeks. They decided to have the labour induced at 41 weeks and 3 days, the earliest that could be booked at the DHB when the reason is prolonged pregnancy.

In other DHBs a formal referral/consult occurs with the secondary services at 41 weeks and 3 days and induction of labour is usually planned at 42 weeks if there are no other risk factors present in the pregnancy.

5. Did [Ms D] provide [Mrs A] with adequate information?

From [Ms D's] letter to the Commissioner on 23rd October 2007 it appears that the Brochure about their practice is given to all women who book under their care. Their brochure and paging service request that the woman when contacting the midwife gives a reason for the call is provided to all women under their care.

[Ms D] states that on [Thursday] following a CTG and a vaginal examination she discussed the procedure for induction and [Mr and Mrs A's] wishes regarding this. It appears that [Mr and Mrs A] decided to have labour induced on day 10 rather than later. A plan to meet on [the ward] for prostin assessment at 6pm on [Saturday] was also made at this stage.

It appears that [Ms D] had also given a labour handout to [Mrs A] and this was referred to when [Mrs A] rang [Ms D] on [Friday] regarding onset of contractions. Information was also shared about comfort measures that may help [Mrs A] at this stage.

On [Saturday] [Mrs A] contacted [Ms D] at midday. [Ms D] contacted [Mrs A] following the birth of the baby she was attending to. During this discussion it appears that [Mrs A] was happy to continue with the plan that had been made about being assessed in [hospital] and that [Ms E] would assess her on the delivery suite as [Ms D] had been at the birth all day. [Mrs A] requested an earlier assessment at 5pm which [Ms E] was aware of. The original plan had also been of an assessment on [the ward] and hence [Mr and Mrs A] waiting there for [Ms E] who located them at 1840hrs and redirected them to the delivery suite. [Ms D] states that [Mrs A] was informed that [Ms E] would be on the delivery suite.

[Ms D] states in her letter to the Commissioner on 23rd October 2007 that when [Mr and Mrs A] arrived at [the] hospital on [Sunday] at 0825hrs they expressed surprise that [Ms D] was not there. This may be because on the phone conversation on the [Saturday] [Ms D] had explained to them that she would return if [Ms E's] assessment showed [Mrs A] was in labour or take an opportunity to get an early night in case she was needed later. However, she also apparently stated that it may not be her who started the induction of labour the next day.

It appears that [Mrs A] was also informed that [Ms D's] practice worked as a team and was agreeable to this as well as the plan that had been made for prolonged pregnancy.

There appears to be reasonable information given to [Mrs A]. However, whenever plans do get changed regarding place or time of contact there is a potential for confusion.

[Mr A], in his letter, has commented that they were not provided with information about the baby's length from the scan on [Thursday]. There is no measurement of the baby's length at this scan. Baby at this stage is often in a flexed position (fetal position) and a head to toe measurement to indicate the length of the baby is not possible on the scan. The scan would not also pick up issues regarding the cord either.

6. *Did [Ms D] provide an appropriate standard of care during the delivery?*

Please see response under question 8.

7. *Please comment on whether you consider the non-clinical aspects of [Ms D's] care were appropriate, with reference to the role of a midwife in general, and when involved with delivery of a stillborn baby.*

[Ms D], in her letter to the Commissioner, states that she did pass the teddy bear from Stillbirth and Newborn Death Support (SANDS) basket to [Mrs A] and mentioned cuddling the bear but it wasn't intended that she should cuddle the bear instead of [Baby A]. She is horrified that [Mr and Mrs A's] friend [Ms C] thought she heard her say 'cuddle this instead'. [Ms D] has apologised in this letter if her comments caused further distress. When the outcome is not what was expected to occur the senses are heightened and the relationship between the LMC, the woman and her family is affected. It is therefore even important to ensure that communication (verbal and non verbal) is appropriate at all times. What may be appropriate for one woman and her family may not be for the other. It appears to me that it would be best practice to show women and their family/friends the packs and the basket provided by SANDS and invite them to look at them closely if they so wished.

It appears that [Ms D] was emotional when [Ms K] was in the room facilitating the birth of [Baby A]. [Ms D] did state that she was also emotional at the time of [Baby A's] birth. Practitioners do often show their emotion and the woman and her family often appreciate such empathy. However, emotion should not undermine the professionalism of the practitioner.

Are there any aspects of the care provided by midwives [D and E] that I consider warrant additional comment?

[Mr and Mrs A] having to repeat information to different practitioners

Though full information may have been provided by [Ms D] to her colleagues they still have the responsibility to get a full history from [Mrs A] to ensure

nothing is missed. This can seem repetitive for the woman and her family and it is important to inform the woman why the history is being revisited with her.

