Midwife, Ms C

Obstetrician, Dr D

A Public Hospital

A Report by the

Health and Disability Commissioner

(Case 00HDC01016)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mr A	Complainant / Consumer's husband
Mrs B	Consumer
Ms C	Provider / Midwife
Dr D	Provider / Obstetrician
Dr E	Obstetrician
Dr F	Obstetrician
Ms G	Service Manager at the public hospital
Ms H	Midwife
Ms I	Midwife
Ms J	Midwife
Dr K	Anaesthetist

Complaint

On 4 January 2000 the Commissioner received a complaint from Mr A and Mrs B about the services provided to Mrs B during her pregnancy and delivery of their tenth child by Ms C, midwife, and Dr D, obstetrician. The complaint was that:

Ms C

- *During Mrs B's pregnancy she understood that she was to visit an obstetrician at a public hospital for an antenatal examination. Ms C, midwife, discouraged Mrs B from seeing the obstetrician because she would not get the obstetrician she wanted and he would probably talk Mrs B into using a hospital midwife. Instead Ms C assured her that if there were any problems with the baby's position Ms C would call the obstetrician as had been done with previous pregnancies.*
- *On 10 June 1999 Mrs B began having contractions but after an hour and a half the contractions stopped. Mrs B asked Ms C about the possibility of having an elective Caesarean section. Ms C told Mrs B that the obstetrician would probably not perform a Caesarean section because she was ten days premature. Ms C did not provide any information on Mrs B's other treatment options or contact the obstetrician to allay Mrs B's concerns.*
- *Ms C recorded Mrs B's baby had an unstable lie and would require careful observation but did not have an obstetrician or anaesthetist available when Mrs B went into labour.*
- *On 14 June 1999 Mrs B was in strong and painful labour. Ms C performed a vaginal examination and told Mrs B that she was not dilated and the baby's head was high. Mrs B doubts these findings. Mrs B was in more pain with this labour than with any of her other pregnancies.*
- *About one hour later Mrs B went to the Maternity Ward of the hospital. It had been arranged that Mrs B would have an epidural as soon as she was in strong labour. Ms*

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C had the epidural equipment ready but left Mrs B for an unacceptably long time while she found an obstetrician.

- *Mrs B has had nine other pregnancies, six of them without pain relief, and Ms C documented that this baby's position was oblique. Ms C did not take any notice when Mrs B told her the pain was extreme.*
- *Ms C tried to attach a scalp electrode to monitor the baby's heart rate but the machine did not have any paper or electrode gel. The machine could not be used immediately and further delayed assessing the baby's heart rate and detection that the heart rate had stopped.*
- *When Mrs B's membranes ruptured the liquor was meconium stained. Ms C called another obstetrician, Dr E, but did not emphasise to him that this was an emergency. As a result of these delays Mr A and Mrs B's baby daughter was stillborn.*

Dr D

- *On 14 June 1999 Ms C, midwife, called Dr D, obstetrician, to see Mrs B, who was in labour. When Dr D arrived he was angry because he had not examined Mrs B during the antenatal period. Dr D's anger at Ms C prevented him from treating Mrs B appropriately. He noted the abnormal position of her baby but left the delivery suite, refusing to treat Mrs B until the epidural was administered.*
- *Mrs B was in such severe pain that she was unable to lie down for an internal examination. Dr D went to perform a vaginal examination. He did not ensure that Mrs B had adequate pain control before attempting this.*
- *Dr D recorded in Mrs B's notes that her cervix was 4–5cm dilated and membranes bulging but he did not perform a vaginal examination.*

An investigation was commenced on 15 March 2000.

Information reviewed

- Mrs B's antenatal records from Ms C and maternity records from the public hospital.
- Policy documents: *Midwives and Medical Practitioners Practising within [the hospital's] Obstetric Services*, *Guidelines for Practitioner for Consultation with an Obstetric Specialist,* and *Policy for Midwives and Medical Practitioner Practising within [the hospital's] Obstetric Service.*
- Transitional Health Authority Project Team: *Guidelines for Referral to Obstetric and Related Specialists Medical Services.*
- New Zealand College of Midwives: *Philosophy, Code of Ethics and Standards of Practice*.
- Royal Australian and New Zealand College of Anaesthetists: *Guidelines for the Conduct of Major Regional Analgesia in Obstetrics*.

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- Expert advice from an independent obstetrician, Dr Jenny Westgate, and independent midwives Mrs Joyce Cowan and Ms Ann Yates.

Glossary of terms

Lie	relationship of the long axis of the baby to that of the mother
Unstable lie	changes frequently from longitudinal to oblique to transverse
Presentation	position of the baby in the uterus
Presenting part	part of the baby closest to the cervix
Cephalic presentation	head first
Vertex presentation	head is flexed so smallest diameter of baby's head is at cervix
Malpresentation	baby is lying longitudinally but presenting part is not the vertex (e.g, breach, shoulder)
Position	the way the baby is facing: • anterior (most common); back of the head is touching the abdominal wall • posterior position (less common); back of the baby's head is against the spine (most posterior babies turn around to an interior position during labour) • persistent posterior position; baby does not turn and is born with its face to the mother's pubes (often known as face to pubes)
Keilland's rotation	type of forceps delivery in which baby's head is turned (from posterior to anterior position) before being pulled out
Epidural	injection of anaesthetic through an indwelling catheter into the epidural space in the spine

Information gathered during investigation

Ms C has been a registered midwife for 27 years. She became an independent midwife in 1990 and has delivered 466 babies as a Lead Maternity Carer (LMC). She is not currently in practice. Dr D, obstetrician and gynaecologist, commenced medical practice in 1983.

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Background

This case relates to the pregnancy and birth of Mrs B and Mr A's tenth child (ninth pregnancy). Mrs B's preceding five babies were born at the public hospital. Ms C knew Mr A and Mrs B well as she had been the midwife for three of Mrs B's pregnancies and had also attended the birth of some of their other children. Ms C was Mrs B's LMC for this pregnancy and delivery.

The history of Mrs B's previous two pregnancies is relevant and will be included in brief.

1994 pregnancy
Mrs B became pregnant with her eighth child at the end of 1993 and Ms C was the LMC. Mrs B remained well during the pregnancy. On 7 April 1994 Ms C found the baby in an unstable lie and referred her for specialist assessment to Dr F, obstetrician. On 12 April 1994 Dr F referred Mrs B back to Ms C to continue her antenatal care. He advised Ms C:

> "As far as ongoing management of the pregnancy is concerned, continue the routine antenatal visits ensuring that she has a stable lie. I have advised her [Mrs B] that when labour starts she should have you examine her properly to ensure the head is in the pelvis. If not, she will need an urgent Caesarean section."

When Mrs B went into labour the baby reverted to a cephalic presentation. Ms C advised me that the delivery was normal. However, the baby presented in a persistent posterior position, requiring an assisted forceps delivery.

1995 pregnancy
During Mrs B's 1995 pregnancy Ms C was the LMC. Ms C referred Mrs B to Dr F because the baby was again in an abnormal lie. When Dr F examined her on 22 August 1995, he found the baby lying transverse, and referred Mrs B back to Ms C. Dr F advised Ms C:

> "I have advised her [Mrs B] regarding the dangers of the unstable lie. That should she start in labour she must proceed to Delivery Suite rapidly so that the lie can be checked. I would suggest that, if at 39 weeks gestation she still has an unstable lie, the safest method of delivery would be by Caesarean section. I would be grateful if you would refer her back to me if the unstable lie persists."

Mrs B went into labour and the baby reverted to a cephalic presentation with persistent posterior position (as in the 1994 delivery). This baby was delivered by rotation with Kielland's forceps. Dr F advised me that with each pregnancy a woman's uterus works less efficiently because of the loss of muscle tone. This means that any future pregnancy is likely to present in the same way.

Present pregnancy

Mrs B was 41 years old when she became pregnant with her tenth child in December 1998. Ms C was the LMC. Because of Ms C's long association with Mrs B she was unable to

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recall the information she gave Mrs B for this pregnancy. She first saw Mrs B on 28 December 1998. Mrs B's pregnancy progressed normally.

In April 1999 Ms C referred Mrs B for an ultrasound scan. In the past Mrs B had been reluctant to have a scan or genetic tests. Ms C recorded in the antenatal notes that Mrs B's reluctance was due to the fact that, if the scan or tests revealed an abnormality with the developing foetus, she would not have the pregnancy terminated. Mrs B said that she did not object to having the scan but it seemed to her that Ms C thought it was unnecessary. Mrs B could not remember whether Ms C told her about the risks and benefits of a scan. Mrs B had the scan on 9 June after Ms C referred her a second time. The scan showed the baby lying across the abdomen in the transverse position.

Services for high risk mothers at the public hospital

Ms G, Manager of Maternal and Children's Health at the hospital, advised me that the hospital's Maternity Services was a facility for independent midwives. At the time of these events the hospital had a number of policy documents and access agreements as a means of setting the standard for maternity services and improving communication between LMCs and secondary services. One document, *Specialist Obstetric Consultation and Management Service* ('the Policy'), was based on the Transitional Health Authority ('the THA') guidelines for referral to secondary services and applied to LMCs seeking consultation with an obstetrician for mothers at risk. The Policy states:

> "The [hospital] has no single access point for pregnant women requiring referral to Secondary Obstetric Consultation. Potential difficulty and inconsistency of access increases the risk of adverse outcomes for both women and babies. … Our objective is to provide a secondary obstetric service which integrates with existing primary care services in the [hospital] and, as such, provides a clearly defined and communicated path for referral and treatment of 'at risk' pregnant women as defined in the C.R.H.A. [Central Regional Health Authority] referral criteria."

The Policy states that the first level of service is provision of assessment of 'at risk' women by a consultant obstetrician with the provision of written advice back to the lead maternity carer, and continues:

> "Women shall be transferred to the care of [the hospital's] lead maternity care secondary team in the event that their condition is assessed by the consultant obstetrician to fall within the transfer of care guidelines. The guidelines are based on the recommendation of the Transitional Health Authority Maternity and Management Team July 1997 for category 3 cases. [According to the criteria Mrs B was category 2 risk and she would have been referred back to the LMC.]"

The hospital's policy on management of labour lists the guidelines for practitioners for consultation with an obstetric specialist. The guidelines are to be read in conjunction with the hospital's obstetric standards for midwifery and obstetric practice for practitioners with a contract to use the facilities. The Policy states that the practitioner should consult a

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specialist about women with factors associated with the possibility of a complicated or abnormal outcome.

The Policy provided guidelines for LMCs referring patients for antenatal obstetric consultations and for the management of women in labour, during delivery and following delivery. The guidelines defined as "high risk" women who came within specific categories. The categories applicable to Mrs B were: a maternal age of over 40 years; a fifth or more pregnancy; a baby lying in an abnormal position.

Dr F said that the Royal Australasian College of Obstetricians and Gynaecologists developed the guidelines and that he was instrumental in developing the hospital's policy. He did not consider that the way the hospital implemented the THA guidelines was unreasonable. Dr F advised that the hospital was finding more women coming into hospital without antenatal assessment by an obstetrician, and that an obstetrician was called only once complications arose. The policy was developed over many years and was an attempt to keep secondary services involved in overall care.

Two midwives, Ms H and Ms I, provided Ms C with support during this investigation. Ms H and Ms I advised me that, in their opinion, the way the hospital implemented the THA guidelines presented problems because a conflict arose between the woman's right to select her carer and the hospital's requirement that a referral be made to a hospital obstetrician. At other hospitals (for example, … Hospital) the LMC and secondary service team complement each other, working together when it is found that a woman is in need of secondary care. At the hospital the LMC can no longer provide services once she has referred her patient to the secondary care clinic, even if it is the woman's choice to remain with the LMC. The decision to transfer care to the hospital is made by the obstetrician. However, according to the hospital policy this is to occur only with women assessed as category III risk.

The hospital advised me that this is incorrect. Ms G said that the guidelines for referral (consultation) and practice are clear. When the LMC refers a woman to the secondary care clinic there is an assessment by the obstetrician and he/she provides an opinion. There is no transfer of care unless there is an agreement to do so between the woman and the LMC. The hospital acknowledged that the referral system to a specialist obstetrician changed in February 1999 from private to public. Ms C acknowledged that she has referred patients to the secondary care clinic in the past and, following assessment, they have been referred back to her. Ms G said that when the hospital reviewed its secondary services it did so in consultation with independent midwives who used its services. The policy allows the client, LMC and specialist, an opportunity to discuss individual needs and work towards agreed outcomes.

The hospital introduced the Special Obstetric Consultation and Management Service clinic in November 1998 (the 'secondary care clinic'). Dr D advised me that the secondary care clinic was for high risk women such as Mrs B. The clinic was well established and available for consultation and advice at the request of the LMC.

