Ms C

A Report by the
Health and Disability Commissioner

(Case 01/09138)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Ms A	Consumer/Complainant
Mr B	Complainant/Consumer's husband
Ms C	Midwife/Provider
Dr D	Obstetrician
Dr E	Anaesthetist

Complaint

On 17 August 2001 the Commissioner received a complaint from Ms A and Mr B concerning the midwifery services provided to Ms A by Ms C. The complaint was summarised as follows:

Ms C failed to provide services of an appropriate standard to Ms A on 10 November 1999. In particular:

- *Ms C failed to transfer Ms A in a timely manner for secondary care when there were indicators of non-progression of labour;*
- *Ms C failed to monitor the baby's heart rate appropriately, in particular during the period including the transfer to hospital;*
- *Ms C failed to communicate fully the risks to the baby given that the labour was not progressing normally.*

An investigation was commenced on 28 November 2001.

Information reviewed

- Complaint letter from Ms A and Mr B, dated 16 August 2001
- Further information provided by Ms A and Mr B, dated 19 May 2003
- Response from Ms C, including clinical notes, dated 20 December 2001
- Further response from Ms C, dated 27 May 2003
- Records from the DHB.
- Transcripts of interviews with Ms C and Dr D, recorded on 25 October 2002
- Letter from Dr E, dated 17 April 2002
- Independent expert advice from Ms Chris Stanbridge, midwife.

Information gathered during investigation

Background
Ms C, midwife, was Ms A's lead maternity carer for the birth of her first child. Dr D, obstetrician, was to provide back-up care if required. A home birth was planned. As this was Ms A's first birth and the baby was positioned posterially, Ms C expected the labour to be slow and especially painful.

Ms A went into labour on the morning of 10 November 1999, at her home. Her husband, Mr B, was present. At 8.00am he called Ms C to advise her that Ms A's contractions were about two minutes apart. Ms C attended at 8.50am. After assessing Ms A, Ms C left at 9.30am to make two other visits. She returned at 11.45am.

At around 1.00pm, when the labour had progressed only slowly, if at all, Ms C attempted to rupture Ms A's membranes to hasten the labour. It initially appeared that she had been successful, although subsequent examinations revealed that the membranes had not been ruptured.

Ms C again attempted to rupture the membranes at 5.00pm, this time successfully.

At 6.00pm Ms C recorded that, following a contraction, the baby's heart rate temporarily slowed. She recorded that the foetal heart rate "decelerated" to 80 bpm (beats per minute). Following the next contraction it was 96 and, after the next, 100. Ms C considered that as there was no meconium-stained liquor (a potential sign of foetal distress) and the foetal heart rate returned to normal after each contraction, the decelerations could be a normal variation in the heart rate, due to Ms A entering the second stage of labour. Following the decelerations, Ms C monitored the foetal heart rate carefully.

By 6.10pm the foetal heart rate was 120 and regular. Over the next 35 minutes Ms C recorded the foetal heart rate three times; at 6.15pm it was 140, at 6.30pm 160 and 6.45pm 140.

By 7.00pm the baby's head had not descended. Ms C conducted a vaginal examination and noted that the cervix was only 5cm dilated. As there was still little or no progress Ms C decided to transfer Ms A to a public hospital for augmentation of her labour and pain control. Ms C rang Dr D to advise her of this. During that call she did not mention the earlier decelerations.

At 7.30pm, just prior to transfer, the foetal heart rate was 100. Ms C advised Ms A that if the foetal heart rate stayed like that and her cervix remained at 5cm, she would need a Lower Segment Caesarean Section.

Ms A, Mr B and Ms C arrived at the public hospital at 8.00pm. They were met by one of the unit's core midwives, and Ms C asked her to call the anaesthetist. Ms C advised me that

the maternity unit was very busy and there was no equipment immediately available with which to monitor the foetal heart rate; she had not brought her own sonicaid with her.

The anaesthetist, Dr E, arrived at 8.05pm to insert an epidural to augment labour and to relieve Ms A's pain. Ms C did not tell Dr E about any possible problems with the baby. Ms C then gave some minor assistance to Dr E in preparing Ms A for the epidural. She did not search other areas of the unit for equipment to monitor the foetal heart rate.

In response to my provisional opinion, Ms A and Mr B stated that they understood that the epidural was being inserted in order to commence Syntocinon, to progress the labour, and not for pain relief.

