Staff Nurse/Midwife, Midwife, Crown Health Enterprise

Report on Opinion - Case 97HDC7813

Complaint The Commissioner received a complaint from a consumer which, along with surrounding facts, is as follows:

- *In the early hours of a day in mid-November 1996 the consumer, who was 22 weeks, five days pregnant with twins, awoke with slight bleeding and cramping. She was admitted to hospital, assessed as not being in labour and transferred to a ward.*
- *The staff nurse/midwife attended the consumer from around 3pm on that day. Although aware that the consumer was in pain, the staff nurse/midwife did not realise that the consumer was in labour.*
- *At 6:37pm and 6:55pm respectively the consumer delivered twins who did not survive. Both the staff nurse/midwife and another midwife assisted with the delivery.*
- *The consumer is concerned that the staff nurse/midwife failed to diagnose her as being in labour. As a consequence, there was no chance to revisit treatment options and the consumer delivered her twins in the ward rather than in a specially equipped delivery room.*
- *The consumer is also concerned about a comment the staff nurse/midwife made after the delivery when referring to the pain the consumer had experienced. The consumer alleges that the staff nurse/midwife described the pain as being awful and said "I would never have a baby."*
- *Following the delivery, the consumer was transferred back to the Pre Labour Unit ("PLU"). The second midwife and the staff nurse/midwife accompanied her. The second midwife subsequently advised the consumer that the twins were transferred to the PLU with the consumer. The consumer later learned that the twins were not transferred with her but were left in the ward for a time before they were taken to the PLU. The consumer says the second midwife lied about this issue and was supported in the lie by the staff nurse/midwife in an effort to cover up negligence.*

Staff Nurse/Midwife, Midwife, Crown Health Enterprise

Report on Opinion - Case 97HDC7813, continued

Investigation

The Commissioner received the complaint on 6 August 1997 and an investigation was undertaken. Information was obtained from:

The Consumer
The Staff Nurse/Midwife
The second Midwife
A Trainee Intern
The Clinical Director-Midwifery, Hospital

The consumer's clinical records and documentation relating to her admission to, and subsequent complaints about, the hospital were obtained and reviewed. The Commissioner obtained independent advice from a midwife.

Information Gathered During Investigation

Admission to hospital

In the early hours of a day in mid-November 1996 the consumer, who was 22 weeks, five days pregnant with twins, awoke with slight bleeding and abdominal cramping. She was admitted to the Pre Labour Unit at the hospital and attended by her obstetrician and a midwife.

Later in the morning an ultrasound was performed and the consumer was examined by members of the Blue Team. At this time the consumer was not aware of cramping. The consumer stated that she was advised that:

> "*It was not possible to judge whether she would go into labour, but there was a risk that she would.*
>
> *The consumer would not be given tocolytic medications as the pregnancy was at less than 24 weeks gestation.*"

The consumer would remain under the care of the Blue Team, rather than her obstetrician, until she reached 36 weeks gestation. She requested that if she did progress into labour she be referred back to the obstetrician for the delivery. She was told that it might be possible to negotiate this at the time.

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Report on Opinion - Case 97HDC7813, continued

Information Gathered During Investigation, *continued*

A note in the clinical record written at around 10.25am states, *"Not in labour currently…"*

Transfer to ward

At around 11.30am the consumer was transferred to a ward under the care of the Blue Team, as it was thought that she was not in labour. The consumer advised the Commissioner that cramping recommenced shortly before 2pm and increased during the afternoon.

The staff nurse/midwife came on duty on the ward at 2:30pm. She was allocated the consumer, along with four other patients, to look after. The staff nurse/midwife was in her fourth week on the ward. Her midwifery experience over the preceding 10 years was in postnatal care and she was unfamiliar with nursing a patient 22 weeks into her pregnancy.

