Midwife, Ms C

Midwife, Ms D

A Report by the

Health and Disability Commissioner

(Case 10HDC00267)

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Executive summary

Background

1. This report is about the care provided by two midwives to their client, Ms A, aged 32 years.

2. Ms A gave birth to her first child in 2005, and required an episiotomy.[1] Ms A suffered a large tear in her perineum which she was told required 90 stitches to repair.

3. When Ms A became pregnant again in 2009, she was anxious about sustaining another perineal tear, and informed her Lead Maternity Carer (LMC), registered midwife Ms C, about her previous birthing experience and her anxiety about tearing again.

4. Ms C took some steps to ascertain further details about Ms A's first birthing experience, but she did not obtain a copy of Ms A's previous labour and birth notes. Ms C provided Ms A with reassurance and advice on what could be done to reduce the risk of tearing again, but did not consider it was necessary to offer Ms A a referral to an obstetrician.

5. Ms C did not document a care plan for Ms A's labour and birth.

6. When Ms A went into labour, Ms C had a rostered day off, and so her colleague, registered midwife Ms D, attended Ms A's birth. Ms D suffers from sinus tachycardia (SVT), which makes her heart beat rapidly and irregularly and leaves her feeling light headed. It is triggered by new and stressful situations. Ms D did not tell her colleagues or Ms A about her medical condition.

7. Towards the end of Ms A's labour, Ms D noticed that Ms A's perineum was tightly stretched and blanching. She decided an episiotomy was required. Ms D's SVT was triggered and she began to feel light headed, but she made the incision.

8. The incision was not long enough and while Ms D was preparing to extend the incision, Ms A's perineum "button-holed"[2] and the baby was born through her perineum. Ms A suffered an extensive second degree perineal tear[3] that required repair in an operating theatre. She has since been advised that any future births should be by Caesarean section.

9. Immediately after the baby was born, Ms D left the room, leaving Ms A and her baby without any midwifery or medical support until the obstetrician, Dr G, arrived.

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[1] A surgical incision on the perineum and posterior vaginal wall during the second stage of labour to make the baby's birth easier and prevent severe tissue tears that can be difficult to repair. Episiotomies are performed under local anaesthetic and sutured closed after delivery.

[2] This is when the skin of the perineum begins to tear in the muscle and skin between the vagina and the anus giving a "button-hole" effect.

[3] A first degree perineal tear is defined as involving the vaginal mucosa and the skin of the perineum. A second degree tear involves the deeper layers of the perineal muscle. A third degree tear is one in which the anal margin has been involved. A fourth degree tear involves the anal sphincter and mucosa.

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Decision summary

10. Ms C did not obtain a copy of Ms A's previous labour and birth notes, which would have been prudent in light of Ms A's anxiety about sustaining another tear. Ms C's failures to identify the extent of Ms A's previous perineal trauma, document her conversations with Ms A, take an adequate obstetric history and ensure the accuracy of the facts that were documented, amount to a failure to provide services with reasonable care and skill and are a breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[4]

11. Ms A was not provided with adequate information to allow her to make an informed choice whether to have her pregnancy managed as suggested by Ms C. Therefore Ms C breached Right 6(1)(b)[5] of the Code. Ms A was not in a position to make a choice as to how the birth would be managed to minimise the risk of tearing. Accordingly, Ms C also breached Right 7(1) of the Code.[6]

12. Ms C did not document a care plan. By failing to document significant discussions and decisions in relation to Ms A's labour and birth, Ms C breached Right 4(2)[7] of the Code.

13. The care Ms D provided Ms A during her labour was, for the most part appropriate. However, Ms D breached Right 4(1) of the Code by failing to ensure Ms A had midwifery or medical support immediately after the birth, and Right 4(2) of the Code by failing to comply with professional standards.

14. Ms D also failed to inform her colleagues and the DHB about her medical condition, and so there was no opportunity to put in place a plan to ensure continuity and quality of care for Ms A in the event Ms D's SVT prevented her from providing care. Accordingly, Ms D breached Right 4(5)[8] of the Code. She also breached Right 6(1) of the Code by failing to inform Ms A about her medical condition and what Ms A should do if Ms D became incapacitated.

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

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[4] Right 4(1) provides: "Every consumer has the right to have services provided with reasonable care and skill."

[5] Right 6(1) provides: "Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including - …
b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option."

[6] Right 7(1) provides "services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise."

[7] Right 4(2) provides "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

[8] Right 4(5) provides "Every consumer has the right to co-operation among providers to ensure quality and continuity of services."

Complaint and investigation

16. On 5 March 2010, the Commissioner received a complaint from Mrs B about the services provided to her daughter, Ms A, by independent midwives Ms C and Ms D. On 15 March 2010, the Commissioner received a complaint from Ms A's husband, Mr A, which raised similar concerns. The following issues were identified for investigation:

- *The appropriateness of care and adequacy of information provided to Ms A by midwife Ms C from August 2009 to February 2010.*
- *The appropriateness of care and adequacy of information provided to Ms A by midwife Ms D from January 2010 to February 2010.*

17. An investigation was commenced on 25 May 2010.

18. Information was obtained from the following parties:

Ms A	Consumer
Mr A	Complainant/consumer's husband
Mrs B	Complainant/consumer's mother
Ms C	Independent midwife/provider
Ms D	Independent midwife/provider
Ms E	Core midwife[9]/provider
Ms F	Registered nurse/provider
Dr G	Obstetrician/provider
The District Health Board	
Midwifery Council of New Zealand	

19. Independent expert advice was obtained from registered midwife, Deborah Souness (**Appendix A**).

20. This report is the opinion of Anthony Hill, Health and Disability Commissioner.

Information gathered during investigation

Background

Maternity services in New Zealand

21. Pregnant women in New Zealand are entitled to free maternity services from midwives or general practitioners to cover their pregnancy, birth, and postnatal care.

22. To access these services, the woman must choose an LMC who is funded by the Ministry of Health to provide maternity services. LMC responsibilities are set out in the Primary Maternity Services Notice, issued pursuant to Section 88 of the New Zealand Public Health and Disability Act 2000 (Section 88). Section 88 states that the

[9] A midwife who is employed by a hospital or birthing facility.

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LMC is responsible for the care provided to the woman throughout her pregnancy and postpartum period.

Birth history

23. Ms A gave birth to her first child in 2005. Ms A advised HDC that she sustained a significant tear, which she was told required 90 stitches to repair.

24. The clinical records from the public hospital indicate that an episiotomy was required following a "button-hole" of 2cm above the anus. This was repaired in layers and large veins were underpinned and closed. There is no mention of the number of stitches used. It is recorded that the sphincter was intact and, although there is a space on the "Delivery Summary" form to describe the location of any perineal laceration and whether it is a first, second, or third degree tear, this has been left blank. It is recorded that there was minimal loss, and Ms A was discharged home the following day.

Second pregnancy — 2009

Antenatal care

25. In 2009 Ms A became pregnant again and her estimated due date was in February 2010. Ms A chose registered midwife Ms C as her LMC. Ms C practised with three other midwives in the area, in a group. The midwives had an access agreement to use the facilities at the public hospital.[10]

26. Ms C advised HDC that she first met Ms A on 18 August 2010 when Ms A was 15 weeks pregnant. At that consultation, she completed the client profile summary, registration with lead maternity carer, obstetric history summary, and maternal history summary. The obstetric history summary was very brief with no reference to any tear. Ms C recorded that Ms A's previous pregnancy had been a spontaneous labour whereas she had actually been referred for an induction because she was postdates at 41 weeks gestation. She recorded that Ms A breastfed for 4/52 [four weeks] but also "good breastfeeding history but milk supply dried up at approximately 4 months".

27. Ms C said that during the antenatal period she had a discussion with Ms A and her husband, Mr A, about Ms A's tear from her previous birth. Ms A recalls that she told Ms C that she tore "really badly last time" and Ms C responded "Well it's not in your notes". Ms A felt that Ms C was dismissive of her concerns and thought she was "making a big deal of things". She said she told Ms C at least three to four times that she was concerned about tearing again.

28. Ms C advised HDC that she understood from discussions with Ms A and Mr A that Ms A had sustained a "significant tear" during the birth of her first child. However, when she reviewed Ms A's discharge summary (**Appendix B**) it did not indicate or mention that Ms A had had an extensive or complicated tear. The section of the discharge summary relating to "episiotomy", "perineal trauma" and "sutures" have not been completed.

[10] The access agreement is a contract between a birthing unit and a practitioner (LMC) who wishes to use the birthing unit's facilities. The agreement, which sets out the various obligations of each party, can be found in Schedule 3 of Section 88.

HDC

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29. Ms C said she asked Ms A about the postnatal period following the birth and Ms A told her that she had received very little postnatal care as she did not get on well with the midwife. Ms A advised HDC that this is not correct as she felt the postnatal care she received was excellent and she received care from both a midwife and a plunket nurse. According to Ms C, Ms A said that she had not required any follow-up treatment or check-up from the obstetrician who had repaired her tear, and she had not experienced any concerns when recommencing sexual relations with her husband after the birth. Ms A does not recall being asked about this and the conversation is not recorded in Ms A's notes.