The epidural was completed by 8.20pm. Dr E advised me that Ms A tolerated the epidural well, requiring only a small dose of pethidine for shivering after the baby was delivered. He did not recall anything unusual about Ms A's condition during the epidural procedure and delivery.

After the epidural was completed, and while Dr E was establishing analgesia, Ms C retrieved a cardiotocograph machine (CTG) from another area to monitor the foetal heart rate. The CTG showed a foetal heart rate of 76. Ms C then urgently sought a foetal scalp electrode (FSE) to attach to the baby's head to confirm the low foetal heart rate.

Once the low foetal heart rate was confirmed, Ms C rang Dr D, and Ms A was taken to surgery shortly thereafter.

Ms A's baby was born via Caesarean section at approximately 9.00pm.

Tragically, her baby died eight days later as a result of birth asphyxia.

Independent advice to Commissioner

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

> "I consider [Ms C's] midwifery care was mostly reasonable. This includes:
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> **Assessment and monitoring at home:**
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> [Ms C] had contact by phone and home visited early in [Ms A's] labour. She established the baby's position (very pertinent because the posterior lie sets the framework for the probability of a long, slow, painful labour), the irregularity of fairly frequent contractions, normal recordings (blood pressure, pulse, temperature), [Ms A]

was coping well, and an internal showing early changes in the cervix indicating labour was establishing.

If both midwife and mother were happy it was reasonable for [Ms C] to leave for a short time if she (or her back up) were freely available to [Ms A] should she want her.

From the notes taken at the time, [Ms C] records:
– regular (1/2 hourly or more frequently) baby heart rate recordings;
– regular (1/2 hourly or more frequently) assessment of [Ms A's] progress and how she was coping;
– internal assessments for specific indications (initial assessment, [Ms A] feeling she wasn't 'getting anywhere' and some rectal pressure, no visible progress with pushing, re-assess progress after ARM and previous slow progress).

These would suggest [Ms C] was providing [Ms A] and her baby with a good level of assessment and monitoring.

Indications for rupturing membranes:

There are various theories and practices in rupturing membranes artificially and if and when is an appropriate time to do so.

In the home labour/birth situation it would not be normal practice to do so unless:
– there was a more specific request from the mother and she understood the potential benefits/disadvantages; and/or
– the labour was protracted and there was the potential for the rate of progress to increase with rupturing of the membranes.

It would be necessary for the head to be at station –2 or below (to lessen the chance of the baby's cord slipping past the head), and for labour to be active (i.e. 3cms or more dilated).

[Ms C's] decision to attempt to rupture the forewaters (membranes) at 1300 hours was appropriate.

Baby's heart rate:

[Ms C] used a hand-held sonic-aid to hear the baby's heart rate (interview 25.10.02). This is an appropriate form of monitoring in this situation.

When the heart rate is heard to be lower than normal (i.e. below 110) it is a time to be more vigilant to look for possible signs of foetal distress. She records the rates as being reduced, but does not comment on:

– their rate of recovery which would have been helpful (a heart beat that returns to normal within the contraction, or very rapidly after, is not unusual; one that takes a protracted time to return after the contraction is finished is more sinister);
– whether the contraction had finished completely, or that it was tapering off but [Ms A] could tolerate her touching her abdomen – this would give a greater idea of whether these decelerations were potentially a problem.

It was reasonable to expect [Ms C] to look for other signs of possible foetal distress (meconium stained liquor, bleeding) and to monitor the baby's heart rate more frequently. There were no other signs of potential foetal distress.

It is reasonable to assume these reduced rates were of dubious nature given they were in the normal range at subsequent listening – if there are late declarations (indicating a distressed baby having difficulty coping) they are usually continuous i.e. occur after every contraction. Irregular declarations are not of such immediate concern. However any deceleration merits closer attention and more frequent monitoring.

[Ms C] notes the baby's heart rates of 80, 96, and 100 after contractions from 1800 hours. She records the heart rate four times in the next 35 minutes – these are normal.

Assuming there was a rapid return to normal rate, it was not unreasonable to assume these decelerations were in possible response to pressure on the baby's head with the probable descent given the indications she may be in/nearing second stage (an hour after an ARM and a strong urge to push).

Options of care and information about the progress in labour:

[Ms A] and [Mr B's] letter of 16.8.01 suggests they were aware of options for care during pregnancy (recommendations from the GP and a friend, desiring a homebirth, [Ms A's] occupation, meeting a back up obstetrician).