The staff nurse/midwife first saw the consumer between 3:00pm and 3:30pm. At this time she became aware that the consumer was anxious and in pain. The staff nurse/midwife considered that the consumer's anxiety was related to the recent death of her step-father and the possibility of losing her twins. In addition, the staff nurse/midwife advised the Commissioner that the consumer described her pain as being constant and that contractions usually cause intermittent pain. However, the consumer advised that she was upset because she was in pain, scared and depressed at the thought of losing her babies.

The staff nurse/midwife asked to palpate the consumer's abdomen but the consumer declined to let her. The staff nurse/midwife advised the Commissioner that she subsequently spoke to a senior registrar about the consumer's condition. The registrar had seen the consumer earlier and decided that he did not need to see her again at that point. There is no record of this conversation in the consumer's medical notes.

As the afternoon progressed the consumer's agitation increased. She was given one Panadol tablet at 3:35pm by another midwife on the ward and a further tablet at 5:00pm by the staff nurse/midwife.

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Staff Nurse/Midwife, Midwife, Crown Health Enterprise

Report on Opinion - Case 97HDC7813, continued

Information Gathered During Investigation, *continued*

The consumer advised the Commissioner that she suggested that someone should check to see if she was dilating but that the staff nurse/midwife decided this was not necessary. The staff nurse/midwife denies that the consumer made this suggestion to her.

Some time after 4:00pm the staff nurse/midwife asked a trainee intern to see the consumer. The intern attended the consumer and recorded that she was contracting once every 10 minutes with contractions lasting for 30-40 seconds. The staff nurse/midwife was not present when the intern examined the consumer and it is unclear whether the intern advised the staff nurse/midwife of the results of her examination. The staff nurse/midwife says that she did not and that she did not see the intern's notes until after the delivery. A record of a meeting held in late January 1997 states:

> *"[Trainee intern] not expected to manage care. Confirmed that information was passed on."*

The (then) trainee intern now has no memory of the consumer, her case or of speaking with the staff nurse/midwife. She advised the Commissioner that when she was a trainee intern she would report any findings to the house surgeon. The intern advised that she would not generally pass information on to a midwife.

At around 5.30pm the consumer's husband arrived on the ward. He was concerned about his wife's condition and telephoned the obstetrician. The consumer's husband then asked for the house surgeon to attend the consumer. The house surgeon saw the consumer at around 6pm and noted that she was anxious and was having *"…?labour like pains…"*.

The staff nurse/midwife then called the second midwife to assist and the consumer's husband telephoned the obstetrician and asked for the registrar to be called. The registrar arrived on the ward around 6:20pm. He performed a vaginal examination and discovered that the consumer was fully dilated.

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Staff Nurse/Midwife, Midwife, Crown Health Enterprise

Report on Opinion - Case 97HDC7813, continued

Information Gathered During Investigation, *continued*

Delivery of twins

The staff attending the consumer felt that there was insufficient time to transfer her to the PLU. The second midwife asked the other patient sharing the consumer's room to move and at 6:37pm and 6:55pm respectively the consumer delivered twins who did not survive. The twins were named.

The consumer advised the Commissioner that at the time of the delivery there was an atmosphere of panic among the medical and nursing staff present. The second midwife denied this but admitted that the delivery was an "*emergency situation*" and that it occurred very quickly. The staff nurse/midwife also said that there was "*no panic, we were merely moving quickly as the delivery was imminent.*"

Transfer of twins

Before delivery of the placenta the consumer was transferred to the PLU. Prior to the transfer the second midwife and the staff nurse/midwife had agreed that the babies would be transported at the foot of the consumers' bed, beneath the covers. The second midwife advised the Commissioner that prior to the transfer to the PLU she left the room to take the delivery equipment to the sluice room.

Both the second midwife and the staff nurse/midwife then accompanied the consumer to the PLU. The second midwife advised the Commissioner that she assumed the babies were under the bedcovers as discussed. Upon arrival at the unit, the second midwife went to the office to complete paper work relating to the delivery. The second midwife advised the Commissioner that she was not present when the consumer was transferred into the PLU bed, however the consumer thought that she was.