30. Ms C said she reviewed a copy of Ms A's MMPO (Midwifery and Maternity Providers Organisation) notes from her first pregnancy, and noted that there was very little written in the notes. Ms C advised HDC that this indicated to her that Ms A's recovery from the tear was nothing to cause her any concern.

31. Ms A's MMPO notes from her first pregnancy, in 2005, record that she had an "episiotomy/tear", but they do not provide details about the extent of the damage to Ms A's perineum or what was required to repair the tear. It is recorded in the MMPO notes that Ms A had "perineal discomfort", and when Ms A was two and half weeks postnatal, there is a note that Ms A "has an appointment with [a local doctor] to review if necessary. Advised to wait until 6/12".

32. In mid 2005, it is noted in the MMPO notes that Ms A reported vaginal "throbbing" and that her perineum was "sensitive". The notes state that swabs were taken because Ms A was concerned about a possible infection. The notes record that Ms A "did not attend [the local doctor's clinic] as advised". Ms A advised HDC that she was subsequently "given the all clear with no reason to follow through" with this appointment. According to the MMPO notes, Ms A was discharged from her midwife's care appromixately 3 weeks later. The notes from this last visit record that Ms A's perineum was "comfortable" and "healing well".

33. Ms C said she did not feel it was necessary to obtain a copy of Ms A's labour and birth notes, but would have done so if Ms A had suffered complications from her tear, such as having found intercourse painful or that the wound was slow to heal, or required treatment with antibiotics due to infection. Ms A advised that the only problem she recalls with the stitches was that a couple of the stitches caught and either the midwife or the plunket nurse snipped them. She said she did not need to see a doctor at any stage postnatally. She thinks she may have taken some antibiotics, but believes this was more a precautionary measure as opposed to needing it for an actual infection. Ms A advised HDC that she did not recall discussing with Ms C her recommencement of sexual relations. She said she does not recall experiencing difficulty or pain at that time, but had delayed recommencing sexual relations for some time. She noted there is always going to be some pain and discomfort when recommencing sexual relations after having had that number of stitches, but she does not recall it being anything significant.

34. Ms C advised HDC that she did not refer Ms A for an obstetric appointment because there is no obstetrician available in the town and the closest is either 200kms away or

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100kms away. She said she was aware that Ms A did not have a drivers' licence and said Ms A "had used a private obstetrician with her last pregnancy and as such this time she chose not to". Ms A advised HDC that she is unsure why Ms C thought she did not have a drivers' licence as she has had her full drivers' licence for over 15 years. Ms A's records from her first delivery indicate that she was referred by her midwife lead maternity carer to an obstetrician because she was post dates and an induction was indicated, rather than Ms A having made a choice to use a private obstetrician.

35. Ms C advised HDC that she did not feel a referral to an obstetrician was indicated in the circumstances, and she did not discuss this possibility with Ms A. Ms C said that, at any time throughout her pregnancy, Ms A could have requested that Ms C "refer her to an obstetrician for a consultation, which [she] would have happily undertaken". On 18 December 2009, Ms C recorded a discussion about where Ms A would give birth. She recorded "[Ms A] still keen on [large public hospital]". Although this suggests a previous discussion had taken place, there are no records of earlier discussions about Ms A's concerns.

36. Ms C said that she explained to Ms A that there was a risk of tearing again and what steps Ms C would take to reduce that risk. This discussion was documented by Ms C on 15 January 2010:

> "[Ms A] a little concerned also about tearing — discussed ways that we can avoid this or lessen eg using water; hot cloths on perineum; perineal massage — over next few weeks."

37. Ms C also documented her advice to Ms A that if she did tear again, and it was uncomplicated, it would be sutured and repaired by Ms C. However, if it was a complicated tear, an obstetrician would be asked to repair it.

Birth location

38. There was a small hospital located in the town where Ms A lived which had a birthing facility. Ms C advised HDC that as Ms A was "concerned about tearing again" she initially wanted to birth at a large public hospital, a four-hour drive from her home. However, after further discussion, Ms A decided to birth at another public hospital as it was closer (two hours as opposed to four hours' travel). This hospital is a secondary hospital.

Information

39. Ms C advised HDC that she provides her clients with two clear folders that contain information on pregnancy, labour, birth, and the early postnatal period, for them to read during their pregnancy. She said she provides the information "as a starting point for discussion" and asks her clients to first read the information contained in the folders, and then at subsequent visits she discusses with them any questions that have arisen from their reading of the information.

40. Ms A advised HDC that when she had questions about her pregnancy, Ms C told her to refer to these folders. She said she is "not a big reader" and would have preferred to have a discussion about things that were of concern to her. She felt that Ms C was

HDC

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complacent because she deals with pregnancy on a regular basis and failed to appreciate this was not the case for Ms A.

Care plan

41. All LMCs are required to document a care plan for the woman and her baby.[11] Ms C did not document a plan of care in relation to Ms A's decisions or preferences for her labour and birth, such as pain relief, interventions and treatments, Vitamin K administration, third stage of labour options, or method of feeding the baby.

42. Documentation of all midwifery decisions made is also one of the Standards of Midwifery Practice[12] and a minimum competency for entry to the Register of Midwives.[13]

Back-up midwife

43. Ms C arranged for Ms A to meet her back-up midwife, Ms D, who would attend the labour and birth if Ms C was unavailable. Ms C advised HDC that she informed Ms D about Ms A's previous tear.

44. Ms D advised HDC that when she met with Ms A on 20 January, Ms A discussed her anxiety over recognising spontaneous labour because her first labour had been induced, her fear of tearing again, and her desire to give birth at the hospital where there would be an obstetrician on site. Ms D said she advised Ms A that once she went into labour it would be important to assess progress at the local hospital, prior to driving to the larger hospital. In the event birth was imminent, the safest option would be to give birth at the local birthing unit. Ms D documented the following in the midwifery notes: "Met with [Ms A] at home. Listened to her wishes for this birth and some of her anxieties. Planning on [larger hospital] birth — aware that if birth progresses quickly will birth locally."

45. Ms D did not discuss her medical condition with Ms A (discussed below).

Ms D's medical condition

46. Ms D advised HDC that she has a medical condition called sinus tachycardia (SVT). Ms D said the condition means that in new and stressful situations her heart beats rapidly and irregularly, which lowers her blood pressure and leaves her extremely light headed and short of breath.[14] Ms D advised HDC that her condition affects her rarely and is generally resolved if she sits down briefly. She said that the "symptoms make it very difficult to hold a conversation".

47. On 30 September 2010, Ms D advised HDC "this is the first time it has been an issue in a clinical setting". On 1 October 2010, her legal advisor advised HDC that Ms D's "medical condition was one which had never presented itself in a midwifery clinical setting and she had not ever received medical advice that it might".

[11] Part DA19, Section 88.
[12] Standard Five.
[13] Competency 2.16.
[14] Ms D advised HDC that her SVT is also triggered by extreme exercise and excessive caffeine consumption.

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48. However in a letter to the Midwifery Council in July 2010, Ms D stated "This is the 10th year I have been practising as a midwife and have experienced SVT within the context of work only 4 or 5 times and believe I am able to self manage it well".

49. When queried about the inconsistency between the statements, Ms D advised HDC that she first experienced SVT when she was a first-year student attending a Caesarean section for the first time. She said she experienced a rapid heart beat, which she was able to control with controlled breathing. She said she experienced SVT again when she was a third-year student when she first sutured a perineum. This was again managed with controlled breathing. Ms D said she also experienced SVT on two other occasions in the midwives' station when she was writing up notes. She believes these episodes were triggered by eating chocolate-covered coffee beans, and were again managed with controlled breathing exercises.

50. On 2 June 2011, Ms D advised HDC that Ms A's delivery was the first time her SVT condition had been an issue in a clinical setting "in that it prevented [her] from continuing to provide care momentarily although [she] had been able to ensure there was a midwife present when [she] had to leave the room". Ms D acknowledged in her response to HDC's provisional opinion that her initial response would have been clearer if she had said "I had never had STV in a clinical setting before that impeded my ability to provide appropriate care". Ms D said that she holds the HDC "in the highest respect" and would never intentionally mislead the HDC. Ms D further advised that, when responding to HDC, she did so to the best of her recollection at all times and apologised for not being clearer in her response.

Informing colleagues about condition

51. Ms D said she had not informed her colleagues, Ms A, the DHB, or any of the core midwives at the facilities where she has an access agreement, about her SVT, as "it had never been an issue in a clinical setting" and she "did not have the foresight to appreciate that her condition might affect the care that she provided to the extent that it did on this particular occasion".

Labour and journey to hospital

52. At approximately 4pm in early February 2010, Ms A contacted Ms D (as this was Ms C's rostered day off), and advised that she was having infrequent contractions and was losing some pink fluid during contractions. Ms D formed the view that Ms A was in early first stage labour and that she should remain at home and contact her again if the nature of the labour changed or if she required ongoing midwifery support.

53. Ms A contacted Ms D again at 8pm to advise that she was going to bed as the contractions were not progressing.

54. Ms A contacted Ms D again at 9.20pm to inform her that sleeping had been impossible and her contractions were now every 10 minutes, lasting 40 seconds, and that she would like Ms D to come to her home.