The antenatal notes record [Ms C's] first visit was to 'discuss options with [Ms A] and [Mr B]. [Ms A] would like a home birth'. It seems probable they would have discussed this option in some depth.

There are various forms of management offered for different issues that arose during pregnancy, and it seems likely this reflects offering different options for care (e.g. bladder infections – assessment [MSU – urine test], basic management [high fluid intake], herbal [cranberry tablets], medical management [antibiotics]).

There are various references to 'we discussed …', 'suggest …', 'we talked about …', 'I left some notes on …', which suggest options being offered.

In labour there is not specific references to options, but it seems reasonable to assume the similar sort of care was continued from the antenatal period, and it seems unlikely [Ms A] and [Mr B] would have been happy with having various assessments (including internals) being done without some feedback on what was found and the implications. In the notes [Ms C] documents 'Due to no progress have advised transfer to hospital for pain relief and syntocinon augmentation' and 'Have advised [Ms A] that if baby's HR (heart rate) remains like that and the Cx (cervix) is still 5 cms she will need a LUCS (Lower Segment Caesarean Section)' which suggests, at that stage at least, she was letting the parents know the implications of her now lack of progress.

Possibly the problem, in retrospect, is that they didn't feel they had been alerted to potential problems – and this is probably because there were not clear indications. There was gradual progress in labour (not unexpected in a posterior, first baby labour) and I assume [Ms C] explained why she was listening to baby's heart rate more frequently around 1800 hours – once again, a reason for more vigilant observation, but not assessed as sufficient to consider transfer or alarm parents. Part of the role of the midwife is to be supportive and encouraging in labour, and if things are moving forward, albeit slowly, it would be reasonable to continue in this manner while still monitoring and assessing.

Contacting [Dr D] and timing of transfer:

[Ms C] could have considered transfer at several times prior to 1900 hours:
- at 1300 hours when there was minimal progress;
- at 1700 hours when there was minimal progress;
- at 1800 hours when several decelerations were noted.

However, it was not unreasonable to continue care at home given:
- the potential for more rapid progress following ARM (artificial rupture of membranes). It was only known at the 1700 hour internal examination that the initial attempt at ARM had been unsuccessful;
- the external signs of probable advancement;
- the return to a regular heart rate without decelerations.

Similarly, there was no indication to contact [Dr D] prior to the decision to transfer.

Transfer:

[Ms C's] care during transfer was reasonable.

It is wise to listen to the baby's heart rate immediately prior to leaving for hospital. Most women in strong labour, and needing transfer, take considerable support and encouragement to move when contractions are all-consuming and breaks, when

movement is possible, brief and uncomfortable. Thus the focus is on achieving the actions that result in the most rapid progress to hospital.

[Ms C] comments in her letter of 20.12.01 that she 'checked the baby before leaving'. She comments the rate dipped to 100 but recovered quickly.

During the actual journey there is little to be gained by putting the woman through more discomfort trying to assess the baby's heart given that any problems would only signal the need to get to hospital and this was already in train.

It is always more important during transfer to drive safely rather than fast whatever the mode of transport.

Transfer by car was reasonable (and generally more comfortable for the labouring woman) on the basis of transfer for epidural and augmentation (encouragement of labour with medication).

At the public hospital:

On admission to hospital, especially after transfer in labour, it would be normal to assess the baby's heart rate as soon as the woman was admitted and settled.

It would certainly be expected that means of assessing the heart rate was readily available. Normally each room used for labouring women would have, at least, a funundoscope (a 'trumpet' for listening to the baby's heart), and commonly a sonic aid (an electronic device that amplifies the heart sounds). Base hospitals generally have a CTG (cardiotocograph – a machine which detects, amplifies the sounds of, and can print out the rate of the baby's heart) available for each or most rooms.

Because of inaccessibility to foetal heart monitoring equipment (in the room or nearby), [Ms C] proceeded with the pressing needs of a strongly labouring woman, and the busy time of preparing for and assisting with drip and epidural insertion. Consequently there was an hour from the previous baby heart assessment until the one at 2030 hours.

[Ms C's] letter of 20.12.01 states 'The Unit was extremely busy' and the lack of available CTGs would support this. The Clinical Practice Group Manager (letter of 21.2.02) tells of the workload, but not the staff numbers, at the time [Ms A] was in the Delivery Unit.