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The hospital's access agreement for an LMC lists the LMC's responsibilities. In signing the agreement the LMC agrees to comply with the hospital's policies, standards and guidelines applicable to the practice or management of their patients. Ms C signed the agreement, which was for a term of three years, on 12 January 1997. Ms G said that the role of the LMC was to plan the patient's care, instruct the hospital staff about the needs of the patient, and to arrange antenatal classes if necessary. The hospital would not stop any LMC from using the facility provided that these criteria were met.

Mrs B said Ms C did not tell her that the obstetric team considered her a "high-risk" mother and she did not consider herself to be "high risk". She knew her blood pressure and everything else about this pregnancy was normal except that the baby was lying across her abdomen. Mrs B expected that the baby would move into the correct position when she went into labour, as her other babies had done, and that the delivery would be straightforward.

Ms C also expected this labour and delivery to be the same as Mrs B's previous two. She spoke to Mrs B at her first antenatal visit, on 28 December 1998, about the hospital's recommendation to consult with a specialist at the hospital during the antenatal period, and reminded her again on 12 April 1999. Ms C explained to Mrs B that this was a new system introduced by the hospital since Mrs B had her last baby. Ms C told her about the secondary care clinic, which had been in existence for only two months, and explained the purpose of the clinic.

Mrs B understood that she was to visit the hospital clinic for a check-up by an obstetrician at some stage during her pregnancy but, in her opinion, Ms C discouraged her from attending. Mrs B understood that Ms C consulted another midwife about her case. Mrs B said that Ms C called her to say that the clinic visit was probably unnecessary, as she could not get the obstetrician she wanted and would have to have the one who was on duty. Ms C told her that the obstetrician might want to talk her into using a hospital midwife and take over the delivery of her baby. In light of this information Mrs B said she decided to stay with Ms C as her LMC. She understood that if she had any problems during labour and delivery Ms C would call an obstetrician, as she had done during her previous pregnancies.

Ms C denied that she advised Mrs B not to attend the secondary care clinic or told her that an obstetrician would force her to use a hospital midwife. She would have referred Mrs B for an obstetric consultation. She discussed a referral to Dr F but he was away for three months, and when she talked with her about other obstetricians, Mrs B would say, "But they do abortions," and that Dr D had hurt her during the delivery of her twins. The hospital employed four obstetricians. Ms C rang the hospital to make an appointment for Mrs B with Dr F but she was told that he was away at the time. Ms C said the only alternative was for Mrs B to see one of the other obstetricians. Ms C knew that Mrs B did not want to see Dr D because, at one of her other deliveries, she thought he appeared angry with her. It was also Ms C's view that Mrs B did not want to see the other obstetricians because she held strong "right to life" beliefs and was aware that the other obstetricians performed abortions. Mrs B advised me that she does have "right to life" beliefs but not to the point of placing her baby at risk. The outcome of these discussions was that Mrs B did not go to the secondary care clinic. Ms C was comfortable with this decision as her

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previous consultations with Dr F had not required any changes in her antenatal management but were directed at specific management once Mrs B was in labour. Ms C knew that Mrs B was terrified of the pain of labour and that this fear was increasing with each pregnancy. They agreed on a plan to admit Mrs B to hospital early in her labour and immediately notify the on-call specialist for an obstetric assessment and referral to an anaesthetist for epidural pain management.

In Mrs B's previous two pregnancies her labour pain was controlled with epidural anaesthesia. This birth plan also focused on pain control. To Mrs B's mind this meant that the anaesthetist would be available to administer epidural anaesthesia the moment she arrived at the hospital. Ms C said that, from her past experience, if Mrs B was pain free she would comply with any examinations or interventions necessary during labour. She knew that if a forceps delivery or Caesarean section was required the epidural would also make that easier to organise.

Antenatal care

In Mrs B's opinion her pregnancy did not differ from any of her other pregnancies. She required one admission to hospital on 27 May 1999 (at approximately 32 weeks) when her varicose veins became inflamed and Ms C was concerned that she might be developing a clot. Dr E, the obstetrician on call, examined Mrs B's leg, but he did not complete a full obstetric assessment. He concluded that Mrs B did not have a clot and she was allowed to go home. Ms C documented this admission in Mrs B's hospital records but not in her own antenatal records. Ms C did not consult the secondary care clinic or inform an obstetrician of the delivery plan upon which she and Mrs B had agreed.

Mrs B had an ultrasound on 9 June 1999, which recorded:

> "A difficult examination because of gestational age. The foetus is lying slightly obliquely with the head in the left iliac fossa and the breech in the right upper abdomen. The back is to the left anteriorly."

Although this report was filed with Mrs B's antenatal notes, Ms C made no formal referral to the secondary care clinic for specialist assessment.

Labour

Mrs B had contractions on 10 June 1999 (at just over 38 weeks). Mr A took his wife to hospital, but before doing so, he telephoned Ms C to inform her that his wife was in labour. Mrs B had been having mild contractions for about six hours but when Ms C examined her at 11.15pm the pains had stopped. Ms C recorded in her private notes that the baby was lying in the oblique position. She did not record this in the hospital notes. Ms C recorded in the hospital notes that Mrs B was aware of the risks of an oblique position once labour started. She recorded in both her private notes and the hospital notes Mrs B's anxiety about the pains of labour and her need for epidural pain management. Mrs B would not consider any other form of pain management. Ms C's private notes recorded:

> "• Wants epidural as quickly as possible OA [on arrival at hospital].

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- Reassured – in labour – quickly to hospital. Consult with obstetrician on call
- Epidural ASAP.
- Discussed 2 (second) care plan or see obstetrician in hospital or [Dr F] x 2 previously.
- Hospital quickly
- Epidural ASAP."

Ms C stayed with Mrs B until 1.25am on 11 June 1999. Before leaving the hospital Ms C left instructions with the hospital midwife that if Mrs B went into labour before she returned in the morning the hospital midwife should arrange for epidural anaesthesia. Later in the morning the hospital midwife recorded that, although Mrs B felt foetal movements, she refused to allow the hospital midwife to listen to the baby's heart rate. Mrs B advised me that the hospital midwife asked whether she should examine her but said that Ms C would be back soon. In light of this information she decided to wait until Ms C returned before having an examination.

At 8.00am Ms C returned to the hospital. Mrs B was no longer in labour. Mrs B was very anxious and reluctant to go home in case she did not make it back to the hospital in time. This information was noted in several places throughout her notes. Ms C discussed with Mrs B whether she should consult the obstetrician on call about inducing labour either that day or within the next two days. Mrs B said that she would think about it. Ms C recorded this discussion in Mrs B's notes.

Mrs B told me that she wanted a Caesarean section, but that Ms C discouraged her from it because she would be unable to nurse her other children. Ms C denied giving Mrs B any such information.

Mrs B was discharged at 3.30pm without deciding whether to consult an obstetrician. The obstetrician on call did not assess her before she went home. Ms C recorded:

> "[Mrs B] is very anxious re birth and she worries more with each baby. Very adamant re having Epidural as soon as she is established in labour. All risks have been discussed re high multiparity – both [Mr A] and [Mrs B] are very aware. Plan: close observation during labour and birth – consult [obstetrician] on admission – aware of unstable lie etc."

At 5.32pm on 14 June 1999 Mr A informed Ms C that his wife had commenced labour. Ms C went to the house to examine her. Ms C recorded that it was still too early to go to hospital but instructed Mr A that if his wife's contractions became stronger she should go. Mrs B's cervix was not dilated and the presenting part was high. Ms C advised that her labour was not established. Ms C recorded the baby's heart rate as "normal" but a numerical value was not recorded.

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Delivery

At 7.15pm on 14 June Mr A informed Ms C that his wife's labour was progressing and he was taking her to hospital. By the time Mr A and Mrs B arrived at the hospital, between 7.30 and 7.45pm, Ms C was already there. The delivery suite had been busy throughout the day and remained busy that night. All delivery suites were occupied. Ms C said that the shelves in the room allocated to her had not been restocked or the bed made up. She commenced preparing for Mr A and Mrs B's arrival but did not complete restocking before they arrived.

Maternity services

The 'day book', which records the cases admitted to the delivery suite at the hospital in the 24 hours of 14 June, notes that 21 women were admitted. At the time of Mrs B's labour, five other women were in labour in the delivery suite. Ms G advised me that under normal circumstances the LMC is responsible for replacing all the equipment but can call on a hospital midwife for assistance when necessary.

Dr D was the obstetrician on call. He said that at about 7.30pm on 14 June he was approached by Ms C, who asked him to see Mrs B. At that time Mrs B had not arrived at the hospital. Dr D was about to see another women for a trial of labour, which if not successful would proceed to Caesarean section. He told Ms C to call him when Mrs B arrived. Ms C said she told Dr D that Mrs B was in labour and required epidural pain management. Ms C said that Dr D did not initially respond when she spoke to him about Mrs B. When asked whether she thought Dr D heard her she stated:

> "Perhaps he didn't but I took [Mrs B's] notes to him. I believed that he did hear as I was standing beside him. I had the previous delivery notes which I placed open on the desk beside [Dr D] to read and in fact I wrote in the wrong place – but left them open for him."

Dr D said that he could not recall Ms C talking about an epidural during this conversation. Dr D told Ms C that he would see his other patient first and, in the meantime, Ms C could complete a 20 minute CTG tracing and prepare her for his assessment. Ms C told me that she tried to tell Dr D that Mrs B needed regional epidural anaesthesia before she would consent to any examination but he would not listen to her.

Dr D read Mrs B's antenatal history for this pregnancy for the first time. He acknowledged that she was 41 years old, at term, and that this was her ninth pregnancy. In view of Mrs B's age and high parity, he considered her a "high risk" patient. He was concerned about any complications she might encounter during labour and delivery. He also noted the absence of the LMC's management plan for labour and delivery. He found that Mrs B had not been seen by a specialist obstetrician and had not attended the secondary care clinic during her pregnancy. Dr D noted that Mrs B was in the delivery suite on 10/11 June 1999 in early labour but was discharged without seeing an obstetrician for a full assessment. He noted that at the admission on 10 June, the position of the baby's head was high in the pelvis and the lie of the baby remained unstable.

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Dr D advised me that he felt concerned and disappointed that the LMC had not recognised the risks involved with Mrs B's pregnancy and he was very worried about the possible complications. It was his reluctance to be coerced into a clinical situation, which he knew to be dangerous, that led to the deterioration in the relationship, not his inability to co-operate. It would have taken about 20 minutes for the anaesthetist to get to the hospital and another 15 to 20 minutes for the epidural to take effect. A delay in assessment in Mrs B's case was unacceptable. Resolution could have been achieved with a very brief clinical examination and placement of a foetal scalp electrode confining the patient for no more than a few minutes. The CTG recording could then have been taken while waiting for the anaesthetist to arrive. Dr D compromised and agreed to an epidural anaesthetic without the fundamental information that would have made the decision comfortable for all concerned. Dr F advised me that he too considered that Mrs B fell into the "high risk" category and that Mrs B's LMC had not referred her for specialist assessment as indicated in the hospital guidelines.

Mr A and Mrs B said that Ms C met them when they arrived at the hospital. The epidural equipment was ready on a trolley outside the delivery room door. Mrs B was relieved because she was in very severe pain, so bad that she was screaming and hitting her leg. She said that, of her nine other babies, six had been born without pain relief but she had never experienced pain like this before. Mrs B expected that she would have the epidural immediately.

Ms C tried to obtain a 20 minute CTG tracing as requested by Dr D. Ms C recorded in Mrs B's notes: "14/6/99 7.55pm Asked [Dr D] to see [Mrs B] – Wanted CTG done first – [Mrs B] will not lie down for monitor – [Mr A] holding same (subsequently trace 10/60 (10 minutes) missing)."

Ms C advised me that Dr D was very angry and would not communicate with her. Each time he was in the room he took the notes and did not return them, but left them out in the office. She was extremely busy and the absence of the notes affected her documentation.

Dr D said that soon after he asked for the trace Ms C returned to the office to tell him that the foetal heart rate was normal. He said that when he looked at the CTG there was only about five minutes of tracing. Ms C told him that Mrs B could not lie still long enough for a longer tracing. Ms C did not take any other recordings. He recalled Ms C asking for an epidural at this time. He went to see Mrs B about 10 minutes after her admission. He found Mrs B standing by the bed. She was in obvious distress from her contractions and appeared to be in established labour. Dr D formed the opinion that Ms C had not spoken to Mrs B about the need for a full obstetric assessment, including a vaginal examination. Dr D said that he tried to explain to Mrs B that he needed to examine her before her epidural could be administered. Dr D said that he had to be quite firm with her. He told Mrs B that he would try to complete the examination quickly and, if appropriate, order the epidural.