55. Ms D arrived at Ms A's home at approximately 10pm and Ms A's parents arrived as planned, at approximately 10.45pm. Ms D advised HDC that on arrival at Ms A's home she observed her labour and palpated her abdomen. Ms A recalls that she

HDC

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mentioned to Ms D her fear of tearing and that she wanted to birth at the larger hospital, and that Ms D responded that she would not let her tear and not to worry.

56. At approximately 11pm, Ms A, Mr A, Mrs B and Ms D travelled to the local hospital where Ms D performed a vaginal examination. Ms A said she asked Ms D why she had to travel there rather than carrying out the examination at home, but received no reply. Ms D decided that while Ms A was "definitely establishing into labour" there was plenty of time to drive safely to the larger hospital. She left the room to allow Ms A and Mr A to decide if they wanted to stay at the local hospital or travel to the larger hospital.

57. Mr A and Ms A were concerned about the number of times Ms D asked Ms A where she wanted to birth, noting that Ms A had made it clear she wanted to give birth at the larger hospital where a doctor would be present in the event she suffered another tear. They reiterated to Ms D their wish to birth at the larger hospital, and at approximately 12.30am they departed in three cars. Mrs B was in the first car, Mr A and Ms A were in the second car, and Ms D was in the third car.

58. Mrs B advised HDC that during the journey she noticed Ms D falling further and further behind to a point where she was lost from sight for a considerable length of time. Mrs B advised HDC that Ms D pulled in just after them when they arrived at the hospital.

59. Ms D explained to HDC that she stopped twice on the journey to empty her bladder. However, she had told Mrs B that she had stopped to walk around her car a few times, as she did not feel it was necessary to share that she had stopped to empty her bladder.

Absences during labour

60. Mrs B advised HDC that, at both the local and larger hospitals, Ms D would leave the room for quite long periods of time causing them to query where she was and, on more than one occasion, Mr A left the room to look for Ms D.

61. Ms D advised HDC that Ms A was admitted to the maternity ward at around 2.45am. Once Ms A was settled, she left the room to get the necessary paperwork together, inform the core maternity staff of their arrival, and provide them with an update of the progress and plan. She is unsure what time she left the room but says she was back in the room by 3.45am as she wrote in the notes at that time. Ms D advised HDC that she does not recall leaving the room again for any extended period of time after this and she was never aware that Mr A had left the room to look for her.

Birth

62. Ms A recalls that during the labour she was in a lot of pain. She felt a burning sensation inside and could tell her skin was not stretching as it should. She was sure something had torn inside and she is "100% sure [she] told the midwife this". Ms A says she was screaming with the pain. Ms D told her everything would be "OK" and to keep pushing.

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63. Mrs B recalls that her daughter had been telling Ms D for over half an hour before the birth that she was in "dreadful pain and [had] burning sensations inside", but that Ms D just kept telling her that she was doing a good job and to keep pushing.

64. Ms D advised HDC that Ms A started to actively push at 5.10am. However, Ms A's mother recalls that Ms A had been pushing for some time prior to 5.10am.

65. Ms D said that when she noticed that the baby had not descended further after a couple of pushes, she asked Ms A to change her position to enable Ms D to see clearly what was happening. After Ms A changed her position, Ms D noticed that Ms A's perineum was stretched tight and blanching and she decided it would be necessary to perform an episiotomy.

66. Ms D advised HDC that performing episiotomies is not part of her normal practice and she does them infrequently. Prior to Ms A's case, she had performed three episiotomies in her career, and it had been 18 months since she had last performed an episiotomy. However, she believes that she is competent in this skill. Ms A said she was not told about Ms D's limited experience, even though she had repeatedly expressed her fear of cutting or tearing.

67. Ms D stated that when she realised she would need to perform an episiotomy, her SVT was triggered and she began to feel unwell.

68. There are differing accounts of the assistance Ms D obtained once she began to feel unwell, and in particular whether another midwife was present during or after the birth.

69. Ms D advised HDC that she called a core midwife into the room to assist with preparations for the episiotomy, as she was unfamiliar with where the local anaesthetic and episiotomy scissors were kept. She also wanted to have a midwife in the room who was familiar with what was happening as she suspected she would need to leave the room.

70. Ms D recalls that a midwife, Ms E, came promptly to the room after she called for assistance. Ms D said she asked Ms E to get another midwife to ring for the obstetric registrar and ask him or her to attend and also asked Ms E to stay in the room and assist with the episiotomy. Ms D did not tell Ms E or Ms A and her family that she felt unwell or that she might need to leave the room.

71. Ms D advised HDC that she wanted assistance from the on-call obstetrician as the fetal heart rate was causing her concern because it was dipping throughout the contractions and recovering much more slowly than previously. She also wanted an obstetrician available if the birth needed to be facilitated with a ventouse.[15] Ms D said she was also concerned that they could encounter difficulty delivering the shoulders once the head was born (shoulder dystocia) and she wanted obstetric support for this. Ms D told HDC "I informed [Ms A], [Mrs A] and ([Ms A's] mother) that I wasn't entirely happy with the heart rate at that point and thought it would be prudent to

[15] A ventouse is a vacuum device that placed over the baby's head to assist with delivery when labour is not progressing adequately.

HDC

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have some assistance in the room prior to ringing the call bell". In contrast, Ms A stated that she was not informed about these concerns.

72. Ms D advised HDC that the core midwife who called the obstetrician at her request was Ms F. Ms D advised HDC that Ms F returned to the birthing room a few minutes later to ask for more details, and that Ms D "expressed urgency for him to attend".

73. In the meantime, Ms D performed the episiotomy and the baby descended further but his head was still not delivered. Ms D advised HDC that as she was preparing to cut an extension to the initial episiotomy, Ms A pushed, her perineum "button-holed" and her baby was born through her perineum. Ms D believes that she performed the episiotomy correctly and that her SVT did not prevent her from providing appropriate care.

74. Ms D advised HDC that she placed the baby on Ms A's chest leaving the umbilical cord attached so he could benefit from his stem cells, and left the room as she felt as if she was going to faint. She advised HDC that she asked Ms E to remain in the room with the family but did not inform her why she was leaving the room or how long she would be gone as her SVT symptoms were making it difficult for her to have a conversation. Ms D said that she expected Ms E to provide some care and support for Ms A and her baby. Ms D said that Ms E "was aware that I hadn't given an ecbolic[16] following the birth of the baby, she was aware that I hadn't clamped or cut the cord, she was aware that the baby hadn't been dried off or that the baby hadn't been covered with a warm towel".

75. In her response to HDC's provisional opinion, Ms D restated her assertion that Ms E remained in the room with Ms A when she left the room.

76. Ms A is sure that, apart from Ms D, no staff member was in the room when she gave birth and that Ms D then left her and her family alone in the room with the new baby. Ms A recalls the baby looked blue and her mother was trying to get the mucus out of the baby's mouth. She does not recall how long it took for someone to return to the room.

77. Similarly, Mrs B also recalls that no midwife or medical person was in the room, other than Ms D, when Ms A's baby was born. Mrs B recalls that soon after making the episiotomy cut Ms D called for assistance, and a young midwife attended. She recalls Ms D telling the midwife that she needed to get the obstetrician. The young midwife left the room and returned a few minutes later and advised Ms D that the obstetrician was really busy with another patient. Mrs B recalls Ms D then yelled at the midwife to "get a registrar NOW", and the midwife left the room.

78. Mrs B recalls that immediately after the birth, Ms D "dumped" the baby on Ms A and left the family alone in the room with no other staff member present. Mrs B said she wiped the baby's face clear of mucus and membranes so he could breathe. She recalls being shocked at being left to look after a baby which had just been born.

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[16] A drug that is used to promote uterine contractions.

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79. Mr A's complaint stated that Ms D disappeared straight after the birth, without notifying anyone, leaving Ms A alone with a nurse, Mrs B and him. Later, when asked whether a nurse was present, Mr A told HDC that it was difficult to recall exactly what happened because things were chaotic and it was a while ago. However, he is sure that when he went to find Ms D, Ms A was left with the baby without medical support. Mr A also recalls his wife being concerned that their baby could not breathe as there was mucus in his mouth, and that Mrs B had to clear the mucus away.

80. Mr A recalls another midwife "coming and going" in the earlier stages of the labour, and that there may have been another midwife present "when things started to get a bit hectic", but he could not recall for certain. Mr A does recall a nurse being present in the room when the obstetrician was there, but is not sure when she entered the room.

81. The District Health Board confirmed to HDC that the core midwife who responded to the bell from Ms A's room was Ms E. They also advised that they had spoken to other staff members, none of whom reported that they had been present in the birthing room during the birth.

82. Ms F[17] advised HDC that she is she is a registered nurse and midwife but that she has not held a midwifery practising certificate since March 2009, and that at the time of these events she was practising in her capacity as a nurse not a midwife. Ms F was on her way to get some equipment to assist a woman who was having difficulty breastfeeding when Ms D approached her and asked her to call an obstetrician. Ms F asked Ms D if she wanted her to stay with Ms A while Ms D made the telephone call, but Ms D declined. Ms D advised Ms F that Ms A was slow to deliver and Ms D wanted assistance and had noticed some dips in the fetal heart rate. Ms F advised HDC that she then telephoned the obstetrician and relayed this information to him and he responded that he would attend straight away. After calling the obstetrician she continued providing postnatal care to her own patient. Ms F said that she did not meet Ms A.