Changes to [Ms E's] practice

It needs to be noted that [Ms E] has made changes to her practice following the outcome of [Baby A]. [Ms E] no longer offers to provide assessments to women booked with other midwives in her group if she is caring for a woman in labour. The group that [Ms E] works with have also become more vigilant in documenting their request from women of reporting reduced fetal movements and that they will contact the midwives as soon as they become aware of reduced movements. They clearly now state to the women that failure to report reduced movements could compromise the well-being of their baby.

Lack of confidence in [Ms D]

[Mrs A's] friend, [Ms C], did not approach the Registrar on call, [Dr J], till 7pm regarding their lack of confidence in [Ms D]. This was the first time the [DHB] staff were made aware of the family's concern. From the reports from [DHB] staff it appears that [Mr B] did not mention lack of confidence in [Ms D]. He apparently asked for information regarding ongoing care and best way to support [Mrs A] following birth of [Baby A].

Documentation

[The midwifery notes from Thursday to Saturday] require [Ms D's] signature.

Midwifery Standards Review and Special Review

[Ms D] has completed her second annual Midwifery Standards Review by the NZCOM and has requested a special review of this case which was scheduled for 7th December 2007.

Communication

[Mrs B's] comments in the phone conversation to the Health and Disability Commissioner's Office that Ms H saw them in the café and mentioned that the cord had been around the baby's neck. Such comments, if they were made and were made in inappropriate settings, have the potential to cause further distress and are better left for discussion during follow-up/case reviews.

Autopsy report

The compression of the cord by the baby's head is not predictable. This may occasionally become evident in labour by fetal heart rate irregularities (CTG not being reassuring). Hence not undertaking fetal well being assessment on the evening of [Saturday] leaves many questions unanswered.

Further comments

[Dr F] states in his response to the Commissioner on 24th January 2007 that he was contacted on the delivery suite regarding whether or not [Mrs A] should have vaginal prostins. [Dr F] does not feel he was formally consulted about [Mrs A] though he did meet them. He feels that his meeting was purely for social reasons as he [knows Mr A]. However, his initial documentation in the clinical records states that [Mrs A] is not for prostaglandins and that she could birth at [the birthing centre] if labour establishes overnight or return to [the] Hospital in the morning for re-examination and induction of labour. The initial documentation does not reflect that it was a social meeting. From the midwives' documentation in the file it appears that he decided to meet [Mr and Mrs A] to get information so that he could give consent for them to leave. He therefore also had a responsibility to obtain information about fetal well-being from [Mrs A] or from [Ms E].

Summary

The incompleteness of the assessment by [Ms E] on the evening of the [Saturday] leaves many questions unanswered regarding [Baby A's] well-being at that stage. [Ms D] needed to ensure that there was negotiation with [the] DHB staff to clarify who was responsible for [Mrs A's] labour and birth care on [Sunday].

References:

MOH (2007) *Guidelines for consultation with Obstetric and related specialist medical services (referral guidelines)*. Ministry of Health. July.

New Zealand College of Midwives (2005) *Handbook for Practice*. NZCOM. Christchurch.”

Appendix 2

Further expert advice from Ms Waller

Ms Waller was provided with the midwives' responses and provided the following additional expert advice:

“As mentioned in my earlier report there is ambiguity relating to who was taking clinical responsibility of midwifery care for [Mrs A's] labour. [Ms D] acknowledges this in her response ...¹⁸ I acknowledge that the issue about hand over of care was discussed before [Ms D] arrived as has been stated by [Ms D] previously and again in her response to the Commissioner. It was apparently discussed when [Ms H] was providing care on the morning of the [Sunday]. Ideally this discussion of handover should have been documented by [Ms H] as she was involved in this three way discussion. [Ms H] in [her] letter to the Commissioner ... says that she informed [Ms D] that [Ms K] had told [Mr and Mrs A] their options and that she had said that their induction was now under hospital care (secondary care). This would be true as per MOH Section 88 referral guidelines (2007). However, who was responsible for midwifery care during this induction of labour was not clarified. The assumption was made that the whole care has been taken over by [the DHB]. [Ms D] as an LMC taking over the care from her colleague [Ms H] needed to ensure that there was documentation regarding who was going to provide ongoing midwifery care. This could have been her as an LMC or [Ms K] or another midwife from [the] DHB. [Dr J] as part of secondary care responsibility commenced induction of labour, did regular assessments, checked on progress of labour and was present at birth of [Baby A]. [Ms D] states in her response that the registrar was always called when a decision or a procedure needed to be made. This is correct as the clinical responsibility of induction of labour was with the secondary services.

[Ms D] states in her response that she assisted hospital staff by caring for [Mrs A's] comfort measures. The documentation in clinical records reflects more than provision of comfort measures. The documentation includes the following:

- provision of information about postmortem,
- assisting during epidural insertion,
- managing syntocinon infusion,
- observations of maternal and baby wellbeing
- undertaking vaginal examination with consent etc

¹⁸ See pages 8 and 9.