The second midwife advised the Commissioner that when she returned to the consumer's bedside the babies were in their kidney dish at the foot of her bed. However, they had not been transferred with the consumer but had been left *"in a guard cloth in a bowl in the room"* where they had been delivered. The staff nurse/midwife advised the Commissioner that *"on arrival in PLU I immediately went back to get them"*.

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Staff Nurse/Midwife, Midwife, Crown Health Enterprise

Report on Opinion - Case 97HDC7813, continued

Information Gathered During Investigation, *continued*

Comments by the staff nurse/midwife

The consumer advised the Commissioner that after the delivery the staff nurse/midwife said, when referring to the pain the consumer had been experiencing, that *"it was an awful pain"* and *"I would never have a baby"*. The staff nurse/midwife denies saying this and advised the Commissioner:

> *"I said to* [the consumer] *that I was sorry that I had not known she was in labour."*

A meeting was held in late January 1997 to discuss matters surrounding the consumer's labour and delivery. In attendance were the consumer and her husband, the manager for maternity services, the clinical director of midwifery at the hospital, a consultant in obstetrics and gynaecology (the "consultant") and the complaints co-ordinator for the Crown Health Enterprise. In relation to the alleged comments made by the staff nurse/midwife, minutes of the meeting recorded:

> *"Issue addressed with* [staff nurse/midwife]. *Acknowledged inappropriateness of comments.*"

A letter dated early July 1997 from the general manager of the hospital to the consumer states:

> *"*[Midwife] *has spent considerable time with management addressing this matter* [babies being left in the ward] *as well as her comment to you after the births. She is aware of the insensitivity of her remark and has since received coaching to ensure that this type of conduct would not happen again."*

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Staff Nurse/Midwife, Midwife, Crown Health Enterprise

Report on Opinion - Case 97HDC7813, continued

Information Gathered During Investigation, *continued*

In a letter dated early December 1998, the manager for maternity services advised the Commissioner that she, along with the service manager, were involved in coaching the staff nurse/midwife and that, while she denied having said to the consumer that she would never have a baby because the pain was too great, she stated:

> *"... we used the opportunity to reinforce a strong message about communication. We reiterated with* [the staff nurse/midwife] *the importance of clarity and sensitivity in communication with birthing women...* [The staff nurse/midwife] *has been coached on this issue and acknowledges the inappropriateness of this type of remark... The reference in* [the General Manager's] *letter stems from a meeting held with [the consumer] and her husband, where it was acknowledged that these remarks were inappropriate.* [The General Manager's] *comment in his letter was based on that record of the meeting, and was not reviewed by* [the staff nurse/midwife]. *As stated,* [the staff nurse/midwife] *does not accept that she said these words."*

Investigation into transfer

After being discharged, the consumer asked the general manager of maternity services at the hospital to investigate how the babies were transferred. The second midwife, the senior midwife present at the delivery, initially advised that they were transferred with the consumer at the foot of her bed under the bedclothes.

Some time later the second midwife received a phone call from the consumer in which the consumer asked how the babies had been transferred. The second midwife informed her that the babies were transferred in her bed. The consumer told the second midwife that she had been in contact with her room mate who had said that for a time the babies had been left on their own in the room where they were delivered. The second midwife advised the Commissioner that she then contacted the staff nurse/midwife about the transfer and discovered that the babies had not been transferred with the consumer as she had thought.

The manager of maternity services at the hospital subsequently wrote to the consumer admitting that the babies had been left and apologising for the incident. She advised the consumer that during the time they spent in the ward the twins were covered and were not visible to others.