83. Ms E has advised HDC that she was not present in the room for the birth. She said that after responding to Ms D's request for support, she prepared the equipment for an episiotomy. She remained in the room while Ms D performed the episiotomy, and Ms D then asked her to find out how far away the obstetrician was. Ms E advised HDC that she left the room and went to the nurses' station to call the obstetrician. As she was making the telephone call, she saw the obstetrician arrive and so she hung up the telephone and went to explain to him which room to go to. As she was doing so, she saw that Ms D was now in the nurses' station. The obstetrician went to attend to Ms A.

84. Ms E recalls that she was the only staff member assisting Ms D.

[17] HDC became aware of Ms F's involvement through information provided by Ms D.

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Events following the birth

85. After Ms D left the birthing room, she went to the midwives' station. She advised HDC that Ms F was in the midwives' station, and asked Ms D if she was "OK". Ms D told HDC that she responded that Ms A had suffered the worst perineal damage she had ever seen.

86. Mr A advised HDC that after Ms D had been gone for a few minutes his wife was in severe pain and he was becoming frustrated with the situation. He said he found Ms D sitting in the midwives' station with her head in her hands telling all those present that his wife's perineum had exploded. Ms D advised HDC that when she realised Mr A was present she reassured him that his baby was fine and that she would be back in the room in a minute and the obstetrician was on his way.

87. Ms E says that she was present in the midwives' station when Ms D told the midwives present about the "blow out of the perineum", and that Ms D asked Ms E to get her a glass of water.

88. Ms F advised HDC that at some point after making the telephone call to the obstetrician (she cannot remember how long exactly but advised it was "quite a while later"), a hospital aid told her that Ms D wanted to see her in the office. Ms F recalls that she went to see Ms D, who was alone in the office, and that Ms D asked her to attend to Ms A who had had a tear. However, before she had a chance to respond to Ms D, the obstetrician "stormed" into the office and demanded that Ms D get back to Ms A and finish the job. Ms F advised HDC that at that time she thought Ms E was with Ms A, and that while Ms E had been registered as a midwife for "some years"[18] in Ms F's opinion Ms E does not have a lot of experience and would not be able to repair a tear.

89. The obstetrician, Dr G, also overheard the conversation between Ms D and Ms F when he arrived on the ward. Dr G advised that he found Ms D sitting in the midwives' station, "head in hands, describing a horrible tear … She was being graphic in her description and I was horrified to find the patient's [partner] standing behind her overhearing this graphic description."

90. Dr G advised that he then went to the delivery room and found Ms A "in considerable agony lying prone with the baby wet still on the abdomen — uncovered and undried". Dr G does not recall any staff member being present when he entered Ms A's room, but can not be sure of this.

91. Mrs B recalls that another staff member entered the room with Dr G, and that staff member told Mrs B to cover the baby so he would not get cold. Mrs B placed a towel over the baby to keep him warm. Dr G then picked the baby up to dry him and found that the cord was still attached. Mrs B recalls that her daughter screamed in agony.

92. Dr G advised that after drying the baby he returned to the midwives' station and instructed Ms D to "get into the room and sort out the patient in there". Ms D advised

[18] Ms E is registered as a midwife.

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that she re-entered Ms A's room, assessed Ms A's bleeding as being within normal limits, gave her an ecbolic, and completed a managed third stage of labour.

93. Ms A was then taken to theatre to have the damage to her perineum repaired by Dr G. Dr G advised that he repaired the complicated second degree tear with "considerable difficulty", noting that the tear was "high reaching near to the cervix posteriorly. There was a transverse tear and also an episiotomy to the right. In addition to this there was a tear extending from the left labium majus to 3cm behind the anal margin and a large bridge of tissue extending from the perineum to the vagina."

94. Ms A and Mr A advised HDC that Dr G spoke to them the following day and advised Ms A that a vaginal birth is not an option she should consider in future pregnancies because of the extent of her injuries. Dr G recorded in his operation note: "Suggest elective Caesarean section next pregnancy".

Communication from the midwives

95. Mr A advised HDC that since the birth of their son, his wife was "slightly upset that she had not had a phone call or even a [text] from either midwife, even to say congratulations". Ms A states that she received absolutely no contact from either Ms D or Ms C after the birth.

96. In contrast, Ms D advised HDC that following the surgery she visited Ms A in recovery and expressed her sorrow that she had suffered another extensive tear. Ms D said that as she was preparing to leave she said to Ms A that they should meet at a later date so she could answer any questions they might have, and that Ms A agreed this would be a good idea.

97. Ms C advised HDC that she sent Ms A a text message the following day, after receiving a handover from Ms D at 10am, congratulating her on the birth of their son, advising she would give her a call later, and asking her to keep her updated with how things were going. Ms C advised that later that day, at approximately 1pm, she called the hospital to speak to Ms A but was informed by the midwifery staff that Ms A and Mr A had decided to discontinue their midwifery care with her.

98. Ms A is adamant that she received no text message from Ms C congratulating her, but said Ms C did send her a text message some time later asking her to put some books Ms C had lent her in the letterbox to be collected.

Changes to practice

99. Ms C advised HDC that she now realises that the perineal trauma Ms A suffered following her first birth was "significant for [Ms A and Mr A]", and that, on reflection, she should have gone through Ms A's labour and birth notes with her, as this may have alleviated some of her concerns.

100. Ms C has also acknowledged that it would have been beneficial for Ms A to have discussed her previous perineal trauma with an obstetrician, and if presented with a similar situation again she will offer her client the opportunity to do so.

HDC

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101. Ms D advised HDC that she is saddened at the breakdown in her relationship with Ms A and she has reflected on aspects of her care. As a result of this case she has taken the following steps:

- Talked with colleagues and accessed articles and research concerning previous perineal trauma and spontaneous perineal tears.
- Reviewed her current management plan, which is to obtain as much experience as possible in a supportive environment where new or potentially challenging situations may present themselves.
- If she needs to leave the room for any reason during a labour, she will ensure that the mother and her support people are aware of how to access a staff member until she returns.
- Ensured that in every birthing environment she works in, a back-up midwife is available. She will discuss with her clients the role of the back-up midwife and the situations in which she may need the back-up midwife to provide support for her, or step in and provide some care directly.

102. Ms D advised HDC that she now informs all her clients about her SVT and the strategies she has in place to deal with her condition.

Relevant Standards

103. Primary Maternity Services Notice, issued pursuant to Section 88 of the New Zealand Public Health and Disability Act 2000 (Section 88).

Part DA19 of Section 88 (Service specifications for first and second trimester) states:

> "… (2) For a woman in the second trimester of pregnancy, the LMC must provide all of the following services:
>
> …
>
> (b) at the start of the second trimester or at the time of registration:
>
> …
>
> (ii) commence and document a care plan to be used and updated throughout all modules including post natal that meets the guidelines agreed with the relevant professional bodies."

104. New Zealand College of Midwives *Midwives' Handbook for Practice* (2008) states:

> "Standard One
> The midwife works in partnership with the woman.

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Criteria
The midwife:

…
- facilitates open interactive communication and negotiates choices and decisions.

Standard Three
The midwife collates and documents comprehensive assessments of the woman and/or baby's health and wellbeing.

Criteria
The midwife:

…
- collects information using all sources in consultation with the woman.

Standard Five
Midwifery care is planned with the woman.

Criteria:
The midwife:

…
- sets out specific midwifery decisions and actions in an effort to meet the woman's goals and expectations and documents these.

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

Criteria:
The midwife:

…

- demonstrates awareness of her own health status and seeks support to ensure optimum care for the woman is maintained.

Competency One
The midwife works in partnership with the woman/wahine throughout the maternity experience.

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

HDC

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Performance criteria
The midwife:

…

2.16 provides accurate and timely written progress notes and relevant documented evidence of all decisions made and midwifery care offered and provided."

Opinion: Breach — Ms C

Introduction

105. Ms A told her midwife her concerns about suffering further injury during the birth of her second baby. She recounted her anxiety on several occasions and explained the severity of the injuries she suffered when her first child was born. Ms A recalls that she told Ms C that she tore "really badly" last time, but Ms C was dismissive of her concerns and responded "well it's not in your notes".

106. Ms C acknowledges that she discussed Ms A's previous tear with Ms A and Mr A. She stated that the discharge summary did not indicate or mention that Ms A had an extensive or complicated tear. However, HDC has obtained the discharge summary (**Appendix B**). I note that the section relating to the episiotomy, perineal trauma, and sutures has not been completed. Consequently, it is difficult to see how Ms C could have reached any conclusion based on the discharge summary.

107. Working in partnership with the woman is key to good midwifery practice.[19] In order to work in partnership with the woman, the midwife must ensure communication is effective, and that she is responsive to the woman's concerns or anxieties.