After Dr D left, Ms C returned to Mr A and Mrs B. Mr A said that Ms C told them that Dr D was very angry with them because Mrs B had not gone to the secondary clinic. Mr A and Mrs B said that when Dr D came back he appeared very annoyed. Mrs B did not want the examination until after the epidural. Mr A said that Dr D shouted at them that their baby

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could die. He was so angry that he tore off his gloves, threw them in the bin and stormed out of the room.

Dr D said that he was not angry and denied tearing off his glove in an angry manner. He was very worried about Mrs B and her baby, and found Ms C unhelpful to the point of being obstructive. She did not try to convince Mrs B about the importance of the examination and kept going in and out of the room. Instead of assisting him he had to ask her for each and every item he needed for the examination. This caused the examination to be unduly prolonged, which added to Mrs B's distress.

Ms C said that it was not usual for the obstetrician to assess a woman in labour before ordering an epidural. She said that often the midwife would telephone the obstetrician on call and obtain permission to call the anaesthetist. If an obstetric assessment is necessary it can be carried out when the woman is free of pain. Ms C said that in Mrs B's case an obstetric assessment was very necessary but that it was impossible to competently assess her, determine the stage of labour, or monitor the condition of the baby, because she was so distressed. She felt that Dr D was not listening to her.

Dr D said that he was concerned about three possibilities with Mrs B: obstructed labour because of the unstable position of the baby; cord prolapse should the waters break spontaneously; and ruptured uterus because of the number of pregnancies. Ms C said that she was more concerned about a uterine rupture than an obstructed labour. Any of these would be an obstetric emergency.

Dr D recorded the following in Mrs B's notes:

"2015hrs Requested to see.
Gravada multiparity
Oblique lie
Has been in labour all day, now brought into delivery suite wants me to see her but patient won't let me examine until she had epidural.
Baby in oblique lie Vx (Vertex) to left
Cx – 4–5cm
Bulging forewaters / needed to rupture waters in a controlled way but pt refused. [Ms C] also did not advise patient accordingly.
Won't allow me to do ARM [artificial rupture of membranes]
For epidural as pt requested
Told her the risks of T [transverse] lie
Cord Prolapse
& will need LSCS [lower section caesarean section]
Risk of PPH [post partum haemorrhage]
Need blood (1) CBC
(2) SP & Cord
(3) IV syntocinon after delivery
Re-examine after Epidural."

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Mrs B said that Dr D did not perform a vaginal examination. However, Dr D said that he was able to complete a quick vaginal examination and found Mrs B's forewaters bulging. He said that if he had been able to rupture the membranes artificially (rather than allow a spontaneous rupture), he could have controlled the descent of the baby's head into the pelvis and eliminated the risk of cord prolapse. Dr D said that he did not have an amnihook in his hand (contrary to the claim by Mr A that he had it behind his back) and that it had to be specifically requested, as it was not a part of the usual examination equipment. Ms C confirmed that Dr D asked for an amnihook and she passed it to him.

Mrs B refused to have her membranes ruptured artificially. She would not change her mind and was insistent on an epidural. Dr D said that in the face of her refusal there was nothing he could do but order the epidural.

Mr A said that Dr D was very angry; he ripped off his gloves and threw them in the bin, and was shouting at them. He told Ms C to arrange the epidural and that he would return to see Mrs B. Ms C left to arrange the epidural with Dr K, the anaesthetist on call, and to prepare the necessary equipment. She did not hear the conversation between Dr D and Mr A and Mrs B.

Dr D denied that he pulled off his gloves in an angry fashion. He was very worried about the baby, because the head had not entered the pelvis and remained very high. While Ms C was out of the room, and he was washing his hands, he tried to explain Mrs B's condition to her, including the dangers to the baby. There was a real risk that the cord could prolapse and there were the complications of transverse lie. He said that he warned Mr A and Mrs B that their baby could die.

Dr D advised me that it is one of his professional obligations to co-operate with fellow health professionals and with women receiving pregnancy care. He believes the duty to provide safe care for the mother and baby is even more important than duty to co-operate. He considers this the fundamental tenet of specialist obstetric care, and could not co-operate with practices that might result in poor obstetric outcomes. In the end, co-operation involves the patient, midwife and doctor. In this case Ms C and Mrs B refused to accept his advice. Furthermore, the Australian and New Zealand College of Anaesthetists stipulates that a medical practitioner must authorise and take responsibility for an epidural. His role was to ensure that it was safe to administer an epidural and that there were no contraindications. He was responsible for the immediate care of the patient following the insertion of the epidural. However, the overall responsibility still remained with the LMC, who assumed ongoing clinical care.

Ms C said that after calling Dr K she went back to Mrs B. She said Mr A and Mrs B told her that they found Dr D rude and upsetting and did not want to see him again. Mr A and Mrs B said that they did not refuse to see Dr D, but that Ms C told them she would contact another obstetrician and that they did not have to see Dr D again. Ms C advised me that she did not initiate seeking a second obstetrician that night. She described Mr A as a very quiet man, but when she returned he told her that he did not want that man (meaning Dr D) back in the room. As a result of this comment, she told them she would try to find another obstetrician and contacted Dr E.

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Dr K arrived at about 8.30pm. The epidural, once administered, did not give satisfactory pain relief. It had to be "topped-up" two or three times before Mrs B obtained any relief and this caused delays. In the meantime Ms C had to go in and out of the room to obtain equipment (because the room had not been completely restocked) and to use the telephone. The delivery room did not have a telephone and the closest one was in the office, which was a short distance away.

At 8.45pm Mrs B's waters broke and the liquor was stained with meconium. Ms C telephoned Dr D, who was performing a Caesarean section. Dr D said that while he was in theatre one of the theatre staff took a message from Ms C requesting that he see Mrs B after completing the Caesarean section. Because there was no other information given, and no urgency conveyed, he completed the surgery before going to see Mrs B. This was at about 9.30pm. He was about to enter Mrs B's room when Ms C blocked his way. She told him that Mrs B did not need him anymore. He said that Ms C told him that Mrs B's membranes had ruptured, she had completed the vaginal examination, the baby's head was in the pelvis and the CTG trace was normal. Ms C told Dr D about the meconium but added that Mrs B was about to deliver and she would call the paediatric registrar. He waited in the office for about 15 minutes to see whether he was needed. At about 9.45pm he recorded his findings in Mrs B's notes:

> "Came back from theatre.
> [Ms C] contacted – she left a message to come down to see patient.
> When I came down [Ms C] said she doesn't need me.
> Says she has SRM and she examined her and head has come down into the pelvis.
> Says there was meconium and told me the CTG was normal.
> She will not allow me to examine the patient
> I DO NOT TAKE ANY RESPONSIBILITY FOR [MS C'S] ACTION AND MANAGEMENT IN THIS CASE."

Ms C said that she did not tell Dr D that the CTG trace was normal. She told him about the meconium, that the baby's head had come down, and that Mrs B was refusing to let him assess her. Ms C said that she might have said that Dr E was coming to see Mrs B, but cannot remember clearly.

Ms C told Mr A and Mrs B that Dr E, who was on his way to the maternity unit to see another patient, would see her. Ms C said that she called Dr E at about 9.10pm. Ms C explained:

> "I did emphasise to [Dr E] that there was meconium and that there was an unstable lie and how many pregnancies [Mrs B] had had, that the foetal heart rate had been okay (140–150) but that she needed to be seen by an Obstetrician. The presence of meconium is not necessarily an emergency but I was very aware that both [Mrs B] and the baby needed a further Obstetric assessment and this is why I rang [Dr E]. He agreed to come and assess [Mrs B]. I expected him to arrive much sooner than he did as usually when he is coming, he arrives within 20–30 minutes, I do not know why he was delayed."

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Dr E recalled that "there was certainly no urgency in Ms C's request". He said that he encountered Dr D in the foyer of the hospital as he was coming to see his other patient and Mrs B. He thought he was called because there had been some disagreement between Dr D and Mr A and Mrs B and he was being asked to sort it out. He had no information about any possible complications.

Ms C advised me that she has never had to ask an obstetrician to attend urgently. It is her usual experience that when she rings an obstetrician and briefs them on a clinical scenario, they either give further instructions or come in.

Ms C said that at about 9.15pm she asked the hospital midwife to telephone the paediatrician. She took blood in case Mrs B needed a Caesarean section and completed a vaginal examination at about 9.20pm. She found the baby's head had descended but was not well flexed and still had a little way to go before entering the pelvis. The labour was progressing rapidly. Ms C was having difficulty getting a good tracing of the baby's heart rate because Mrs B disturbed the CTG equipment with her movements. At this time the baseline heart rate was between 130–140 bpm. At about 9.35pm the CTG machine ran out of paper and it took time to find where the paper was stored. When she was able to restart the machine the baby's heart rate was faster, less reactive and harder to pick up. It was at this time that Dr D came back from theatre.

Ms C said that at about 9.50pm she became concerned about the quality of the CTG tracing. Mrs B was moving around with her hands between her body and the CTG straps and with each contraction contact was lost. She noted that the baby's heart rate was increasing and she had to rely on intermittent recordings heard through a foetal stethoscope.

At about 9.55pm Ms C performed another vaginal examination and found Mrs B was ready to deliver. She notified the paediatrician. She was still having trouble picking up the baby's heart rate because the belt would slip down and she could hear only the mother's heart rate. She continued to record the foetal heart intermittently by listening with the foetal stethoscope. She said that she could hear the heart rate "dipping with pushes", which is not unusual in the second stage of labour but needs to be carefully monitored for any change. Ms C said that at this point the heart rate was between 109–120 bpm. Mrs B told them that she could feel the baby was close but she was unable to push her out. Ms C asked one of the hospital midwives, Ms J, to help her by setting up the intravenous syntocinon drip.

Ms J suggested she attach a foetal scalp electrode. Ms J recalled that she had no difficulty attaching the electrode to the baby's head and was able to record for a short time (the rate was 120), but then the recording stopped and she thought the electrode had become detached. When Dr E arrived at about 10.20pm Ms J left to attend to another woman in labour.

CTG recordings between 8pm and delivery

The CTG recording from 8.06pm lasts for five minutes and shows a deceleration, with some loss of contact. There was no tracing between 8.10pm and 8.47pm because the epidural was inserted during that time. Intermittent recordings with foetal stethoscope showed heart rate of 150 bpm. The CTG was recommenced at 8.44pm. It ran for about ten minutes

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(8.54pm) and recorded that the heart rate was normal. The next seven minutes of recording is of poor quality (9.01pm).

The paper in the CTG machine ran out at 9.20pm. The baby's heart rate was recorded, using a foetal stethoscope, at 130 bpm. The CTG tracing recommenced at 9.33pm. The tracing showed a foetal heart rate of about 180 bpm followed by a rapid deceleration to 60 bpm followed by recovery then a further decrease. There is a gap in recording of about two minutes (9.40pm) but the notes record a foetal heart rate of 120–140 bpm. Recording was re-established at 9.43pm and showed a baseline heart rate of 100, with frequent gaps. The next recording, at 9.55pm, was possibly from the scalp electrode and was ineffective. The second midwife reapplied the electrode but could not detect any heart rate.

Delivery

Dr E said that when he arrived the midwife was unable to record the foetal heart rate and thought the electrode was disconnected. He reapplied it. He examined Mrs B but was unable to hear the foetal heart rate. Dr E did an ultrasound but was unable to pick up any cardiac activity. In his opinion the baby was dead. Dr E wanted to apply forceps to lift the baby out but Mrs B would not let him until she had further pain relief. Even working as rapidly as possible the epidural top-up took at least five minutes. Dr E tried to turn the baby manually but this was unsuccessful. Dr E said that by the time they delivered the baby, attempts at resuscitation by the paediatrician were unsuccessful. Mr A and Mrs B refused permission for a post-mortem.

Ms C advised me that she believed this was an extraordinarily bad night and that the systems "fell apart" for everyone involved. Dr D was busy and upset but he did not call a second obstetrician to help him. The support she needed to care for Mr A and Mrs B was not there, and she believes that if Dr E or Dr F had been involved, authority for an epidural would have been given immediately, and an assessment could have been made when Mrs B was pain-free. After the baby's birth she offered to go through the notes with Mr A and Mrs B but her offer was not taken up.

Ms G acknowledged that the delivery suite was busy the evening Mrs B was admitted, but disagreed that the delivery suite was understaffed. There were four midwives on duty that evening; two rostered to the delivery suite and two to the postnatal area. One of the midwives could have assisted if called. Ms C's absences from the delivery room were avoidable because she could have rung the call bell for assistance, rather than using the telephone. The call bell system provides two options for assistance, routine or emergency. There were systems in place for the LMC to access assistance from the hospital staff, whether seeking equipment or additional personnel. Ms G confirmed that the call bell system operated in Mrs B's room.