These are not the roles of a support person but that of a midwife providing clinical care.

I acknowledge that [Ms D] did this with the best intention that is to support her [DHB] colleague, [Ms K], but it resulted in causing ambiguity regarding provision of midwifery care to [Mrs A] and her family.

[Ms D] had two opportunities where she should have discussed and clarified her role as a midwife when caring for [Mrs A]. One was at the time when [Ms H] states [Mr A] informed [Ms D] that “everything had been explained by [Ms K]” and the second was when [Ms K] came in to help birth [Baby A] as family had lost confidence in [Ms D]. As a support person [Ms D] would not have had to undertake any clinical care nor document in clinical records.

[The DHB] advised that there was no formal transfer of care to the hospital team at any stage of the labour. My understanding from reading all the documentation and responses is that there was never an explicit conversation between the LMC and secondary care team regarding who was taking responsibility for [Mrs A’s] labour and birth. The LMC as a co-ordinator of care or her back up midwife has the obligation to do this. The Section 88 Primary Maternity Notice (2007, Part C, DA8, point 2) state “every transfer of care must be documented in clinical notes, including the date and time of transfer”.

The standard 7 of the NZCOM *Midwives Handbook for Practice* (2005) require that the midwife clarifies issues of responsibility. [Ms D] as an LMC needed to ensure this clarity was evident.

Further comments

1) As a practising midwife I acknowledge [Ms E’s] comment that it is extremely difficult to sometimes field off personal enquiries and conversations and keep clinic appointments focusing on the woman and her antenatal care. Within the partnership model of care we have to develop trust between each other so there is some sharing of personal information between the midwife and the woman. This is unique to the midwifery profession in New Zealand and envied by other countries. The challenge within that partnership is how to be a professional “friend” to the women we provide care to. This relationship does come under the spotlight when the outcome is different. As practitioners we are unable to predict when the outcome would be different so it is essential to maintain relationship of a professional “friend” at all times. Dr Sally Pairman’s¹⁹ research provides some useful insights on being a professional “friend”.

¹⁹ See Pairman, S, Pincombe J, Thorogood C, Tracy S, *Midwifery: preparation for practice*, 2006.

- 2) [Ms E] states that the decision to hand over the care is generally made by the obstetrician on call, the registrar or the core midwife shift co-ordinator though the guidelines state that the LMC midwife may still be involved in the decision. She further states that the LMCs are often left providing a mix of ‘shared care’ as there are no staff to hand over to. I am not sure whether [the DHB] have meetings with access holders on regular basis as these issues need to be discussed and addressed at such meetings. Under the guidelines (MOH, 2007) the woman should be part of the discussion regarding ongoing responsibility and care not just the practitioners. If LMCs are left to provide a mix of shared care due to workforce issues then the LMC should document this in clinical records and raise the issues at meetings with the DHB.

- 3) [Ms E] ... states that ‘surely [Ms D’s] written documentation of handover, which would not have been read by [Mr and Mrs A] that day, would have made any difference to their perception of who had undertaken responsibility’. My understanding is that [Mr and Mrs A’s] perception was that [Ms D] was providing midwifery care and therefore was taking the responsibility. Under the Health and Disability Commissioners Code of Rights (1996) the woman has a right (Right 6) to be kept fully informed of her care which includes who is responsible for the care. See further comment “No. 2” regarding involvement of the woman during discussion of ongoing care and responsibility. The MOH Section 88 (2007, Part D, DA19, Point 2 (b) iii) states that if the woman prefers she should be given a copy of her clinical notes at the completion of each module. Therefore even if [Mr and Mrs A] may not have read the documentation on the day they may have read it later and raised the issue of responsibility of care.

References:

Health and Disability Commissioner (1996) *Code of Health and Disability Services Consumers Rights*. HDC, July, Auckland.

MOH (2007) Guidelines for consultation with Obstetric and related specialist medical services (referral guidelines). Ministry of Health. July.

New Zealand College of Midwives (2005) Handbook for Practice. NZCOM. Christchurch.”

Appendix 3

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

RIGHT 4

Right to Services of an Appropriate Standard

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

RIGHT 5

Right to Effective Communication

- (2) *Every consumer has the right to an environment that enables both consumer and provider to communicate openly, honestly, and effectively.*

Other relevant standards

The New Zealand College of Midwives, *Midwives Handbook for Practice* (2005).

Standard 7:

“The midwife is accountable to the woman, to herself, to the midwifery profession and to the wider community for her practice.

Criteria

The midwife:

...

in situations where another dimension of care is needed, ensures negotiation takes place with other care providers to clarify who has responsibility for the care.”

The Primary Maternity Services Notice pursuant to section 88 of the New Zealand Public Health and Disability Act 2000 (effective from 1 July 2007).