108. This Office has previously stated:[20]

> "a general issue raised by the case is the apparent failure of the midwives to listen carefully to what Mrs A was telling them … Providers should always treat consumers with respect and listen carefully to their concerns. This case is a reminder of why this is so important."

Access to previous labour and birth notes

109. My expert midwifery advisor, registered midwife Deborah Souness, has advised that an LMC is able to request a copy of a woman's old notes. Ms Souness stated that although Ms A was aware that she had had a lot of stitches, she did not have a good understanding of what had occurred at her first birth and was unable to give Ms C an adequate history. However, Ms A was anxious about her previous perineal trauma, and planned to give birth at a secondary hospital because of that concern.

[19] Competency One and Standard One contained in the Midwives Handbook for Practice (2008 ed.)
[20] 07HDC04325, 13 October 2008.

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110. Ms Souness advised that it would have been prudent for Ms C to have accessed the labour and birth notes. Ms Souness is of the opinion that Ms C did not practice to an adequate standard in regards to identifying the extent of Ms A's previous perineal trauma and that peers would view this with moderate to serious disapproval. I agree.

Care planning and documentation

111. Ms Souness advised that Ms C did not practice in an adequate manner with regard to documentation of her conversations with Ms A, her obstetric history taking and the accuracy of the facts that were documented. She advises that peers would view this conduct with moderate disapproval.

112. Ms C stated that based on her discussions with Ms A and the information contained in Ms A's MMPO notes and the discharge summary there was nothing to indicate to her that Ms A has suffered any complications following the birth of her first child.

113. There should have been a discussion with Ms A about the possibility that she would need another episiotomy. This discussion should have taken place during the development of the birth plan. However, there is no record of any birth plan and only a brief reference to an episiotomy is recorded on 15 January 2010, stating that ways to avoid or minimise tearing were discussed and that Ms C would be able to repair a first or second degree tear, but a doctor would be required if the tear was complicated.

114. Ms C did not document a plan of care for the labour and birth, such as pain relief, vitamin K administration, third stage of labour options, or the method of feeding the baby. While Ms Souness acknowledges that not all women wish to formally write a birth plan, documentation of any discussions around the issues noted above is required in accordance with Section 88 and is particularly helpful in instances where back-up practitioners are providing care.

115. This Office has previously made clear the expectation of midwives in documenting all aspects of care planning:[21]

> "the documentation of a mother's care must be illustrative of clear and specific planning between the mother and midwife or the pregnancy, birth and other associated issues."

116. Documentation of all midwifery decisions made is also one of the standards of midwifery practice[22] and a minimum competency for entry to the registry of midwives.[23] Failure to document a birth plan was suboptimal practice.

Referral to an obstetrician

117. Johnson and Keenan[24] describe consent not as a single act, but as "a process involving communication between consumer and practitioner in which the

[21] 05HDC18619, page 40.
[22] Standard Five.
[23] Competency 2.16.
[24] Johnson, S, and Keenan, R. (2010). Consent in R Keenan, ed Health Care and the Law Bookers: Wellington, Chapter 6 page 88.

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practitioner openly and honestly provides full information in an environment, and in a manner, in which the consumer can understand it". Midwives have a crucial role to ensure their ongoing processes of communication and information sharing allow women to be fully informed and make their own choices throughout their pregnancy and birth.

118. Ms A stated that although she raised the issue of the previous tear on several occasions, Ms C did not take her seriously. A reasonable patient would want to be adequately and appropriately informed of any risks. This patient was concerned about the risk of tearing, based on her previous experience. As this Office has previously stated,[25] "It cannot be assumed by health professionals that patients have an understanding of the significance of their personal history and understand their risk factors, in the absence of full explanation".

119. Ms Souness advised that there is no requirement for an LMC to refer a client to an obstetrician if a client has previously suffered significant perineal trauma. However, she notes that Ms A was anxious about tearing again and had spoken to both midwives about it. Ms Souness comments "[g]iven her concerns it would have been advantageous for Ms C to offer Ms A a referral to an obstetrician during her pregnancy to review her previous experience and to have a discussion about this birth and to make a plan of care for it. This would have also given Ms A an opportunity to discuss her options. These would have been to have a vaginal birth or an elective caesarean section (should the obstetrician think it would be appropriate)." She considers her peers would view Ms C's conduct with mild to moderate disapproval.

120. In my view, there were a number of matters that should have been discussed with Ms A in order for her to be in a position to make an informed decision about the management of the birth, in light of her concerns. Ms A needed to be aware of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option. Ms A had made it very clear that a further tear was of concern to her and was an outcome she wished to avoid. She needed an explanation of her condition, the risks and benefits of a vaginal delivery, and how the birth should be managed to minimise the risk of a further serious tear.

121. The choices about the management of the birth should have been made by Ms A, not Ms C. This Office has previously stated[26] "the legal position is clear in New Zealand, where Right 6(1) of the Code is based on the prudent patient test adopted by the High Court of Australia in *Rodgers v Whitaker*."[27] As noted by Mason CJ in that case:[28]

> "because the choice to be made calls for a decision by the patient on information known to the medical practitioner but not to the patient, it would be illogical to hold that the amount of information to be provided by the medical practitioner can be determined from the perspective of the practitioner alone, or, for that matter, of the *medical profession* …"

[25] Opinion 03HDC00837, 2 December 2003, page 27.
[26] 07HDC11318, 17 October 2008, page 33.
[27] *Rodgers v Whitaker* [1992] HCA 58.
[28] Ibid , para 14.

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122. Ms C's failure to explain to Ms A the options available for managing the birth, in light of her particular history and concerns, was a breach of Right 6(1)(b) of the Code, as this was information that a reasonable person in Ms A's circumstances would need to take into account before giving informed consent to Ms C's proposed management plan. Ms A was not provided with adequate information to allow her to make a choice as to how the birth would be managed to minimise the risk of tearing. Accordingly, Ms C also breached Right 7(1) of the Code.

Response to Ms A's questions

123. Ms C advised Ms A to refer to her manual if she had questions. Ms A found this method of communication unsatisfactory. She, like many people, finds it easier to talk matters over and ask questions. The process adopted by Ms C to address any issues or questions, made Ms A feel her pregnancy was a routine matter for Ms C and that her concerns were dismissed.

124. Ms Souness reviewed the manual that Ms C provided to Ms A and found it to be comprehensive. Nevertheless, Ms Souness advised that Ms C should have had a general discussion with Ms A in response to any questions or concerns she had, and then referred her to the manual if she wanted to read more widely on the subject. Ms Souness considers peers would view this conduct with mild to moderate disapproval.

125. I accept this advice. In my view, Ms C should take care to tailor her mode of communication to suit the communication preference of the particular pregnant woman.

Summary

126. An important issue for Ms A throughout her pregnancy was her desire to minimise tearing. This was communicated clearly to Ms C at least three to four times, and was reinforced by Ms A's decision to travel two hours to a secondary facility where there would be access to an obstetrician. However, Ms C says she was reassured by the discharge summary and appears to have paid insufficient attention to Ms A's account of having torn badly the previous time.

127. In these circumstances, Ms C should have obtained a copy of Ms A's labour and birth notes from her first birth. These notes would have provided further information about Ms A's previous experience and assisted Ms C to have a thorough discussion with Ms A about the risks of a further tear and the options for this birth. In light of Ms A's anxiety, Ms C should have explained to Ms A the option of consulting an obstetrician to discuss her concerns.

128. Ms C failed to explain to Ms A the options available for managing the birth, including the option of consulting an obstetrician. This was information that a reasonable person in Ms A's circumstances would need to take into account before giving informed consent to the proposed management plan. Accordingly, in my view, Ms C breached Right 6(1)(b) of the Code. Ms A did not have the information necessary to make an informed choice whether to have her pregnancy managed as suggested by Ms C, or whether she should seek the advice of an obstetrician. She was also not in a position to make a choice as to how the birth would be managed to minimise the risk of tearing. According, Ms C also breached Right 7(1) of the Code.

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129. Ms C's failures to identify the extent of Ms A's previous perineal trauma, document her conversations with Ms A, take an adequate obstetric history and ensure the accuracy of the facts that were documented, amount to a failure to provide services with reasonable care and skill and are a breach of Right 4(1) of the Code.

130. By failing to document significant discussions and decisions in relation to the care plan, Ms C did not meet professional standards and also failed to meet the requirements of Section 88. Accordingly, she breached Right 4(2) of the Code.

Opinion: Breach — Ms D

Questioning birth location

131. Ms A and Mr A are concerned that, despite having made it clear during the antenatal period that Ms A wanted to give birth at the larger hospital, Ms A was asked again by Ms D while in labour at the local hospital if she wished to stay and give birth there. I accept the advice of Ms Souness that, given the progress of Ms A's labour, it was appropriate for Ms D to ask Ms A again if she still wished to travel to the larger hospital.

Notifying obstetrician

132. Ms A and Mr A have both expressed concern that Ms D did not notify the obstetrician earlier about Ms A's presence and her history of tearing in her previous birth.