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Independent advice to Commissioner

Midwife Mrs Joyce Cowan
The following expert advice was obtained from an independent midwife, Mrs Joyce Cowan:

"…

In response to the Commissioner's questions:

Question One

'Was it reasonable for [Ms C] to refrain from referring [Mrs B] to an antenatal clinic for obstetric assessment during the antenatal period?'

The reasons stated by [Dr D] for [Mrs B] to be referred for antenatal obstetric assessment were:

1. Maternal age (41)
2. Grandmultiparity
3. Unstable lie

To address this issue I refer to the **Transitional Health Authority Guidelines for Referral to Obstetric and Related Specialist Medical Services**

Point 1.

According to the guidelines Maternal Age greater than 37 years (Code 3027) requires a level of action 2. Specifically, the Lead Maternity Carer **must recommend** to the woman **that a consultation with a specialist is warranted** given that her pregnancy, labour, birth or puerperium (or the baby) is or may be affected by the condition. The reason stated in the guidelines is **assessment for foetal abnormality and chromosome studies.**

[Ms C] stated in her letter to the Commissioner that she first spoke about the recommendation to consult with a specialist at the first antenatal visit with [Mrs B]. [Ms C] also mentions [Mrs B's] belief in the right to life and her reluctance to have an ultrasound scan. Referral to a specialist for assessment for foetal abnormality would therefore not have the same significance for [Mrs B] as it would to a woman who would want investigation in order to terminate a pregnancy where the baby was found to have a chromosome abnormality. In [Mrs B's] antenatal record, [Ms C] wrote on 28/12/98, the date of the first antenatal visit '**Not wanting scan under any circumstances. Would never have a T.O.P. (termination of pregnancy). Not interested in any genetic tests.**'

[Ms C] acted appropriately in recommending referral in this instance and respecting the wish of [Mrs B] to decline screening for abnormality.

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Point 2.

Grandmultiparity is not listed in the guidelines as a reason to refer for specialist consultation.

Point 3.

Unstable lie is covered in the guidelines under the category of malpresentation (Code 3026). Again this requires a level of action 2. In her letter to the Commissioner on 7 April 2000 [Ms C] stated that the issue of referral was discussed with [Mrs B], on 12/4/99 when the baby was in an unstable lie.

Referral may not have been strongly recommended due to the perceived possibility of handover of care following a visit to the high-risk clinic, and the unavailability of the private obstetrician. However, a specialist visit at this stage would not have changed the management because [Ms C] and [Mrs B] agreed on a birth plan appropriate to the possible problems in labour with an unstable lie.

Antenatally there may be a problem with prolapse of the umbilical cord if the membranes rupture when the baby is in an unstable lie but [Ms C] had instructed [Mrs B] in the appropriate action should her membranes rupture prior to labour. In the antenatal notes there is an entry dated 10/6/99 stating '**Oblique lie** **Aware of risks of prolapsed cord**'.

In retrospect, referral to the high-risk clinic may have prepared the way for a more harmonious working relationship between the midwife and the obstetrician when [Mrs B] was admitted to hospital in labour.

However, given:
(a) The history of previous pregnancies in which there had also been an unstable lie of the foetus, for which obstetric advice was sought and followed, and
(b) The formulation of a birth plan based on advice given for the same situation previously, in my opinion it was reasonable for [Ms C] not to strongly recommend specialist referral.

Question Two

Was it necessary for [Dr D] to assess [Mrs B] before ordering the epidural anaesthesia?'

Ideally, a woman should be assessed before an epidural anaesthetic is administered. In reality, it is not always possible to examine a woman satisfactorily in the absence of adequate pain relief without causing extra distress in a situation where she is already not coping with severe pain.

In my experience it is not uncommon for an obstetrician to authorise an epidural and then examine a woman once she is comfortable. When that happens the midwife gives the obstetrician information about the woman's medical and obstetric history and her own assessment of the labour to that point.

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[Ms C] had documented in the antenatal care plan that [Mrs B] should be seen by an obstetrician on admission to the delivery suite and then have an epidural inserted. This was the intention, but it is sometimes impossible to adhere to a birth plan. Labour can accelerate suddenly and become extremely distressing. It is very difficult for a woman to lie on her back to be examined when she is in the throes of a tumultuous labour as was the case with [Mrs B].

It would have been 'best practice' for [Dr D] to examine [Mrs B] abdominally and vaginally before the epidural was inserted but from the notes it seems that the reality of a severely painful and distressing labour made this almost impossible.

I note that in the records for [Mrs B's] labour in 1995 in which she had an epidural anaesthetic commenced 35 minutes after admission, there is no documentation of an examination by any other person than the midwife until over four hours after the epidural was sited.

Question Three

'Was it reasonable for [Dr D] to prescribe a CTG tracing of 20 minutes duration before ordering the epidural anaesthesia?'

Again, 'best practice' would have been to prescribe a CTG tracing of 20 minutes duration before the epidural. [Ms C] did try to obtain a tracing of the foetal heart at that stage but was only able to obtain a 5 minute trace. I understand how difficult it can be to obtain a continuous tracing with the monitor when a woman is moving around constantly with severe pain and often not able to tolerate the pressure of the abdominal transducer. It is not uncommon in practice to establish epidural anaesthesia before obtaining a continuous tracing if the woman is unable to stay still because of severe pain.

As the anaesthetist had to be called in to the hospital, the delay in commencing the epidural caused by waiting for a 20 minute trace before calling the anaesthetist would seem very hard for [Mrs B] to tolerate.

Intermittent monitoring with a hand held transducer could have been carried out during the administration of the epidural had there been concern about the well being of the baby. If foetal distress severe enough to necessitate emergency delivery had been diagnosed at that stage it would have been advantageous to have the anaesthetist present.

Question Four

'From the CTG tracing available was it possible to detect foetal distress and if so what steps should have been taken to remedy the situation?'

There are a lot of gaps in the CTG tracing, and from the tracing it is not clear whether the apparent decelerations were actual foetal heart recordings or false readings caused by loss of contact, or even maternal heart rate.

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With the wisdom of hindsight there are a few concerning features on the tracing but it is not possible to say without doubt that the markings on the trace accurately represent the foetal heart at the time. The records of foetal heart rates recorded on pieces of paper and then later documented by the midwife, and the rates documented by the hospital midwife who assisted [Ms C] do not tally with the markings of the foetal heart rate on the trace. It would have been prudent for [Ms C] to mark on the trace the places where she felt the apparent recording of foetal heart was inaccurate due to loss of contact.

Working chronologically through the records:

[Mrs B] was admitted in a distressed state in a very strong labour at 1945, requesting an immediate epidural anaesthetic. Labour appeared to be progressing rapidly.

Prior to the epidural [Ms C] stated that the foetal heart was 145–160. She documented that a 10-minute trace was done with [Mr A] holding the transducer on to his wife's abdomen. Unfortunately the section of paper from that part of the trace was missing.

There are two sections of the trace available in the notes.

The first trace, which is interrupted, covers the time period from 2000hrs to 2100hrs. At the beginning of this trace there is a five-minute record which looks reasonable with either a short deceleration or loss of contact but a quick recovery if it was in fact a deceleration. From the description of [Mrs B's] inability to tolerate the pressure of the transducer it seems that the latter explanation is most likely.

There is a gap in the trace between 2010 and 2044hrs. As it is recorded that the epidural was inserted at 2030hrs I presume that continuous monitoring was stopped during this time. It is difficult to continue monitoring with an abdominal transducer whilst administration of an epidural is in progress, and I note that there is a mark on the trace in the middle of this gap in continuous monitoring indicating that the foetal heart was heard at 150 during this time. This is reasonable practice, particularly as there had been no indication of foetal distress by this time.

From the time the trace was recommenced at 2044hrs there is approximately 10 minutes of acceptable trace and there follows 7 minutes of poor tracing which may again indicate a deceleration or loss of contact. There appears to be a piece of trace missing at the end of the paper as the numbers indicate there would have been another ten minutes of trace available before the paper ran out. In fact it is stated in [Ms C's] letter that the paper ran out at 2120 which is 20 minutes after the time recorded at the end of the first trace. However in the clinical notes [Ms C] stated that the foetal heart baseline was 130 (normal) at 2120hrs.

The second available trace was begun at 2133hrs. At this stage there was a marked increase in foetal heart above the normal range (tachycardia), at 180. This may have been a sign of distress. Following this there appears to have been a deceleration to 60 with recovery over one minute followed by a further deceleration, then a gap in the trace of two minutes. I cannot say from the trace whether there was in fact a deceleration to

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60 or a loss of contact as there is no comment on the paper. In the clinical notes it is stated that at 2140, which is the time of the gap in the trace, the foetal heart was 120–40. When the recording was re-established at 2143 the baseline had dropped to below normal at approximately 100. Following that the trace had several gaps presumably from loss of contact and at 2155hrs [Ms C] applied a foetal scalp clip. Unfortunately the clip did not appear to be effective and another midwife also attempted to apply a clip. The second clip picked up no foetal heart but [Ms C] has stated that she definitely heard the foetal heart at 2210.

[Dr E] arrived at 2220 and sadly found that the baby had died. I note that there was no cord blood pH taken. This may have helped indicate the severity and duration of the baby's distress. This omission was not the sole responsibility of [Ms C].

This is a tragic outcome and I am saddened to hear of the loss of [the baby]. My condolences to her parents.

Both the severity of the labour and the situation in the labour ward at the time of [Mrs B's] admission, made this a nightmare situation both for the parents and the midwife. It is extremely difficult to work effectively and safely when stock and equipment have not been properly replaced and checked. As well as the problems caused by the poor state of the equipment, the unit was under staffed. I am also concerned about the fact that the midwife had to leave the room to use the phone. **It is crucial to have access to a phone in the room in such a case.** Not only is safety compromised when the midwife has to leave the room to make phone calls but it can be very distressing to the woman when the midwife has to continuously go out of the room.

It seems very harsh to be critical of [Ms C's] midwifery care for the following reasons:

- She had to spend time looking for equipment which should have been at hand
- [Mrs B] was extremely distressed and obviously needed a lot of support
- It was difficult to obtain continuous abdominal monitoring due to [Mrs B's] pain and inability to tolerate the abdominal transducer during contractions
- The labour was progressing very rapidly and it was reasonable to expect that birth would proceed quickly in a grandmultiparous woman
- She recorded intermittent foetal heart readings which were normal (written retrospectively in the clinical notes).

However, I do have some concerns:

[In stating these concerns I realise that I have the wisdom of hindsight which [Ms C] did not have and I acknowledge that she was working under extreme stress.]

- As [Mr A] and [Mrs B] had refused to see the on duty consultant [Dr D] again:- at 2133 when there was evidence of foetal tachycardia it may have been prudent to phone [Dr E] again to see when he was expected to arrive, and update him on the features of the trace, which may have been indicating distress at that stage.

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- Over the following 20 minutes when there was an abnormal trace and meconium stained liquor it would have been better to apply a scalp clip earlier than 2155hrs, as even though the intermittent recordings made by [Ms C] seemed satisfactory the trace was abnormal (reduced baseline with decelerations).

In summary:

- It was reasonable for [Ms C] to refrain from referring [Mrs B] to antenatal clinic for assessment. She did recommend and discuss this matter with [Mrs B] and therefore followed the guidelines for referral.

- It would have been optimal but in the circumstances not necessary for [Dr D] to assess [Mrs B] before ordering the epidural.

- It was reasonable for [Dr D] to prescribe a 20 minute trace of the foetal heart before ordering the epidural but under the circumstances unreasonable to refuse an epidural in the absence of a 20-minute trace as [Mrs B's] distress prevented the effective application of the abdominal transducer.

- From the CTG tracing available it is possible to say that foetal distress was likely, and that earlier diagnosis and delivery may have improved the outcome. However, the predictive value of an abnormal CTG is not precise. An abnormal trace in the presence of meconium is related to foetal acidosis in less than 30% of cases (1). However, because of the intermittent nature of the trace and the doubt about whether the markings represent the foetal heart accurately, it is only possible to surmise about the significance of the available trace.

- While obviously working very hard to provide sensitive midwifery care for [Mrs B] in this difficult and rapid labour, [Ms C] may have missed the deviation from normal in the foetal heart trace and missed the optimal time to consult with the obstetrician. She may have disregarded the trace as it was poor due to the frequent lack of contact, and she obviously listened intermittently and reported hearing an acceptable foetal heart rate. [Ms C's] lack of early action concerning the abnormal features of the trace has possibly fallen short of the midwifery standards (2). The circumstances would have made it difficult for any midwife to provide optimal care. The outcome has been tragic for the parents and the midwife, who worked hard to provide care for a woman she was concerned for in a very challenging and stressful situation.

(1) Policy for midwives and Medical Practitioners Practising Within [the hospital's] Obstetric Service p.65.

(2) New Zealand College of Midwives Handbook for Practice (Standard Six)."