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Staff Nurse/Midwife, Midwife, Crown Health Enterprise

Report on Opinion - Case 97HDC7813, continued

Information Gathered During Investigation, *continued*

Supervision of the staff nurse/midwife

As previously stated, the staff nurse/midwife had recently transferred to the ward and her experience over the preceding 10 years had been in a postnatal ward. The Commissioner was advised that for many years the staff nurse/midwife had been a charge midwife. However, the ward she was working on closed and the staff nurse/midwife chose to transfer to the ward. The staff nurse/midwife was not directly supervised on the ward but had been allocated a "buddy" who was available to support and to assist her. She was assigned the consumer to look after *"as she had been medically assessed at the time as at little risk of going into labour."*

The clinical director of midwifery advised that at the time of the consumer's stay, the hospital was instituting a new clinical training scheme to ensure that all midwifery staff were able to practice in all areas of maternity care rather than in postnatal or antenatal care only. The staff nurse/midwife's up-skilling programme was planned to commence shortly after the incident involving the consumer. The clinical director of midwifery described the staff nurse/midwife as a *"highly regarded and competent practitioner"*.

Sympathy letter

In early December 1996 the hospital sent a letter to the consumer stating:

> *"We were very sad to hear about the recent loss of your baby and extend our deepest sympathy.*
>
> *This letter is to invite you to return to* [the] *Medical Clinic to see one of our Specialists* […]*, to discuss what happened to your baby and what this may mean for the future. We normally offer such an appointment to families of babies who have died so their questions can be answered and any events surrounding the baby's death which may be causing concern can be discussed…"*

The letter set an appointment time in mid-January 1997.

Staff Nurse/Midwife, Midwife, Crown Health Enterprise

Report on Opinion - Case 97HDC7813, continued

Midwifery Advice

The Commissioner obtained advice from an independent midwife in relation to whether the staff nurse/midwife should have realised the consumer was in labour prior to her being seen by the registrar and, if so, what actions she should have taken.

The Commissioner was advised that had the staff nurse/midwife been more experienced in the care of a woman in premature labour she may have diagnosed the onset of labour sooner. The midwife advised that the staff nurse/midwife should have consulted a senior midwife or registrar earlier and that if she had been more experienced she would "*almost certainly*" have insisted on palpating the consumer's abdomen. However, the midwife advised that an earlier diagnosis of the onset of labour would have made "*little difference*" to the outcome in the consumer's case.

In a letter dated early December 1997 from the consultant to the consumer's own doctor he says:

> *"…had labour been diagnosed earlier there would have been no change in the ultimate outcome for their babies…".*

The Commissioner's expert advised that, in her experience, labour pain was not usually constant. Given that the consumer was in pain, however, the midwife advised that the staff nurse/midwife should "*probably have arranged for a medical assessment*".

Staff Nurse/Midwife, Midwife, Crown Health Enterprise

Report on Opinion - Case 97HDC7813, continued

Code of Health and Disability Services Consumers' Rights

RIGHT 4
Right to Services of an Appropriate Standard

...

2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

3) Every consumer has the right to have services provided in a manner consistent with his or her needs.

...

RIGHT 10
Right to Complain

...

3) Every provider must facilitate the fair, simple, speedy, and efficient resolution of complaints.

...

Opinion: No Breach - Second Midwife

In my opinion the second midwife did not breach Right 4(2) and Right 4(3) of the Code of Health and Disability Services Consumers' Rights. In my opinion she made a genuine mistake in advising that the consumer's babies were transferred to the PLU with the consumer. This was what had been arranged. The second midwife advised the Commissioner that she was not in the room in the ward for the entire period prior to the consumer's transfer and she was not in the room at the PLU when the consumer was transferred into the PLU bed. It was therefore reasonable for her to assume that the babies had been transferred by the staff nurse/midwife as arranged.

Staff Nurse/Midwife, Midwife, Crown Health Enterprise

Report on Opinion - Case 97HDC7813, continued

Opinion: No Breach - Staff Nurse/ Midwife

The staff nurse/midwife is adamant that she did not make the comment alleged to have been made about labour pain and not wanting a baby herself for this reason. The consumer is equally adamant that she did make the comment.

The minutes of the meeting held in late January 1997 and the general manager's letter of July 1997 indicate that the comments were made. However, as the staff nurse/midwife was neither at the meeting nor consulted in relation to the record of the meeting, the minutes are hearsay. Therefore, neither the minutes nor the general manager's letter assist me to resolve the difference between the consumer's and the staff nurse/midwife's accounts.