133. Ms Souness has advised that it is not usual practice to inform an obstetrician about a woman's admission to the labour ward, unless there are pre-existing risk factors or complications expected. In this case, Ms D was aware of the previous tear and Ms A's anxiety about the birth, despite believing that Ms A's previous perineal trauma was uncomplicated. Ms Souness considers Ms D provided an appropriate standard of care in this respect. Even though, in light of the advice from Ms C, Ms D did not recognise the risk factors, Ms A had made it clear to Ms D how concerned she was about the birth. It would therefore have been prudent for Ms D to have alerted the obstetrician to Ms A's obstetric history and her arrival at the maternity suite.

Management of second stage of labour

134. Ms A recalls that during the labour she was in a lot of pain and felt a burning sensation inside. She could tell her skin was not stretching as it should. She was sure something had torn inside and she is "100% sure [she] told the midwife this". Ms D told her everything would be "OK" and to keep pushing. Ms A says she was screaming with the pain.

135. Ms Souness noted that Ms A's labour progressed normally until the baby's head stopped advancing, at which point Ms D asked Ms A to re-position, so she could have a better view of the perineum. Ms D noticed that Ms A's perineum was tightly stretched and blanching and decided that she would need to cut an episiotomy.

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136. Ms D said she has limited experience with cutting episiotomies, as they are not part of her normal practice and she does them infrequently. Prior to Ms A's case, she had cut three episiotomies in her career, and it had been 18 months since she had last cut an episiotomy. However, she is confident that she is competent in this skill.

137. At this stage, Ms D also noticed irregularities in the fetal heart rate, which indicated the baby might be in distress. Ms D said she became concerned about the risk of shoulder dystocia, and says she began to feel unwell. She called a midwife to assist with the episiotomy and requested medical assistance. However, she did not advise Ms A or her family what to do should she become incapacitated. Nor did Ms D inform the hospital midwife that she felt unwell.

138. Ms Souness considers Ms D's management and decision making during the second stage of Ms A's labour was appropriate. However, in my view, Ms D's lack of response to Ms A communicating that she was in pain and her feeling that she was tearing, is concerning.

Management of third stage of labour

139. Ms D's account of events immediately after the birth differs from those of Ms E, Ms A, and Mrs B. Ms D advised HDC that after placing the baby on Ms A's chest she left the room to find somewhere to sit down, as her SVT was causing her to feel faint. She said that before leaving the room she asked Ms E to remain in the room. She said she expected Ms E to provide care and support to Ms A and her baby.

140. However, several witnesses do not support Ms D's account of events, advising that no other provider was present in the room between Ms D leaving and Dr G entering. Ms E denies that she was in the room for the birth, advising that she left the room just prior to the birth, at Ms D's request, to find out how far away the obstetrician was. Ms E does not recall a midwife other than Ms D being present in the room when she left. Ms E said that she was on the telephone calling Dr G when he arrived. She then noticed that Ms D was in the midwives' station, and directed Dr G to Ms A's room.

141. Mrs B recalls that Ms D "dumped" the baby on Ms A's chest and then left the family alone in the room with no midwifery or medical support. She recalls being shocked at being left to look after a newborn baby and having to wipe the membranes and mucus from his mouth so he could breathe. She also recalls that when Dr G arrived in the room with another staff member, she complied with a request to cover the baby so he would not get cold. Mr A recalls that his wife was concerned that their baby could not breathe as there was mucus in his mouth and that Mrs B had to clear the mucus away. Ms A recollects that Ms D left them alone in the room, that her baby looked blue and that her mother was trying to clean the mucus from the baby's mouth.

142. Mr A's complaint stated that Ms D disappeared without notifying anyone straight after the birth leaving Ms A alone with a nurse, Mrs B and him. Later, Mr A said it was difficult to recall exactly what happened because things were chaotic and it was a while ago. However, he is sure that when he went to find Ms D, Ms A was left with no clinical support. He does remember a nurse being present when the obstetrician was there.

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143. After making enquiries, the DHB has been unable to identify any other midwife who provided assistance to Ms D during Ms A's birth. I also note Dr G's statement that, although he could not be certain whether another staff member was present when he arrived in Ms A's room, he found the baby was wet and uncovered on Ms A's abdomen.

144. I conclude that immediately after the birth, Ms D left Ms A and her family without any midwifery or other clinical support. This view is supported by Ms E, Ms A, Mrs B and the DHB. Mr A's recollection is less clear.

145. Ms Souness has advised that following a birth, a midwife needs to be watching expectantly for third stage complications such as postpartum haemorrhage, and checking to see that the baby is breathing, warm, and generally adjusting to extra uterine life. In this case, the risks were greater as the baby had shown early signs of distress at the end of labour and Ms A had sustained major perineal damage during the birth, meaning her blood loss was likely to be greater than normal.

146. Ms Souness noted that Ms D could have asked one of the hospital midwives to attend to Ms A until she felt able to return and provide care, and considers her failure to do so to be a contravention of Standard Six of the Standards of Midwifery Practice and would be viewed by peers with moderate to serious disapproval.

147. Ms D had a duty to ensure that Ms A and her newborn baby were safe by arranging medical or midwifery support before leaving the room. This could have been as simple as using the emergency call bell and outlining the situation to the attending staff member. Once she reached the midwives' station she could have asked one of the staff present to attend to Ms A. I note that although Ms D may have been feeling unwell, once she was in the midwives' station she was able to relate to Ms F in graphic terms a description of the injuries suffered by Ms A. By leaving Ms A and her newborn baby alone with no medical or midwifery support, Ms D not only left Ms A and her family feeling extremely vulnerable, but also put Ms A and her baby at risk. In these circumstances this was a serious dereliction of her duty as a midwife.

Leaving cord attached

148. Mr A has expressed concern that Ms D did not cut the umbilical cord immediately to prevent the risk of further harm to his wife. Ms Souness has advised that there are two ways of managing the third stage of labour. "Physiological management" involves leaving the cord attached to the baby and waiting until the cord stops pulsating, and there are signs that the placenta has separated (such as a gush of blood and lengthening of the cord). The mother then pushes the placenta out. The cord is not cut until the cord has stopped pulsating and often not until the placenta is delivered.

149. Ms Souness advised that "Active management" involves injecting the woman with an oxytocic[29] drug soon after the birth of the baby, followed by clamping and cutting of the cord, and delivery of the placenta by controlled cord traction. Ms Souness said that it may be advantageous to leave the umbilical cord attached for at least three to

[29] A drug to stimulate contractions of the uterus.

HDC

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four minutes following the birth, before administering an oxytocic drug. This reduces the risk of anaemia in the baby in the first six months of life.

150. Ms Souness advised that leaving the cord uncut would not have caused any additional perineal trauma to Ms A.

151. Nevertheless, while it was appropriate to leave the cord attached, Ms Souness reiterated that the practitioner still needed to be present to watch for any complications, such as haemorrhaging.

Information sharing with colleagues and clients

152. Ms D advised HDC that she did not inform Ms A or any of her other clients, or her colleagues, about her SVT, as “it had never been an issue in a clinical setting”. However, she advised the Midwifery Council “This is the 10th year I have been practising as a midwife and have experienced SVT within the context of work only 4 or 5 times and believe I am able to self manage it well”. When this inconsistency was questioned, she listed four occasions where she had experienced SVT while on duty and stated she had managed the SVT by controlled breathing. In response to my provisional opinion, she stated she “did not have the foresight to appreciate that her condition might affect the care that she provided to the extent that it did on this particular occasion”.

153. The nature of midwifery practice is that there is potential for an emergency or unexpected event at any time. Knowing that her SVT might develop if she was stressed or facing a new situation should have alerted Ms D to the need to ensure that her clients, her colleagues, and the DHB were aware of this and that strategies were in place to ensure no woman or baby was put at risk.

154. I agree with Ms Souness that Ms D should have appreciated there was a risk of her SVT occurring during a labour or birth, which might result in her not being able to continue providing care. Accordingly, she should have informed her midwifery colleagues, including the midwifery staff at the facilities with which she had an access agreement, of her condition, and put in place a plan in the event her SVT was triggered during a woman’s labour or birth. Ms D’s failure to do this contravened Standard Six of the Midwifery Standards of Practice, in particular, that the midwife demonstrates an awareness of her own health status and seeks support to ensure optimum care for the woman is maintained.

155. I also consider that Ms D should have informed Ms A about her SVT and the strategies in place to ensure she and her baby would continue to receive safe and appropriate care in the event Ms D had an episode of SVT during the labour or birth. In my view, this is information that a reasonable consumer would expect to receive.

Ms D’s responses

156. I view with concern Ms D’s responses to this Office. Ms D asserted in her initial response that this was the first time her SVT condition had been an issue in a clinical setting.

HDC

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157. When asked to explain the discrepancy between her response to HDC and her letter to the Midwifery Council, she stated that her SVT had not been an issue as it had not previously prevented her from continuing to provide care. Later, in June 2011, she said that Ms A's case was the first time it was an issue in a clinical setting "in that it prevented [her] from continuing to provide care momentarily although [she] had been able to ensure there was a midwife present when [she] had to leave the room".

Summary

158. By failing to take steps to alert the DHB staff that alternative midwifery or medical support was required for Ms A, Ms D failed to provide services with reasonable care and skill and contravened professional standards. Accordingly, she breached Rights 4(1) and 4(2) of the Code.