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Ms Cowan clarified her advice by responding to the specific questions set out below:

"**Can you recall the guidelines set by the Transitional Health Authority and comment on how the THA's guidelines compare with [the hospital's] protocols for lead maternity caregivers as far as the identification of at risk women is concerned?**

I cannot recall them specifically.

If you are the lead maternity caregiver and the Transitional Health Authority guidelines and [the hospital's] protocols are not the same, which should you be guided by?

They are guidelines and are not necessarily legally binding. A midwife could be criticized for not using the guidelines but they are not an absolute authority. The THA guidelines are nationwide and must be balanced with the individual maternity facility protocols. The health professional must balance the two. As far as I can recall [Ms C] advised [Mrs B] about the protocols.

Are the 'at risk' categories – over 37 years of age, multiparity and unstable lie – cumulative?

I find that very difficult to answer.

How strongly would you recommend a woman attend a High Risk Clinic if she had one, two or even three of the at risk categories identified? [Mrs B] was over 37 years and having her tenth child and the foetal presentation was unstable given those three at risk factors, would the recommendation be even stronger that she attend the High Risk Clinic?

At the time attending the clinic was discussed frequently between [Ms C] and [Mrs B]. [Mrs B] was well, and this pregnancy was the same as the last two pregnancies. You take each situation as it presents and advise accordingly. I understand that a private obstetric referral would have been made had the specialist preferred by [Mrs B] been available. In his absence, a care plan using advice given by the obstetrician in the previous two pregnancies with similar risk factors, was drawn up.

[Ms C] documented that she advised [Mrs B] what to do if her membranes ruptured spontaneously. Was that advice reasonable?

[Ms C] advised [Mrs B] to go immediately to the hospital to be assessed by the obstetrician. As [Mrs B] was going to have her baby in the hospital this did not seem to be much of a problem. It would have been different if [Mrs B] had decided to have a home birth. There was no suspicion that the baby was in any foetal distress. (I assumed we were discussing early labour when I made this point.)

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[Mrs B] said that she had never suffered pain like this before. Was there any indication to you about what could have been causing [Mrs B's] severe pain?

I don't really know. It was a precipitous labour [very rapid] which does not allow the woman to recover between her pains. It could have been a placental abruption that was causing the distress. Or it may have been that [Mrs B] was particularly stressed herself. When a person is distressed they feel pain more acutely. In this situation [Mrs B] expected to have an epidural straight away. When this did not happen it could have caused her more distress.

How vital was the CTG tracing?

CTG tracing is a tool but we should not over-emphasise its importance. I think the research says that in a percentage of CTG tracings which indicate foetal distress it is later found out not to be the case. [Ms C] said that she was listening intermittently and each time she listened the foetal heart rate was okay. This must be contrasted to the recordings which show that about 50 minutes before the baby was born the CTG tracing indicated that there may have been some need to call an obstetrician urgently. But at the same time [Ms C] records that the foetal heart rate was 140, which is normal. A continuous trace is not automatically recorded. It is to be remembered that if [Mrs B] had been taken into the care of the hospital she may not have had a continuous trace or a midwife with her all the time. At the hospital where I usually deliver my babies they have a protocol which says that a woman should have a continuous 20-minute CTG trace on admission to the hospital. I do not always comply with that because it is a practice not supported by research, in the absence of specific risk factors. If the labour has been normal and the woman is progressing well I don't always do a 20-minute CTG tracing. However when there are risk factors present it is advisable to carry out a continuous trace on admission for 20 minutes and in some cases continuous monitoring throughout the labour is indicated. If one was being overly critical when [Dr D] came back from theatre and [Ms C] did not let him back in the room and told him that the foetal heart rate was okay that was about the time that the tracing, if it could be relied upon, was showing that the baby may be in some distress. But it is to be emphasised that the tracing is not a good tracing and may not be reliable in terms of showing foetal distress. There are many sections of the trace which cannot really be interpreted due to frequent apparent loss of contact.

It is also to be remembered that we are making these decisions with the wisdom of hindsight. For example it may have been prudent for [Ms C] to insist that [Mrs B] attend the At Risk Clinic and she could have been criticised for not doing so but the guidelines are not an absolute authority.

It is also to be remembered that this baby probably died because of the labour. The baby did not die because of any incorrect treatment or action on the part of [Ms C]. It could have been possible to save the baby if distress had been recognized and acted on earlier. However, as there was no postmortem examination the exact cause of death is not certain."

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Midwife Ms Ann Yates

The following additional expert advice was obtained from an independent midwife, Ms Ann Yates:

"**Antenatal History**

[Mrs B] was having her 10th pregnancy; her due date was 16 June 1999. [Ms C] had looked after [Mrs B] on two previous pregnancies and knew her well. [Mrs B] was well apart from varicose veins and a low iron count.

[Mrs B] did not want any genetic tests performed during pregnancy and was not keen to have an ultrasound scan which is routinely carried out around 18 weeks gestation. It was documented in her antenatal record that these diagnostic investigations were discussed with her and offered by her LMC [Ms C]. Her low haemoglobin was treated appropriately with iron tablets.

[Mrs B] had regular attendances with [Ms C] throughout her pregnancy. Her pregnancy was monitored appropriately with blood pressure and foetal growth all recorded as normal. During these antenatal visits a birth plan was commenced and it is documented that there were concerns by both [Ms C] and [Mrs B] about the impending labour and delivery. The concerns were related to risk factors and to [Mrs B's] fear of pain during labour.

The risk factor documented in antenatal notes was an Unstable Lie with potential for prolapsed cord or malpresentation such as oblique lie, and postpartum haemorrhage. [Mrs B] and [Ms C] also had discussed pain management and had planned an epidural anaesthetic early in labour.

There was a note (undated) in [Ms C's] antenatal records referring to a discussion about the secondary care clinic or whether to see an obstetrician on arrival in hospital. A plan was formulated to transfer to hospital quickly once labour had commenced, to consult an obstetrician on call at the hospital on arrival and to have an epidural as soon as possible.

It is clear from this that referral antenatally to a specialist obstetrician was given as an option, however, the reason this did not happen was as follows:-

(a) In the two previous pregnancies where [Ms C] had also been her LMC, [Mrs B] had been referred antenatally to [Dr F] obstetrician for an unstable lie. This resulted in a management plan consistent with the plan for [Mrs B's] subsequent pregnancy. Each time [Dr F] referred [Mrs B] back to the LMC for ongoing antenatal management but advised early hospitalisation in labour, assessment of fetal position and lie, intravenous cannulation, notification of the on-call specialist and active management of third stage of labour.

(b) The system of antenatal referral at [the hospital] had changed and [Dr F] was unavailable for consultation during this pregnancy. This meant that [Mrs B] would

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not be able to choose her caregiver, or have the same obstetrician for her labour and delivery.

(c) [Mrs B] had had a previous experience with [Dr D] (one of the four obstetricians on-call) when she had her twins. He had become angry with her during an internal examination. She also wished to avoid obstetricians who performed abortions.

HFA Guidelines for referral to Obstetric and Related Specialist Medical Services.

These guidelines are to provide recommended best practice for LMCs. They are not expected to be restrictive, and the document recognises that situations may require a course of action different from these recommendations. The principles of informed consent to the woman are required for all referrals and practices, and advises discussion and documentation in accordance with good professional practice.

Referral guidelines for malpresentation over 36 weeks are that the LMC 'must recommend to the woman that a consultation with a specialist be warranted. The specialist will not automatically assume responsibility for ongoing care. This will depend on the clinical situation and the wishes of the individual woman'.

It is evident from documentation by [Ms C] and acknowledgement by [Mrs B] in her statement that she was aware of the risks and had made a decision not to have a routine antenatal referral. [Ms C] states that at no time did she discourage [Mrs B] from being referred to an obstetrician or that an obstetrician would force her to use another midwife. [Mrs B] may have been unaware that care could not be taken over unless a patient agreed to it. [The hospital] also had its own referral guidelines – recommending referral for consultation for women over 35 years of age, parity greater than 5 and malpresentation after 36 weeks gestation.

[Mrs B] demonstrated trust in her midwife and worked on the assumption that all previous unstable lies had become cephalic at the time of delivery, and that [Mrs B] would be able to get obstetric help and an epidural as soon as they were required.

[Mrs B] had an antenatal ultrasound scan at 38 weeks to check the lie of her baby. This indicated a normal grown foetus, lying slightly obliquely with the head in the left iliac fossa.

[Mrs B] was referred by [Ms C] and seen by [Dr E] obstetrician in late pregnancy when she developed pain in her varicose veins. He examined her and she was discharged home.

Admission to Hospital in False Labour

[Mrs B] had an episode of contraction without established labour on the 10 June 1999. She was seen and examined in Delivery Unit by [Ms C] and remained overnight for observation. She was nervous about the impending labour and anxious to have an epidural. It would not have been appropriate to do this until labour was established. A CTG demonstrated a normal reactive trace and frequent contractions. There was a

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documented plan by [Ms C] to examine [Mrs B] and arrange an epidural in her absence, if her labour progressed to cervical dilation beyond 3cms.

A hospital midwife has written that [Mrs B] declined to have a foetal heart recording taken during the night. [Mrs B] was discharged home the next day after a long discussion and after reassuring her she was not in labour. She declined to be referred to the on-call obstetrician ([Dr D]) for further assessment where issues of induction of labour and elective Caesarean section could have been discussed.

The risk factors of high multiparity were once again discussed with [Ms C] and a plan agreed upon to consult an obstetrician on arrival to Delivery Unit in labour, and to insert an epidural as soon as possible.

Labour and Delivery

[Mrs B] began having contractions an hour apart at lunchtime on the 14 June 1999. She describes them as irregular and painful with backache. She rang [Ms C] at 1730 hours, [Ms C] visited her and performed a vaginal examination. [Mrs B's] cervix was not dilated and the presenting part was still high. She advised waiting until the contractions became stronger before transferring to hospital. At this stage labour was still not established. [Ms C] advised her to wait until the contractions became stronger before going to hospital.

This would be usual advice having checked for dilation of the cervix and observed the woman during her contractions.

The contractions became strong and painful about an hour later and [Mrs B] and her husband [Mr A] transferred to hospital. [Ms C] was waiting in Delivery Unit and had prepared an epidural trolley in anticipation. She arrived at 1945 hours. [Mrs B] described her pain as unbearable. She was unable to lie down and states she was screaming with pain, swearing and slapping her leg. [Ms C] described [Mrs B] as very distressed on arrival. Her labour having accelerated rapidly since leaving home.

At this stage her membranes were still intact and [Ms C's] primary concern was to relieve [Mrs B's] pain. She had approached the on-duty specialist obstetrician [Dr D] while awaiting [Mrs B's] arrival and had presented him with her case notes and requested that he see her on arrival.

[Ms C] states [Dr D] was unhappy that [Mrs B] had not been to the Secondary Care Clinic antenatally.

He was in the Delivery Unit upon [Mrs B] and [Mr A's] arrival but did not consent to the epidural until a 20 minute CTG strip was performed. [Ms C] describes him as 'impossible to communicate with'. 'He would not listen to me.' [Ms C] tried to explain that a CTG strip was not possible as [Mrs B] was moving about too much and was very distressed.

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This conversation occurred in the office before [Ms C] attempted to monitor [Mrs B's] labour by physically holding the transducer onto her abdomen. [Mrs B] could not tolerate a belt around her as it was too uncomfortable.

[Ms C] approached [Dr D] once again – he came at 2015 hours after they had achieved a 5 minute tracing. He requested an amnihook from [Ms C] prior to performing an internal examination. His intention was to rupture her membranes and control the descent of the presenting part. This was to minimise the risk of a prolapsed cord. However, [Mrs B] was in too much pain and did not want her waters broken. She already felt out of control and could not co-operate. [Ms C] states she was out of the room calling [Dr K] the anaesthetist, gathering intravenous equipment and setting up the epidural equipment. When she returned to the room [Mrs B] and [Mr A] were very upset. [Dr K] inserted the epidural at 2030 hours, 45 minutes after [Mrs B] arrived in delivery unit.

Under normal circumstances a CTG strip may be obtainable on admission, however, in advanced labour and in extreme pain, few women would tolerate being made to keep still for an adequate recording. It would be of questionable value and would be difficult for any midwife to comprehend putting a woman through unnecessary delay for pain relief.

It is not routine for women to have a CTG strip on admission to hospital in labour, nor is it routine to perform a 20 minute CTG strip prior to inserting an epidural in many other maternity units in New Zealand.

Experienced midwives and doctors would also acknowledge that labour can often accelerate very rapidly and the need to prioritise and react to the woman's immediate clinical needs is essential.

It is extremely difficult for midwives to focus on assisting the woman in pain, and organise equipment and document notes at the same time and assist obstetricians. Most obstetricians would also be capable of examining a woman without the assistance of a midwife.