In the circumstances it would have been necessary for [Ms C] to have actively requested a (busy) core midwife to find a CTG machine – which she did do once the need for a FSE (foetal scalp electrode) compatible machine was established, having already had to spend time away from [Ms A] going to the day assessment unit to get a basic CTG machine.

In my opinion it was reasonable to expect [Ms C] to assess the baby's heart rate very soon after admission, and preferably before the epidural insertion commenced.

Once the heart rate of 80 was noted, the rest of [Ms C's] care was appropriate and timely.

It would be wise for core staff at base hospitals to have a CTG machine immediately available for any transfer in – once the need for transfer is established there is a high chance of more intensive monitoring being needed.

It is a very busy time for the midwife around the time of insertion of an epidural in a labouring woman and it would be a good policy for core staff to routinely offer assistance through this time, thus lessening the chance of basic recordings being delayed unacceptably.

General:

[Ms C] appears to have given comprehensive antenatal care to [Ms A]. This seems to have continued with frequent assessments and reasonable management through a typically long, hard, posterior labour until the lapse in foetal heart assessments at what, in retrospect, was a crucial time.

I think she provided insightful postnatal care, and was certainly willing to give time and attention to [Ms A] and [Mr B] and their high level needs through this very difficult time."

Additional advice

In a telephone conversation with the Commissioner's office on 7 April 2003 Ms Stanbridge was asked to clarify the following comments:

> "It was reasonable to expect [Ms C] to assess the baby's heat rate very soon after admission, and preferably before the epidural insertion commenced."
>
> "[Ms C gave] comprehensive antenatal care ... until the lapse in foetal heart assessments at what, in retrospect, was a crucial time."

Ms Stanbridge acknowledged that Ms C was in a very difficult situation, with a distressed mother in need of pain relief and no monitoring equipment immediately available at the hospital. However, Ms Stanbridge stated that, because there had been a delay in monitoring the foetal heart rate while they transferred to hospital, Ms C should definitely have assessed the foetal heart rate before the epidural was inserted, even if that meant delaying the epidural in order to find the necessary equipment.

Ms Stanbridge was also asked to comment on whether Ms C should have reconsidered her conclusion that the dips in the foetal heart rate at 6.00pm were related to Ms A entering the second stage of labour, once it became apparent (at 7.00pm) that Ms A was not in second stage. Ms Stanbridge stated that it was reasonable for Ms C not to reassess the significance of the decelerations at that stage. She had acted appropriately by increasing her monitoring. Further, by 7.00pm, reassessing the significance of the decelerations would not have changed the plan to transfer to hospital.

Code of Health and Disability Services Consumers' Rights

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

RIGHT 4
Right to Services of an Appropriate Standard

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

RIGHT 6
Right to be Fully Informed

1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including –
   a) An explanation of his or her condition; and
   b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option …

Opinion: Breach

Monitoring of the foetal heart rate
My expert advised that Ms C's monitoring of the foetal heart rate was generally of a good level. When, at 6.00pm, she noted three consecutive decelerations in the foetal heart rate, it was reasonable for her to assume that the decelerations were a result of Ms A entering the second stage of labour.

My expert explained that when the foetal heart rate shows a deceleration it is a time to be more vigilant about other signs of foetal distress, and to monitor the foetal heart rate more closely. I note that Ms C did consider the possibility of foetal distress. However, the liquor was clear and, apart from the decelerations, there were no signs of foetal distress. I also note that Ms C recorded the foetal heart rate four times over the next 35 minutes, and it returned to normal.

In response to my provisional opinion, Ms A and Mr B stated that Ms C should have relied on an "objective" vaginal examination to determine whether Ms A had entered the second stage of labour. Ms C's notes record that, at that time, Ms A was 5cm dilated and was having strong urges to push. According to my advisor, these factors, along with the recent rupturing of the membranes (which may progress labour) and the decelerations, led Ms C to form a reasonable opinion that Ms A was nearing the second stage of labour. In those circumstances, I accept that Ms C took adequate steps to monitor the foetal heart rate following the decelerations.

At 7.00pm Ms C did carry out a vaginal examination. This led her to reconsider her view that Ms A was entering the second stage of labour. Ms C considered that Ms A was failing to progress and needed to be transferred to the public hospital for pain control and augmentation of labour. Prior to leaving for the hospital at 7.30pm, Ms C recorded the foetal heart rate as 100, which was slightly low. Although they arrived at the hospital at 8.00pm, Ms C did not record the foetal heart rate again until around 8.30pm.