I have not found sufficient evidence of a breach of the Code of Rights in relation to the alleged comments.

Opinion: Breach - Staff Nurse/ Midwife

In my opinion the staff nurse/midwife breached Right 4(2) of the Code of Rights in relation to her non-diagnosis of the consumer's labour. The consumer advised the staff nurse/midwife at 3.30pm that she was in pain and this should have alerted her to the possibility of labour. Whether the pain was described as intermittent or continuous, it warranted further investigation.

The consumer was almost certainly in labour between 3.30pm and 6:00pm when seen by the house surgeon. The staff nurse/midwife should have either diagnosed labour earlier or at least further investigated the possibility of labour. If the staff nurse/midwife was not present when the trainee intern assessed the consumer, she should have taken steps to find out the results of her assessment.

In my opinion, the ultimate outcome of the premature birth and death of the consumer's babies was not affected by the staff nurse/midwife's care of the consumer. However, had labour been diagnosed earlier the consumer would have been better prepared for the delivery which may have occurred in a more controlled environment. I note that while the staff nurse/midwife had not recently undertaken any antenatal education, she was a charge nurse and a registered midwife and therefore should have undertaken basic antenatal examination.

Staff Nurse/Midwife, Midwife, Crown Health Enterprise

Report on Opinion - Case 97HDC7813, continued

Opinion: Breach - Crown Health Enterprise

In my opinion the Crown Health Enterprise breached Right 4(3) and Right 10(3) of the Code as follows:

Right 4(3)

The staff nurse/midwife was inexperienced in nursing women antenatally but was working on a ward where there were antenatal patients and was allocated the consumer to look after. The Crown Health Enterprise bears significant responsibility for the fact that the staff nurse/midwife was working on a ward with antenatal patients when her experience had been caring for patients postnatally. The Crown Health Enterprise should have ensured that the staff nurse/midwife undertook the planned upskilling programme prior to working on the ward with antenatal patients.

I note that the clinical director of midwifery has advised that all midwives at the hospital have now been through a clinical up-skilling process. I have not found evidence of a systems problem at the hospital likely to lead to a recurrence of the situation experienced by the consumer. The evidence is unclear as to why the staff nurse/midwife was not aware of the trainee intern's assessment of the consumer. I suggest, however, that the Crown Health Enterprise ensures that it has appropriate systems in place to facilitate the hand-over of information by medical staff.

In my opinion the Crown Health Enterprise compounded its process errors by sending the consumer a sympathy letter which was not tailored to her individual situation. In this regard, the Crown Health Enterprise also failed to provide a service which met the consumer's needs.

Right 10(3)

In my opinion, by not efficiently and fairly resolving the consumer's complaint, the Crown Health Enterprise's actions were in breach of Right 10(3). The Crown Health Enterprise should have spoken to both the staff nurse/midwife and the second midwife before responding to the consumer's complaint.

Staff Nurse/Midwife, Midwife, Crown Health Enterprise

Report on Opinion - Case 97HDC7813, continued

Future Actions: Staff Nurse/ Midwife

I recommend that the staff nurse/midwife apologises in writing to the consumer for her breach of the Code of Rights. This apology should be sent to the Commissioner, who will forward it to the consumer. The staff nurse/midwife should ensure she keeps up to date with midwifery education to ensure she is able to provide services of an appropriate standard.

Future Actions: Crown Health Enterprise

I recommend that the Crown Health Enterprise takes the following actions:

- Apologises in writing to the consumer for its breach of the Code of Rights. This apology should be sent to the Commissioner, who will forward it to the consumer.
- Revises its policy on handling complaints to ensure responses include the views of individuals who are the subject of any complaint.
- Ensures staff are competent prior to placing them on duty.
- Reiterates to staff the need to look carefully at all standard correspondence to ensure the individual's needs are recognised.

Other Actions

A copy of this opinion will be sent to the Nursing Council and the College of Midwives.