It is quite common for women to request an epidural prior to any examination or intervention taking place. Artificially rupturing the membranes of a multigravida was also likely to have accelerated labour and many women report this increase in intensity as very painful and would prefer to wait until an epidural was effective. It would be common practice to discuss the case with the on-call obstetrician. Use intermittent auscultation if continuous recording is unobtainable, insert an epidural as soon as possible, then provide a full and complete examination once the woman is comfortable. A fetal scalp electrode would be applied at delivery if the presence of copious meconium stained liquor and paediatric assistance sought.

[Mrs B's] membranes ruptured spontaneously at 2045 hours with meconium stained liquor. It does not state whether the meconium was fresh or old or the consistency, in the clinical notes. [Ms C] attempted to notify [Dr D] who was by then in theatre.

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The epidural was not effective initially and [Mrs B] needed to be topped up again at 2055 Hours. In the meantime [Mrs B] and [Mr A] declined to see [Dr D] again, [Dr E] was phoned at home at 2100 Hours – he agreed to review her when he came to see another patient. He was informed of the meconium liquor and the circumstance of the referral.

[Ms C] called hospital midwife [Ms J] to assist her by notifying the paediatric team about the meconium liquor at about 2050 hours. [Ms J] assisted [Ms C] in preparing equipment for delivery and encouraging [Mrs B] to push as [Mrs B] was now in second stage labour.

CTG RECORDING FROM CLINICAL NOTES

2100 Hours [Ms C] describes the CTG as OK with a foetal heart rate of 140–150.

2120 Hours Baseline of 130, reactive with 5–10 beats variability, contractions every 2 minutes. The CTG machine ran out of paper at 2120 Hours requiring [Ms C] to locate a refill outside of the room.

2140 Hours The FHR was 120–140 beats per minute.

2155 Hours There was loss of contact with FHR. [Mrs B] was rapidly progressing to full dilation. A foetal scalp electrode applied with no recordable heart rate thereafter.

The CTG tracings are difficult to interpret. There are no numerical ranges to assess foetal heart rate. There are gaps in recordings and it is difficult to distinguish between loss of contact and some decelerations. By superimposing a standard CTG graph over [Mrs B's] monitor strip it is possible to estimate FHR in some places. There are times noted automatically by the machine and this occurrence of contractions is also recorded.

The baseline appears to have risen to 180 BPM at 2133 Hours followed by a late deceleration to 60 beats per minute, with minimal variability. [Mrs B] was rapidly approaching second stage labour. [Ms C] acknowledges a poor CTG tracing at this point but states that the trace is reasonable to observe. It is sometimes possible to auscultate the heart rate when contact is poor and unrecordable.

A foetal scalp electrode was applied at around 2200 Hours. A paediatrician was called to attend the impending birth and attend to the baby. The foetal heart rate is not recorded on the tracing after this time. [Ms C] was anticipating [Dr E's] arrival at any time and was about to contact him again, when he arrived at 2220 Hours – 1 hour and 10 minutes after being phoned.

Dr E was unable to pick up a foetal heart rate with a new scalp electrode. He used an ultrasound scanner but was unable to locate any cardiac activity. The [couple] were told there was no foetal heartbeat. [Mrs B] was again experiencing pain and requested a top up of her epidural before the baby was delivered by forceps. [Dr E] describes [Mr A] as quite rational and distressed at this point and [Mrs B] as being preoccupied with having

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more pain relief via epidural. He was unable to proceed with an instrumental delivery until a top up of the epidural had taken effect.

The baby was delivered by forceps at 2245 hours, 25 minutes after [Dr E] arrived. Despite attempts to resuscitate her, she showed no sign of life.

The death of a baby intrapartum is a tragic event, which undoubtedly raises questions as to whether appropriate management and intervention took place. I have been asked to advise on whether [Ms C] provided [Mrs B] with obstetric services with reasonable care and skill and whether she met professional standards in relation to the following questions:-

1. Is it reasonable for [Ms C] to refrain from referring [Mrs B] to an Antenatal Clinic for obstetric assessment during the antenatal period?

   It is evident that there was ample and frequent discussion on this matter with [Mrs B] and [Mr A]. They were aware of the risks, consequences and choices. They also believed that referral may disadvantage their choice of caregiver and continuity of care.

   They ultimately decided not to see another obstetrician in [Dr F's] absence. It would seem that the [couple] were able to comprehend and formulate their own views on other matters, e.g. prenatal diagnostic screening and ultrasound scans and would appear equally as capable of comprehending the issues of grand multiparity and the referral system at [the public hospital]. Similarly [Ms C] was aware of referral requirements and recommendations and acted within these guidelines.

2. Was it necessary for [Dr D] to assess [Mrs B] before ordering the epidural anaesthesia?

   [Ms C] made a timely and appropriate referral to the on-duty obstetrician. When [Mrs B] arrived in labour to Delivery Unit, [Dr D] allegedly was difficult to communicate with and reluctant to discuss [Mrs B's] needs.

   His attitude towards both the Midwife and the [couple] was unprofessional and may well have caused an unnecessary delay in being able to adequately assess [Mrs B's] labour. It would have been reasonable to have discussed the obstetric history, individual birth plan (HFA requirement) with [Ms C] before introducing himself to the [couple] in a reasonable and tolerant manner.

   It is usual to perform preliminary examination of temperature, pulse, blood pressure, abdominal palpation, foetal heart recording and a vaginal assessment of labour progress if an epidural is being requested. A note of regularity and strength and frequency of contractions is also noted, and usually a partogram commenced if labour is established.

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All of the above is generally performed by the LMC, however, in this instance [Mrs B] had agreed to an initial assessment by an obstetrician to establish the lie and presentation of the baby on arrival in Delivery Unit.

[Dr D] was under the impression that [Mrs B] had been in labour all day – this was in fact not so. Her labour had established one hour previously and had become intense and unbearably painful. She was unable to co-operate by lying down and was out of control with pain. Under these circumstances, it would have been extremely difficult to establish anything with certainty and it would normally have generated a rapid referral to an anaesthetist before proceeding any further.

I have cared for women under similar circumstances, and have never met with any opposition from an obstetrician to initiate analgesia or epidural anaesthesia. The main risk is that the woman may well be in advanced labour and delivers before the epidural is effective. It was conceivable that [Mrs B's] waters may have broken and umbilical cord present, which is indeed an emergency, which [Dr D] was anticipating could happen. However, artificially rupturing her membranes when she was already in terrible pain, would almost certainly have created more discomfort, when a short delay while the epidural was being inserted would have been a reasonable and humane thing to do.

3. Whether it was reasonable for [Dr D] to prescribe a CTG tracing of 20 minutes duration before ordering the epidural anaesthetic?

No I do not agree that in these circumstances this was reasonable. [Dr D] was aware of [Mrs B's] distress, her LMC had desperately tried to explain her need for an urgent epidural. He also knew that [Ms C] had no other option as this system of accessing epidurals was through the obstetricians.

It is unlikely that a 20 minute strip would have been readable as [Mrs B] was unable to keep still and the straps increased her discomfort during the contractions, when contact is most required.

Again I have never experienced an obstetrician create a delay to pain relief under such circumstances. I do not feel that if [Mrs B] had been forewarned that a 20 minute CTG strip was warranted prior to an epidural, that her pain would have been any more tolerable, or that she would have been able to co-operate more.

It is simply a situation where her labour progressed rapidly within a short time and in order to get any recordings and co-operation an epidural was required.

Recent evidence by the Royal College of Obstetricians and Gynaecology does not recommend routine admission 20 minute CTG strip. (RCOG Algorithim attached.)

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4. Whether from the CTG tracing available it was possible to detect foetal distress, and if so what steps should have been taken to remedy the situation?

   The CTG tracing is difficult to read with any degree of accuracy because of loss of contact throughout most of the trace. There is an episode at 2133 hours where the fetal heart rate increased to 180 beats per minute with a limited baseline variability. This is followed by a long late deceleration of 2 minutes and a return to the baseline of 180. It is unclear after this recording what happened to the fetal heart. It is possible that it recorded maternal pulse as this tracing was between 80 and 100 beats per minute.

   [Mrs B] was nearing second stage as expected and [Ms C] appropriately examined her internally for any possible causes in change of foetal heart rate. It is not clear why a fetal scalp electrode was not placed at this point. [Ms C's] evidence is that she was reassured by listening after each contraction and was aware of the deceleration. Decelerations are common in second stage labour and require very frequent auscultation to ensure the baby is not compromised. Again it is possible that what they were hearing was not the foetal heart and they were falsely reassured.

   It is also unfortunate that [Ms C] did not call [Dr E] back when she observed the non reassuring heart rate changes at 2133 hours.

   The quality of the CTG may have been better had [Mrs B] had effective anaesthesia from her epidural, and a scalp electrode applied earlier. These comments are made in hindsight with a poor outcome, which is not always helpful, when assessing if there was anything predictable about the CTG tracing which could have changed the course of events.

   The earlier CTG tracing is not in my view predictive. It is also difficult in practice to get an agreement on the significance of some features of CTG tracings.

5. Was the standard of care provided by [Ms C] to [Mrs B] of a reasonable standard and skill?

   With regard to antenatal care, [Ms C] worked under unusual circumstances and advocated for her patient as best she could without compromising a reasonable standard of care. It is clear that she applied knowledge and skill in negotiating secondary care with [Mrs B] when this was required. She was aware of and had discussed fully the potential for problems to arise and the significance of these complications if they occurred.

   Her management of events, intrapartum, were compromised by the delay in accessing adequate pain relief as planned. At all times [Ms C] continued to advocate for her patient in a complicated and unfortunate situation. She appears to have demonstrated reasonable skill in attempting to obtain appropriate assistance when the [couple] refused to have the on-call obstetrician attend them.

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She acknowledged the significance of meconium in the liquor. She continued to monitor the foetal heart rate and the rapid progress of labour. She requested assistance from another midwife when it was clear that she was unable to manage alone. Both midwives were reassured by an audible heart rate that in hindsight was quite possibly maternal.

This does not demonstrate a lack of skill or reasonable care. In my own experience, even with a foetal scalp electrode in place it is possible to pick up an audible rhythm when the foetus is no longer alive.

[Ms C's] care and attention would have been directed primarily to relieving [Mrs B's] pain and obtaining assistance from the five other practitioners who ultimately became involved in [Mrs B's] labour and delivery.

Having a poorly equipped delivery room was not her responsibility, and under such circumstances it is my opinion that [Ms C] did provide care with reasonable care and skill.

COMMENTS

When assessing any adverse event, it is also important to consider all factors which may have created problems.

It may not have seemed significant to others but the fact that the unit was busy, and vital equipment was not stocked in the Delivery Room, is quite relevant as this is the responsibility of the facility.

It is unreasonable for midwives to be expected to do their best to care for women in all circumstances and also to leave the room frequently to perform basic tasks, e.g. find equipment and make phone calls. This can appear to the women that the midwife is not helpful. However, midwives are also required to plan ahead for any likely eventuality and this means gathering intravenous and delivery equipment, etc in anticipation.

I wish to extend my condolences to the family of [the baby]."

Obstetrician Dr Jenny Westgate
The following expert advice was obtained from obstetrician Dr Jenny Westgate:

"…

1. Was it reasonable for [Dr D] to expect [Mrs B] to attend an antenatal clinic for obstetric assessment during the antenatal period?

The answer [is] yes. [Mrs B] had a number of risk factors which required clear identification and a management plan for each. She was a 41 year old, grandmultip with a past history of unstable lie in the two previous pregnancies and a rotational delivery by Kiellands Forceps in her last pregnancy with a face presentation. This is not clearly recorded in her Booking sheet (this in itself is a concern) but [Ms C] mentions it on page

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4 of her letter to the Commissioner dated 7.4.2000. It is very unusual for a grandmultip to require a rotational forceps delivery. I note that two of [Mrs B's] previous babies were delivered in the occipito-posterior position (face upwards instead of downwards). This position of the baby's head presents a larger diameter to the pelvic outlet and these deliveries can be much more difficult for the mother, both in terms of being more painful and taking longer to push the baby out. I note that [Dr E] had to manually rotate the baby's head before he delivered the baby by forceps in this pregnancy which suggests a malposition of the foetal head also occurred in this pregnancy. In addition, [Ms C] repeatedly states that [Mrs B] appeared to be coming more anxious and fearful with each pregnancy and appears to have been unusually eager to have an immediate epidural on arrival at hospital.

All these factors lead me to conclude that [Mrs B] was at substantial risk of intrapartum complication in this pregnancy; especially unstable lie, ruptured uterus, delay in second stage and the need for an instrumental or LSCS delivery. Had she been seen by a specialist, these issues would have been discussed and a management plan made for the pregnancy and labour. [Mr A] and [Mrs B] would have had the opportunity to discuss particular concerns and issues in a considered, calm environment rather than in the heat of labour.