I accept my expert advice that it was reasonable for Ms C not to monitor the foetal heart rate during the trip to the hospital. To do so would have been difficult, and, in any event, they were already en route to the hospital.

The District Health Board (DHB) advised me that in November 1999 there were four CTG machines, four handheld dopplers and four CTG monitors available in the maternity unit. On the evening of 10 November there were seven women in the unit, including Ms A, who may have required monitoring. The DHB advised that, if a midwife required urgent CTG monitoring, she could alert core staff, who would deliver a monitor to the room. This is a well known procedure in the unit. I note that a core midwife did come to assist Ms C when they arrived at the unit at 8.00pm. However, Ms C considered that monitoring the foetal heart rate was of secondary importance to placing the epidural, and she did not ask a core midwife to obtain a foetal heart rate monitor until after 8.20pm.

I accept my expert advice that, having transferred a woman in labour, it would be normal practice to assess the foetal heart rate as soon as the woman is admitted and settled. In this case, in light of Ms A's failure to progress, the time spent in transferring to hospital, the earlier decelerations and the foetal heart rate of 100 just prior to the transfer, the foetal heart rate should have been checked as soon as possible after arriving at hospital, even if that required a delay in administering the epidural.

I accept that Ms C was presented with a very difficult situation. Ms A was experiencing a very long and painful labour, with the baby in a posterior position. It was difficult for Ms C to examine Ms A and check the foetal heart rate because of the discomfort it caused Ms A and, when they arrived at the hospital, the resources Ms C needed to properly monitor Ms A were not immediately available. Ms C was attempting to strike a balance between monitoring Ms A and her baby, and meeting Ms A's other needs in a difficult labour. However, despite these difficulties, given the history of Ms A's labour, Ms C should have taken further steps to assess the foetal heart rate on arrival at the hospital.

In my opinion, in failing to assess the foetal heart rate as soon as possible after arriving at the hospital, Ms C did not provide midwifery services with reasonable care and skill and breached Right 4(1) of the Code.

Opinion: No breach

Timely transfer
I accept my expert advice that it was reasonable for Ms C not to transfer Ms A to hospital prior to 7.00pm.

Ms C could have considered transferring earlier in the afternoon, when there was only minimal progress, or once the decelerations were noted at 6.00pm. However, I accept that Ms C's decision not to transfer was reasonable, given the external signs of progress in the labour, her apparently successful attempt to rupture the membranes, and the quick recovery of the foetal heart rate following the decelerations. I also accept that it was not until 7.00pm that it became evident that Ms A was not progressing to the second stage of labour and needed to be transferred to the hospital.

I note that during the investigation Dr D stated that Ms C should have contacted her earlier in the labour, or transferred Ms A to hospital earlier. While I acknowledge Dr D's opinion, I am legally required to assess Ms C's conduct by the standard of her peers. My expert midwifery advisor informed me that Ms C's decision to continue the labour at home was reasonable in the circumstances. She advised that there were no indications that should have prompted Ms C to contact Dr D prior to deciding to transfer to hospital at 7.00pm, and clearly identified the factors on which she based her advice.

I accept my expert advice that Ms C's actions were in accordance with reasonable midwifery practice. In my opinion Ms C's decision to transfer at 7.00pm was timely and she did not breach Right 4(1) of the Code.

Opinion: No breach

Communication of risks
At 7.00pm, when it had become clear that labour was not progressing, Ms C promptly arranged for Ms A to be transferred to the hospital. I note that Ms C recorded that she "advised [Ms A of the need to] transfer to hospital for pain relief and syntocinon augmentation", and that she "advised Ms A that if baby's HR remains like that [at 100] and the [cervix] is still 5 cms she will need a LUCS [Caesarean section]."

In my opinion, once it became apparent that labour was not progressing, Ms C provided Ms A with sufficient information about her condition and the options for further treatment, and did not breach Right 6 of the Code.

I note my expert's comments that Ms A may, in retrospect, be concerned that Ms C did not inform her of obvious potential problems earlier in the labour. However, I accept that Ms C was not aware of any likely problems.

Action taken

Ms C has informed me that she has reviewed her practice in light of my report and has provided a written apology for Ms A and Mr B.

Follow-up actions

A copy of this report will be sent to the Nursing Council of New Zealand and the New Zealand College of Midwives.

A copy of this report, with all identifying details removed, will be sent to the New Zealand College of Midwives, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.