159. Ms D failed to inform her colleagues and the DHB about her medical condition, and so there was no opportunity to put in place a plan to ensure continuity and quality of care for Ms A in the event Ms D's SVT prevented her from providing care. Accordingly, Ms D breached Right 4(5) of the Code. She also breached Right 6(1) of the Code by failing to inform Ms A about her medical condition and what Ms A should do if Ms D became incapacitated.

160. I am of the view that Ms D's breaches of the Code are of such seriousness that they warrant the referral of Ms D to the Director of Proceedings to consider whether any proceedings should be taken.

Recommendations

161. I recommend that Ms C:

- apologise to Ms A for her breaches of the Code. The apology is to be sent to HDC by **5 June 2012** for forwarding;
- ensure all her clients have written care plans;
- discuss with her clients the option of a consultation with an obstetrician if the client expresses serious concerns about the management of her pregnancy or birth;
- communicate with her clients in the manner preferred by the client and refer her clients to the information manuals in the context of effective discussion in response to their questions or concerns;
- undertake further education and training on documentation and care plans in conjunction with the New Zealand College of Midwives.

162. Ms C should report back to HDC by **11 June 2012** on any steps she has taken to implement these recommendations.

163. I recommend that Ms D:

- apologise to Ms A for her breaches of the Code. The apology is to be sent to HDC by **5 June 2012** for forwarding;
- amend her practice to ensure that, at material times, another midwife or medical practitioner is available and able to provide the required care should she be unable to do so;
- ensure that all clients are aware of her SVT, the effects it may have on her and the procedures she has put in place to ensure continuity of care for the clients;
- ensure all colleagues with whom she works and institutions within which she works are aware of her condition.

164. Ms D should report back to HDC by **11 June 2012** on the steps she has taken to implement these recommendations.

Follow-up actions

- Ms D will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.
- A copy of the final report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Midwifery Council of New Zealand, the New Zealand College of Midwives and the DHB and they will be advised of Ms C's and Ms D's names.
- A copy of the final 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.

Addendum

The Director of Proceedings decided to issue proceedings, which are pending.

Appendix A - Independent midwifery advice to Commissioner

The following expert advice was obtained from registered midwife Deborah Souness:

"I, Deborah Janet Souness, have been asked to provide an opinion to the Commissioner on case number 10/00267, and I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

Qualifications

My qualifications are Registered Obstetric and General Nurse (RGON) 1979, and Registered Midwife (RM) 1992. I have provided a primary LMC service for urban, rural and remote rural women who wish to birth in hospital or at home for the last 16 years. I have also worked as a RM in a hospital which provides a primary and secondary service for approximately two years.

Purpose:

To provide independent expert advice about whether independent midwives Ms D and [Ms C] provided an appropriate standard of care to [Ms A].

I have viewed the following document: **Information gathered during investigation**.

Antenatal Care

[Ms C] was [Ms A's] LMC. All of [Ms A's] antenatal visits were with [Ms C] except one where [Ms A] met the backup midwife [Ms D].

The adequacy of the advice provided by [Ms C] to [Ms A] about giving birth vaginally with a history of perineal tears, including the risks and options for this birth.

From the history obtained, [Ms C] understood that [Ms A] had sustained an uncomplicated episiotomy with her first birth. In this circumstance it would be usual to advise the client to do some perineal massage and to suggest using water and hot cloths during the birth. With an uncomplicated tear or episiotomy, there is a very small risk of worse tearing at a subsequent birth. It is more likely that there would be less tearing, as the tissues have already been stretched during the previous birth. A repeat episiotomy is rarely needed and the decision to do one is made at the point of birth. Unfortunately, in the antenatal and labour, there is no way of being able to foretell how well the perineal tissues will stretch during the birth of a baby.

The adequacy of the steps taken by [Ms C] to identify the extent of [Ms A's] previous tear.

Standard 3 of the Midwifery Standards of Care states "The midwife collates and documents comprehensive assessments of the woman and/or baby's health and wellbeing". One of the criteria is "collects information using all sources in consultation with the woman"

[Ms C] has documented a brief summary of [Ms A's] first birth. She has incorrectly recorded that the labour was spontaneous (it had been induced for post maturity) and

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has not recorded that there was any perineal damage. [Ms A] had a discussion with her LMC ([Ms C]) about [Ms A's] previous perineal tear at 36 weeks gestation. There had been a discussion about [where to birth]) at 32 weeks. A reason for wanting to birth at a secondary institution is not documented, but I assume there was some discussion about [Ms A's] previous perineal trauma at this visit.

[Ms C] has not documented the information [Ms A] gave her about the perineal trauma she sustained, or that she had checked [Ms A's] discharge summary from her previous birth.

[Ms C] stated that she had viewed [Ms A's] discharge summary from [the first birth] and that it recorded "vaginal delivery w/o (without) complicating diagnosis" and an episiotomy. I have viewed this discharge summary. The discharge summary had not been completed and there was nothing recorded in the space for the third stage which included any perineal trauma and how it was repaired.

I have also viewed [Ms A's] midwifery postnatal notes from her first pregnancy, which [Ms C] states that she had also viewed.

The documentation does not record the detail of the damage sustained and the repair made to [Ms A's] perineum. The notes refer to the wound as an episiotomy / tear. This is a summary and does not accurately describe the sequence of events and outcome of [Ms A's] first birth. An episiotomy is performed for different reasons e.g. in response to the fetal heart rate not returning to baseline between contractions, or it is felt that the perineum is not stretching as it should in the second stage of labour or when the birth is being assisted with instruments such as forceps. It is not uncommon for an episiotomy wound to extend (tear) further into the muscle after it is cut, as the baby's head is born. This does not usually cause any problems unless the tearing is into the anal sphincter (which is called a third or fourth degree laceration).

In [Ms A's] case the episiotomy was cut in response to "button-holing" of the perineum. Button-holing is uncommon and occurs in the second stage of labour as the baby's head distends the perineum. The perineum begins to tear in the muscle and skin between the vagina and the anus (like a button hole) and may extend up and down. Most often a perineal laceration would begin at the vaginal edge and extend down towards the anus. Many practitioners recommend that an episiotomy be performed when button-holing is seen, to try to prevent tearing down into the anus.

Documented in the notes was reference to an appointment made for a postnatal consultation with [a local doctor]. The midwifery notes regarding [Ms A's] perineum written on 18th July (2 ½ weeks postnatal), state "has an appointment with [a local doctor] to review if necessary. Advised to wait until 6/12". On 27th July (3 weeks 5 days postnatal), the midwife has written "Did not attend [local] clinic as advised". It is not clear from the notes who made this appointment and for what reason. It may have been made for her on her discharge from the hospital as a follow up to review her perineal repair, or it may have been made by the postnatal midwife in response to [Ms A's] concern at the amount of pain she was experiencing or concerns that the wound was not healing as it should.

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An LMC is able to request copies of old notes from another DHB through the medical records department of a DHB. [Ms A] was aware that she had had a lot of stitches but did not have a good understanding of what had occurred at her first birth and was unable to give [Ms C] an adequate history, she was anxious about her previous perineal trauma, and planned to birth at a secondary hospital because of that concern, it would have been prudent to access the labour and birth notes from [the first birth].

[Ms C] did not practice to an adequate standard in regards to identifying the extent of [Ms A's] previous perineal trauma. Peers would view this with moderate to serious disapproval.

[Ms C] has not practiced in an adequate manner with regard to documentation of her conversations with [Ms A], her obstetric history taking, and she has not documented some facts correctly. Peers would view this departure from the standard with moderate disapproval.

Whether [Ms C] should have referred [Ms A] to an obstetrician during the antenatal period.

In Section 88 of the Maternity Services Document, there is no requirement to refer a client to an obstetrician if she has had previous significant perineal trauma, but that does not mean that a referral could not be made if thought necessary by the LMC, or requested by the woman.

[Ms A] was concerned and anxious about tearing again and had spoken with both midwives about it. She had decided to birth at [a larger hospital] because of her concerns.

Given her concerns it would have been advantageous for [Ms C] to offer [Ms A] a referral to an obstetrician during her pregnancy to review her previous experience and to have a discussion about this birth and to make a plan of care for it. This would have also given [Ms A] an opportunity to discuss her options. These would have been to have a vaginal birth or an elective caesarean section (should the obstetrician think it would be appropriate).

Peers would view this conduct with mild to moderate disapproval.

The appropriateness of [Ms C's] advice to [Ms A] that she should "refer to her manual" when she had questions.

I have viewed both [Ms C's] manuals and they are comprehensive. However, it would be usual practice to have a general discussion with a woman about her queries and then refer her to the manual if she wanted to read more widely on the subject.

Peers would view this with mild to moderate disapproval.

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Birth Plan
A documented birth plan is required in Section 88 and referred to in the Midwives Handbook for Practice.

Although there is a plan for contacting midwives and relatives documented in the antenatal notes there is no documentation of a discussion about or a plan for [Ms A's] care in labour and birth, such as pain relief, Vitamin K administration, third stage of labour options, or method of feeding the baby. While not all women wish to formally write a birth plan, documentation of any discussions around these issues is required and helpful when back-up practitioners are being utilised.