2. Was it necessary for [Dr D] to assess [Mrs B] before ordering the epidural anaesthesia?

The answer is yes. In fact had he not done so in these circumstances I would have criticised him. [Mrs B's] labour was very high risk. She had not been reviewed by an obstetrician in the pregnancy. Her extreme pain may have indicated uterine rupture or abruption. It was entirely correct to want to assess both maternal and foetal condition before arranging an epidural.

In other circumstances, when a woman has been assessed by a specialist prior to labour or earlier in labour and is relatively low or medium risk, a specialist may choose not to examine a patient before agreeing to an epidural. In such cases the specialist will rely on the Midwife's most recent findings on abdominal palpation and vaginal examination in making that decision. It is obvious that [Mrs B's] labour was quite a different scenario and mandated specialist review before an epidural.

I believe that [Dr D] was placed in a very difficult situation on 14 June. [Ms C] and [Mr A] and [Mrs B] had come to an agreement about the management of [Mrs B's] labour, in particular that she would have an epidural as soon as she arrived in hospital. Unfortunately, in order for this to happen [Dr D] had to approve the epidural and in doing so he would automatically take on the overall responsibility for [Mrs B's] labour. Thus he was expected to execute their plan and carry the responsibility for doing so without the opportunity to carefully and thoroughly assess [Mrs B] first. Now add to the fact that [Mrs B] had multiple risk factors, her labour was very high risk and she had not had a specialist review, and I believe that any obstetrician would have been dismayed and upset when faced with these demands.

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3. Was it reasonable for [Dr D] to prescribe a CTG tracing of 20 minutes duration before ordering the epidural anaesthesia?

The answer is yes. An epidural is an invasive procedure which carries risk for both mother and baby. The mother's blood pressure may fall during or shortly after injection of local anaesthetic which results in a fall in foetal oxygen supplies to the baby. The local anaesthetic can be directly absorbed into the mother's blood stream, can cross the placenta and cause the foetal heart to slow dramatically for many minutes. A healthy baby is likely to tolerate these events as they usually resolve after 4 to 6 minutes, however, a baby who is already compromised will not cope with further interruptions to its oxygen supply. That is why foetal condition must be assessed by CTG prior to the insertion of an epidural. In addition, as already mentioned, [Mrs B's] extreme pain may have been an indication that she was experiencing an abruption or uterine rupture. The most reliable diagnostic sign of these conditions is abnormalities of the foetal heart rate. This was another reason to monitor the foetal heart rate.

4. Was it possible to detect foetal distress from the CTG tracing available?

The answer is yes. This must be qualified by the statement that the quality of the photocopies I have is poor (I cannot read the heart rate scale) and the quality of the recordings themselves are poor. However, I believe that there were enough concerning features to warrant both attempts to improve the quality of the recording and specialist review.

The CTGs on 11 and 12 June 99 are normal.

The CTGs on 14 June 99 are recorded by abdominal ultrasound. They are of generally poor technical quality either due to poor placement of the transducer or to lots of maternal movement. A higher quality recording could have been obtained by applying a foetal scalp electrode directly to the baby's head. This signal is much less susceptible to noise from maternal movement. So when I indicate that the quality of the recording is poor and affects interpretation, the correct action should have been to apply a foetal scalp electrode to obtain a better quality signal. The ability to recognise that a foetal heart rate record is too poor quality to be interpreted correctly is an integral part of foetal monitoring during labour.

2006: 4 to 5 mins of record, probably shows a deceleration – there is some loss of contact. 2044 onwards there appear to periods of bradycardia when the foetal heart is probably less than 100 (I can't see the scale). This is unusual and could indicate that it was the mother's heart rate that was being monitored or that there was foetal distress. Either way, action to improve the quality of the recording was required.

2120 There is a period of bradycardia just before the paper runs out.

2133 CTG restarted after new paper inserted. Now there is a foetal tachycardia with a large severe variable deceleration. This is very abnormal and indicates significant 'foetal distress'. The CTG then is of poor quality but appears either significantly bradycardic or

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to be maternal heart rate. Neither of these options is acceptable and a foetal scalp clip should have been applied. There is no effective record of the foetal heart from here onwards. [Ms C] states that she could hear the foetal heart dipping with contractions after this. She also states that the CTG was of poor quality because [Mrs B] kept lifting up the transducer off her abdomen. Given this plus the appearance of the CTG it was mandatory that she take some action to obtain an accurate signal from the foetus and obtain a consultant opinion on the appearance of the recording.

5. Additional comments.

There are two main issues in this case and it is important that they are considered separately. The first and most critical was that the baby was inadequately monitored during labour with the result that foetal distress was not recognised, diagnosed or acted upon. Foetal monitoring during labour is a basic component of intrapartum care for every labour, irrespective of risk status. [Mrs B] appears to have been in very strong labour – contracting frequently and strongly and the intensity and frequency of the contractions was sufficient to compromise foetal oxygen supply and cause the baby to perish in utero. …

The second issue relates to the question of specialist review during pregnancy and the events which took place between [Dr D], [Ms C] and [Mr A] and [Mrs B]. There are clearly many inconsistencies in the various reports of what occurred, which is not unexpected, particularly given the bad outcome. [Ms C] should have recommended a specialist review during pregnancy: she says she did but it was not accepted by the [couple], meanwhile they said she told them it was unnecessary. [Ms C] said they did not want [Dr D] to see them again in labour, however, they say it was [Ms C] who decided to use another specialist. [Ms C] told [Dr D] his services were not required because the labour was progressing normally at that time. Whatever happened it resulted in a delay in specialist review after the epidural had been inserted. [Ms C] did not communicate any concerns about the foetal condition to the second specialist because she had failed to both adequately monitor the foetal heart and recognise the abnormalities, which were present. Had any specialist critically reviewed the CTG, I believe that they would have insisted on a foetal scalp electrode and a better quality CTG that is likely to have resulted in the foetal distress being diagnosed and appropriately managed. The Commissioner will have to unravel the tangled web of responsibility and communication but it is clear that a specialist was present, ready and willing to see [Mrs B] again when he was prevented from doing so."

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Code of Health and Disability Services Consumers' Rights

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

RIGHT 4
Right to Services of an Appropriate Standard

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

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

…

5) *Every consumer has the right to co-operation among providers to ensure quality and continuity of services.*

RIGHT 6
Right to be Fully Informed

1) *Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including –*

2) *a) An explanation of his or her condition; and*

b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; …

Other Relevant Standards

The New Zealand College of Midwives, *Philosophy and Code of Ethics and Standards of Practice July* (1997)

CODE OF ETHICS

Responsibilities to Clients

a) Midwives work in partnership with the woman.

b) Midwives accept the right of each woman to control her pregnancy and birthing experience.

c) Midwives accept that the woman is responsible for decisions which affect herself, her baby and her family/whanau.

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d) Midwives uphold each woman's right to free, informed choice and consent throughout her childbirth experience.

e) Midwives respond to the social, psychological, physical, emotional, spiritual and cultural needs of women seeking Midwifery care, whatever their circumstances, and facilitate opportunities for their expression.

f) Midwives respect the importance of others in the woman's life.

g) Midwives hold information in confidence in order to protect the right to privacy.

Confidential information should be shared with others only with the informed consent of the woman unless there is a danger to her or her baby's life.

h) Midwives are accountable to women for their Midwifery practice.

i) Midwives have a responsibility not to interfere with the normal process of pregnancy and childbirth.

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

k) Midwives have a professional responsibility to refer to others when they have reached the limit of their expertise.

l) Midwives have a responsibility to be true to their own value system and professional judgements. However, Midwives' personal beliefs should not deprive any woman of essential health care.

The New Zealand College of Midwives, *Standards of Practice* (1997)

STANDARD ONE

The Midwife works in partnership with the woman.

CRITERIA

The Midwife:

- recognises individual and shared responsibilities;
- facilitates open interactive communication;
- shares all relevant information within the partnership;
- identifies her Midwifery philosophy and Code of Practice, and freely shares this information with the woman;
- does not impose her value system on others;
- is culturally safe.

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STANDARD TWO

The Midwife upholds each woman's right to free and informed choice and consent throughout the childbirth experience.

CRITERIA

The Midwife:

- shares all relevant information, including birth options, and is satisfied that the woman understands all the implications;
- facilitates the decision-making process without coercion;
- negotiates her role as care-giver and clearly identifies mutual responsibilities;
- acts as the woman's advocate;
- develops a plan for Midwifery care together with the woman;
- respects the decisions made by the woman, even when these decisions are contrary to her own belief;
- respects the woman's right to decline treatments or procedures;
- clearly states when her professional judgement is in conflict with the decision or plans of the woman;
- discusses as necessary with the woman and consults with colleagues in an effort to find mutually satisfying solutions;
- attends when requested by the woman in situations where no other health professional is available;
- documents decisions and her Midwifery actions.

…

STANDARD FIVE

Midwifery Care is planned with the woman.

CRITERIA

The Midwife:

- provides information from her knowledge and experience;
- provides other information sources;
- supports the woman in seeking out information;
- facilitates the decision-making process;

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- demonstrates in the Midwifery care plan an analysis of the information gained from the assessment process;
- sets out specific Midwifery judgements and actions required to meet the woman's goals and expectations;
- ensures the care plan is woman-centred;
- considers the safety of the woman and baby in all planning and prescribing of care;
- involves the woman's significant others in care as desired by the woman.

STANDARD SIX

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

CRITERIA

The Midwife:

- plans Midwifery actions on the basis of current and reliable knowledge and in accordance with Acts, Regulations and relevant policies;
- ensures assessment is on-going and modifies the Midwifery plan accordingly;
- ensures potentially life threatening situations take priority;
- demonstrates competency to act effectively in any emergency situation;
- identifies deviations from the normal, and after discussion with the woman, consults and refers as appropriate;
- works collaboratively with other health professionals and community groups as necessary;
- has the responsibility to refer care to the appropriate health professional when she has reached the limit of her expertise;
- can continue providing Midwifery care in situations where medical skills are required;
- demonstrates awareness of her own health status and seeks support to ensure optimum care for the woman is maintained;
- has easy access to appropriate emergency equipment;
- acknowledges every interaction with the woman as a teaching/learning opportunity.

Australian and New Zealand College of Anaesthetists *Guidelines for the Conduct of Major Regional Analgesia in Obstetrics* (1998)

Major regional analgesia is a safe and effective method of pain relief during labour. Safety is enhanced by adherence to the following guidelines:

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1. Cannulation of the epidural and/or subarachnoid spaces should only be carried out by a medical practitioner with appropriate training and experience in all relevant techniques. Major regional analgesia has the potential to change many of the normal physiological attributes of labour and delivery. From the time that major regional analgesia is instituted, it is essential that the mother is under the care of a medical practitioner with obstetric training who can assess the mother as necessary and rapidly effect delivery of the foetus by whatever technique is appropriate.

The hospital's *Specialist Obstetric Consultation & Management Service* (February 1999).

MISSION STATEMENT

Specialist Obstetric Consultation and Management Service will provide an appropriate service for the assessment, co-ordination and/or management of women with identified needs.

Objective of the Service

- Provide a clearly defined and communicated path for referral and treatment of "at risk" pregnant women.

- Consultation regarding Management Plan has occurred with the client and significant others. The plan is reflective of the client's clinical and personal needs.

- Outpatient clinics will be operated by [the hospital]. The outpatient, antenatal and intrapartum service will be managed by the "On call" Consultant and supported by the HHS (Hospital and Health Service) Midwives.

- Actively work towards a smooth transition back to primary care.

Our Objective is to provide a secondary obstetric service which integrates with existing primary care services in the [hospital] and, as such, provides a clearly defined and communicated path for referral and treatment of 'at risk' pregnant women as defined in the C.R.H.A. referral criteria.

A Specialist Obstetric Consultation and Management Service would take advantage of skills and personnel already in place. Minor changes to focus and structure augers well for a model between fundholder, Practitioner and [the hospital] for facilities and services and provides the "platform" for an integrated centre of excellence.

STRUCTURE The service is designed around the following principles.

1. Specialist Obstetrician assessment co-ordination

The first level of service is the provision of assessment of 'at risk' women by a Consultant Obstetrician, with the provision of written advice back to the Lead Maternity Carer.

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2. Specialist management of care to 'at risk' women.

Transfer of Care to [the public hospital] as Lead Maternity Carer

Women shall be transferred to the care of [the public hospital's] Lead Maternity Carer Secondary team in the event that their condition is assessed by the Consultant Obstetrician to fall within the transfer of care Guidelines. The guidelines are based on the recommendations of the Transitional Health Authority Maternity Management Team July 1997 for Category III cases.