Peers would view this with moderate disapproval.

Labour and Birth Care

Please advise on the standard of midwifery care provided by [Ms D] to [Ms A].
I have based my advice on the fact that [Ms D] was the back-up midwife and therefore relied on the history taking and information gathered by [Ms C]. [Ms D] did not have the knowledge that [Ms A] had had an episiotomy due to a button holing laceration of the perineum during her first birth. She was aware that [Ms A] was anxious about her perineum.

[Ms D] states that she did check [Ms A's] previous birth notes and that "they indicated a 2nd degree tear secondary to an episiotomy and forceps assisted birth". I am unsure where this information came from as this information is not correct. The notes I have read from [Ms A's] birth in 2005 state that [Ms A] had an unassisted birth with button-hole and subsequent episiotomy repaired in delivery suite.

And in particular, please advise on:

The appropriateness of taking [Ms A] to [the local hospital], when [Ms A] had made it clear she wanted to birth at [the larger hospital].
The reason for seeing [Ms A] at [the local hospital] was to ascertain how far advanced the labour was by vaginal examination. This was part of the documented birth plan. [Ms A] had a rapid first stage of labour with her first baby once the labour established (2 hours 45 minutes) There was a real risk that this labour could progress quickly and the baby be born in the car during the two hour trip to [hospital].

This was appropriate care.

The appropriateness of asking [Ms A] at [the local hospital] to advise again where she wanted to birth.
[Ms D] was concerned that the labour may progress quickly and that there was a risk of the baby being born in the car during the two hour trip to the hospital. [Ms D] completed the vaginal examination, advised the family of the information she had gained about the stage of labour and gave them time to decide if they wanted to travel. Vaginal examinations tell us how dilated the cervix is at that point in time, but not how long it will take for the cervix to become fully dilated. There was still a risk that the labour may progress quickly. The family needed to make the decision to

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transfer with the knowledge that there was a risk of the baby being born en route. The alternative option was to stay and birth at [the local hospital].

I believe it was appropriate for [Ms D] to again ask [Ms A] where she wanted to birth.

The appropriateness of [Ms D's] explanation for falling behind on the journey to [the hospital].
I have no reason to doubt [Ms D's] explanation. Midwives often drink a lot of water prior to a birth and this results in them needing comfort stops.

Whether [Ms D] should have alerted the obstetrician to [Ms A's] presence in the maternity ward earlier, and advised him about her previous tear.
[Ms D] understood that [Ms A's] previous perineal trauma was not complicated and made her decisions accordingly. [Ms D] was aware that [Ms A] was anxious about tearing again. It is not usual practise to inform an obstetrician about a woman's admission to the labour ward unless there are pre-existing risk factors or complications expected. [Ms D] was not aware of a reason to notify the obstetrician of [Ms A's] admission to the hospital.

This was an appropriate standard of care.

The appropriateness of [Ms D's] management and decision-making during the latter stages of [Ms A's] labour.
[Ms A's] labour had progressed normally up until the baby's head was beginning to stretch the perineum. At that point the presenting part stopped advancing. [Ms D] recognised a variation from normal, called for assistance, and re-positioned [Ms A] so that [Ms D] had a better view of the perineum.

This is appropriate management.

[Ms D] made a decision that an episiotomy was required and prepared for and performed this intervention in a timely manner. At this point in the labour the only intervention possible is an episiotomy. It is too late to consider a caesarean section. It is difficult to assess how big to make an episiotomy but [Ms D] realised that she needed to extend the incision but did not get time to do it before [Ms A] pushed the baby out.

I believe [Ms D's] management and decision-making during the latter stages of the labour was appropriate.

Should [Ms D] have requested assistance at an earlier stage in [Ms A's] labour?
[Ms D] called for assistance when she identified a variation from normal. There was no indication before this time that there were any problems. The labour was progressing normally.

This is appropriate care.

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The appropriateness of [Ms D's] actions immediately after the birth, including her failure to tend to [Ms A] and the baby, failing to cut the umbilical cord, and discussing the tear in detail at the midwives station within earshot of Mr A.
Following the birth of the baby [Ms D] was feeling unwell with a sinus tachycardia which made her feel faint. The baby was born in good condition and placed on [Ms A's] abdomen. [Ms D] states she then asked the DHB midwife to stay with the family while she left the room so that they were not left alone.

There are two ways of managing the third stage of labour (birth of the placenta). Active management of the third stage of labour involves the woman being given an injection of an oxytocic drug such as Syntocinon or Syntometrine soon after the birth of the baby, followed by clamping and cutting of the cord and delivery of the placenta by controlled cord traction. Physiological management involves leaving the cord attached to the baby, and waiting until the cord stops pulsating and there are signs that the placenta has separated such as a gush of blood and lengthening of the cord. The mother then pushes the placenta out. The cord is not cut until the cord has stopped pulsing and often not until after the placenta is delivered. [Ms D] states that it is "normal practice" to leave the cord attached so that the baby "can benefit from his stem cells". There is now good evidence which suggests it may be advantageous to leave the cord attached for at least 3-4 minutes following the birth before administering an oxytocic drug (if actively managing the third stage). This reduces the risk of anaemia in the baby in the first six months of life. Leaving the cord uncut would not cause any additional perineal trauma to [Ms A]. It was appropriate care to leave the cord attached. However, a practitioner needed to be watching for problems with the third stage such as haemorrhaging.

[Mr A] and [Mrs B] advise that their recollections are that [Ms A] and her baby were left alone in the room immediately following the birth and before the delivery of the placenta and that there was not a midwife or nurse present. [Mrs B] in particular says she has a very clear memory of the events around the birth. [The DHB] has investigated and has been unable to identify a midwife that was in the room for the birth and after [Ms D] left it. Midwife [Ms E] advised that she had answered a call bell and assisted [Ms D] to prepare for and cut an episiotomy and left the room just before the baby was born to contact the obstetrician as she had been asked to do by [Ms D].

In this scenario [Ms D] did not provide an adequate standard of care. Midwifery professional standard six states "Midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk.

Following a birth a midwife needs to be watching expectantly for third stage complications e.g. postpartum haemorrhage and that the baby is breathing, warm and generally adjusting to extra uterine life. The third stage of labour was being managed physiologically at this point. [Ms D] was aware of the major perineal damage that had occurred during the birth. There was an increased risk of a larger than normal blood loss from the perineal damage. [Mr A] advises that when he left [Ms A] to find [Ms D] there were several midwives in the midwives' station having a coffee break. [Ms D] could have requested that one of these midwives attend [Ms A] until [Ms D] felt able to return to provide care.

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[Ms D] did not provide [Ms A] and her baby an adequate standard of care following the birth. Peers would view it with moderate to serious disapproval.

[Ms D] has advised HDC that this was the first time her medical condition (SVT) had "been an issue in a clinical setting". However, [Ms D] has also stated (in her "Learning following Special Midwifery Standard Review 1 July 2010") that "this is the 10th year I have been practicing as a midwife and have experienced SVT within the context of work only 4 or 5 times and believe I am able to self-manage it well".

Has your initial advice in relation to the adequacy of [Ms D's] communication with staff/clients about her medical condition, changed in any way in light of this comment?
[Ms D] should have previously understood that there was a risk that she could suffer an episode of SVT during a labour and birth and that she may require assistance to provide care in such an instance. I would expect that she would have already advised her midwifery colleagues in her practice and at the various hospitals that she has access to, of her condition and made a plan with them for assistance to be provided when requested. Failure to do so would be viewed by peers with moderate to serious disapproval."

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Appendix B – Discharge summary

FACILITY DISCHARGE (Mother)

Discharge Report Date: * Delivery Place: Admission Date: * 23:59

WOMAN'S DETAILS
Family Name: *
Given Names: *
Address: *
Phone Home: * Mobile:

NEXT OF KIN
Name: Ph Home: Ph Work:
Address: Mobile:

LABOUR DETAILS
Anaesthesia: Epidural
Pharmacological Pain Management:
Complementary Practices:
Labour Care By: *
2nd Midwife:
Highest BP: 140 66 Highest Temp: 38.0

Membranes Ruptured * 13:3[illegible] 15:23
Labour Est * 20:[illegible]
Full Dilatation * 22:45 02:45
Third Stage * 23:57 00:04
Labour Notes: Induction indication: Post Dates

Birth(s)	On		Delivered By
Vaginal (Normal)	*	23:53	*

THIRD STAGE
Ecbolic: BP 118 74
Temp 37.0
Placenta: Blood Loss Measured 0
Episiotomy: Estimated 350
Perineal Trauma:
Sutured With: Total 350
Sutured By:

OUTPATIENT APPOINTMENTS

DISCHARGE CHECK
BP: / Temp:
Pulse: Hb:
Fundus: - Bowels: -
Breasts: - Legs: -
Nipples: - Lochia: -
Bladder: - Perineum: -
CS Scar: -
Complications:

DISCHARGE DETAILS
Date / Time: * 12:00 Discharged To: Discharge Type:
Discharged By: Days in Hospital 1 days
Discharge Notes:

Signature of discharge ____________________

* Information removed

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