The hospital's *Guidelines for Practitioners for Consultation with an Obstetric Specialist* (1994)

These guidelines are to be read in conjunction with the [hospital's] Obstetric Standards Committee's *Standards and Guidelines for Midwifery and Obstetric Practice for Practitioners with a Contract to use the Facilities*. A practitioner should consult a specialist about women with factors associated with the possibility of a complicated or abnormal outcome.

1 BOOKING VISIT

…

(c)	Current Pregnancy		Associated Risks/Rationale for Listing
	Maternal age		
		…	
		– over 40 years	Higher maternal and foetal mortality
	Parity	– above 5	Higher perinatal mortality, twins, abortion, hypertensive disease, abnormal lie, malpresentation, abnormal labour

2. DURING PREGNANCY

(a)	Foetal welfare assessment	Associated Risks/Rationale for Listing
	…	
	Malpresentation after 36 weeks	Operative delivery, cord prolapse

The hospital's *Policy for Midwives and Medical Practitioner Practising within [the hospital's] Health Obstetric Service* (1994)**.**

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INTRA PROFESSIONAL COMMUNICATION

Effective communication is an essential element of maternity and obstetric care. Information and knowledge is shared between practitioners working in the community and within the hospital.

> **Antenatal** – when a second practitioner becomes involved in the care of a woman, this person has the responsibility to initiate contact with the other.
>
> **Intrapartum** – while the woman is in the Delivery Suite, the practitioners liaise regularly with the shift co-ordinator and/or the midwife who provides intermittent or permanent relief for the woman's care.
>
> **Postnatal** – while the woman is an inpatient, the practitioners liaise with the hospital midwives caring for her at any time.

The nature of the communication will vary, but the following criteria are to be observed:

- The health professionals speak together regularly about the care of the woman or plans for future care and supervision.
- All decisions influencing the care provided to a woman are made jointly by the woman, the practitioner providing care at the time, and the midwife who will be affected by the decision.
- The woman's record, H678 or its equivalent, provides a written record of decisions and plans.

Practitioner = midwife, general practitioner, or obstetrician.

…

MANAGEMENT OF LABOUR

Management may vary, but some principles are important.

- Distinguish primigravidae (nulliparous) from multigravidae. Prolonged labour is more common in primigravidae.
- Accurate diagnosis of labour is important. Interventions in the latent phase may amount to induction, with its associated problems.
- Antenatal risk factors (or their absence) do not necessarily predict labour problems, but an awareness of the antenatal history will aid appropriate labour management.

I Assessment on admission includes:

- Enquiring about the woman's birth plans.

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- Making an appraisal of maternal and foetal welfare (see also Monitoring and Maternal Distress).
- Identifying obstetric risk factors.
- Confirming the normality of the pregnancy (or otherwise).
- Making an accurate diagnosis of labour. In some circumstances this may require observing and examining over a short period (2-4 hours).
- Admission CTG 20 min (note influence of foetal behavioural state which may necessitate a longer trace).
- Informing the practitioners involved in the management of the pregnancy.

Transitional Health Authority Project Team, *Guidelines for Referral to Obstetric and related Specialist Medical Services* (1997):

Purpose of Guidelines

This document provided guidelines for best practice on a consensus of expert opinion and available evidence. It is expected that these criteria will be validated or amended to represent best practice that is evidence based. This process will be dependent on the development and appropriate analysis of the data in perinatal information systems as well as local and international research.

These guidelines have been developed in consultation with the Royal College of Obstetric and Gynaecological Specialist (RNZCOG), The New Zealand College of Midwives (NZCOM), the Royal New Zealand Medical Association (NZMA) and the Paediatric Society of NZ. It has been agreed that these same organisations will be involved in a review of these guidelines after one year.

Circumstances Where Guidelines May be Varied

The THA does not intend the guidelines to be restrictive to good clinical practice and therefore recognises that there are at least five ways in which there may be some flexibility in the use of these criteria:

1. The THA recognises the need for the practitioner to make clinical judgements depending on each situation and some situations may require a course of action which differs from these guidelines. The practitioner will need to be able to justify his/her actions should he/she be required to do so by their professional body.

   It is expected that the principles of informed consent will be followed with regard to these criteria. If a woman elects not to follow the recommended course of action it is expected that the practitioner would take the usual appropriate actions such as

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seeking advice, documenting discussions and exercising wise judgement as to the ongoing provision of care.

…

Timing of Referrals

Referral to a specialist should occur as soon as a problem is suspected or identified.

The Referral Process

Referral for most of the criteria will be to an Obstetrician and, for those listed under Services Following Birth, to a Paediatrician. However in some instances, particularly those criteria involving associated medical conditions, a referral to another Specialist such as a Physician, Anaesthetist, Surgeon, Paediatrician, Infectious Diseases Specialist or Psychiatrist, may also be appropriate or be more appropriate. For some situations a multidisciplinary team will be necessary. Many of the criteria under Labour and Birth Services will require both Obstetrician and Paediatrician.

It is recognised that referral to a woman's usual GP may be appropriate in some circumstances. However these guidelines refer specifically to medical Specialists as on the New Zealand Medical Specialist Register.

These Guidelines for Referral define three levels of referral and consequent action

1 = the Lead Maternity Carer **may recommend** to the woman (or parents in the case of the baby) **that a consultation with a specialist is warranted** given that her pregnancy, labour, birth or puerperium (or the baby) is or may be affected by the condition. The specialist will not automatically assume responsibility for ongoing care. This will depend on the clinical situation and the wishes of the individual woman.

2. = the Lead Maternity Carer **must recommend** to the woman (or parents in the case of the baby) **that a consultation with a specialist is warranted** given that her pregnancy, labour, birth or puerperium (or the baby) is or may be affected by the condition. The specialist will not automatically assume responsibility for ongoing care. This will depend on the clinical situation and the wishes of the individual woman.

…

THE GUIDELINES …

MATERNITY ASSESSMENT – CURRENT PREGNANCY

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Malpresentation	> 36 weeks	Breech, Unstable Lie, Transverse or Oblique lie (Category 2).
Maternal Age	> 37	Assessment for Foetal abnormality and chromosomal studies. (Category 2).

Opinion: Breach – Ms C

In my opinion Ms C breached Rights 4(1), 4(2), and 4(5) of the Code of Health and Disability Services Consumers' Rights.

Rights 4(2) and 4(5)

Referral to antenatal secondary care clinic
Mrs B had the right to maternity care that met professional standards. Mrs B believed that Ms C would seek the help of an obstetrician if there were any problems with the position of her baby. According to the THA guidelines, Ms C should have recommended Mrs B for obstetric assessment at 36 weeks if the lie remained unstable.

In 1999 maternity services and the responsibilities of LMCs were guided by three sets of policy guidelines: the College of Midwives *Standards of Practice*, THA *Guidelines for Referral to Obstetric and related Specialist Medical Services*, and the public hospital's *Referral to Secondary Care* clinic guidelines and access agreements.

The College of Midwives *Code of Ethics and Standards of Practice* focus on providing a woman with optimal maternity care. Standard 2, in keeping with the principles of informed consent, respects the woman's right to refuse or decline treatment and holds the midwife responsible for providing relevant information. Standard 5 addresses issues of planning maternity care and places the obligation on the midwife "to ensure the care plan is women-centred".

The hospital developed a secondary service clinic facility based on THA guidelines. The purpose of the secondary care clinic was assessment, co-ordination and/or management of women in labour and its objective was to provide a clearly defined and communicated path for referral and treatment of 'at risk' pregnant women such as Mrs B. Ms C signed the access agreement in which she agreed to abide by the policy set by the public hospital. Ms C knew about the clinic and discussed its purpose with Mrs B.

According to THA guidelines Mrs B came within category two risk, and therefore her LMC (Ms C) was required to recommend a specialist obstetric assessment during the antenatal period. Ms C told Mrs B about the clinic and made this recommendation to her. She telephoned to make an appointment with Dr F. However, there is no evidence that, in Dr F's absence, she sought Mrs B's consent to discuss her labour and delivery plan with other members of the obstetric team. In my opinion Ms C's omission to seek Mrs B's consent to

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appropriately follow up her labour and delivery placed Mrs B at risk and was a breach of Standard 6 of the College of Midwives *Standards of Practice*.

Under the Code, Mrs B also had the right to co-operation between her maternity care providers, in this case her midwife and the secondary care team, as a means of ensuring quality and continuity of care. Ms C, as Mrs B's LMC, failed to take the necessary steps to ensure co-operation with other members of the obstetric team.

One of my midwifery advisors suggested that if Mrs B had attended the clinic it could have paved the way for a more harmonious relationship between her, Dr D and Ms C. It is clear that Mrs B posed a real risk and was likely to require intervention in the form of forceps delivery or Caesarean section. This possibility should have been discussed between Mr A and Mrs B, Ms C and an obstetrician and plans should have been put in place to address any problems that might arise during labour and delivery.

Mrs B had the right to refuse to attend the clinic. However, in my view, Ms C should have sought Mrs B's permission to discuss her case with the secondary care team so they would be aware of her condition on her arrival at the delivery room and an agreed management plan could have been set up in advance. Ms C failed to provide services in compliance with relevant professional standards and in co-operation with the secondary care team. Accordingly, Ms C breached Rights 4(2) and 4(5) of the Code.

Right 4(1)

Delays in assessing the foetal heart rate

Ms C acknowledged that Mrs B faced real risks during labour and would require careful monitoring. In my opinion she did not adequately monitor the baby's heart rate and missed signs of foetal distress.

Mrs B was unable to tolerate the pressure required to hold the CTG transducer in place. As a result the CTG tracing was of poor quality, there were gaps in the tracing and it was difficult to detect whether decelerations were actual foetal tracing or false foetal reading or the mother's heart rate. The poor quality made detecting any alteration in foetal heart rate and diagnosis of foetal distress difficult. In the early part of Mrs B's admission the baby heart rate did not cause concern. However, as labour progressed, and in the presence of meconium liquor, it became important to reliably and accurately record the foetal heart.

My midwifery advisors agree that, using the CTG tracings, it was possible to detect significant foetal distress from 9.40pm. The baby's heart rate dropped significantly just before the paper in the machine ran out at 9.20pm. When Ms C replaced the paper at 9.33pm the tracing showed a very rapid baseline heart rate to 180 bpm, followed by a drop in rate to 60 bpm. There is no reliable CTG tracing after 9.33pm.

In the absence of a reliable trace Ms C attempted to keep a record of foetal heart rate using a foetal stethoscope. Ms C recorded hearing a foetal heartbeat at 9.40pm and at 10.10pm. She attempted to apply a scalp clip at about 9.55pm but could not record a heartbeat using this method. Her recordings were intermittent and infrequent, mainly because she was

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required to leave the room to obtain equipment or contact other members of the delivery team.

My first midwifery advisor said that readings of foetal distress may not be reliable, and that an abnormal tracing with meconium is related to foetal distress in less than 30% of cases. Given the risks involved with this delivery, it would have been prudent for Ms C to secure a reliable reading and check any indications of foetal distress, even if the reading should later prove to be false.

In mitigation, the room in which Mrs B was placed was not a normal delivery room and did not have a telephone. The room had a call bell system for routine and emergency use and Ms C did not need to leave the room for equipment or to seek help from a hospital midwife. However, between 8.50pm and 9.55pm Ms C made four telephone calls, replaced the paper in the CTG machine, performed three vaginal examinations, took a blood sample in case Mrs B required surgery, administered the epidural and monitored the baby's heart rate intermittently. In this situation she was not available to provide continuity of care to Mrs B, to calm her and seek her co-operation. These interruptions made securing a reliable foetal heart tracing difficult. My advisor concluded that given the circumstances operating that night it was possible that the significance of the trace was lost on Ms C.

It is the role of the midwife to ensure reliable foetal heart rate monitoring. In my opinion Ms C failed to take steps to appropriately monitor the foetal heart rate and did not provide midwifery services with reasonable care and skill. Accordingly, Ms C breached Right 4(1) of the Code.

Communication with Dr E
Ms C contacted Dr E at 9.10pm, before dismissing Dr D. She told him about the number of children Mrs B had, the foetal heart rate and the meconium stained liquor. She told him about the baby's presentation and that Mrs B needed to be seen by an obstetrician. Ms C knew that meconium stained liquor alone did not necessarily mean foetal distress, but she was becoming concerned about the baby's heart rate by 9.50pm when Dr E still had not arrived. It had not been her usual practice when calling an obstetrician to state that he or she was needed urgently, because they would usually come when called, or if unable to do so would brief her on the most appropriate course of action. She expected Dr E within 20–30 minutes of her call. In the meantime, she obtained the assistance of a hospital midwife.

Dr E arrived at 10.20pm. He did not think there was an emergency. Ms C's telephone call conveyed no sense of the urgency expected of a situation where a baby is in distress. Dr E understood that the reason Ms C had asked him to see Mrs B was because of an argument with Dr D. Dr E was not on call and he agreed to see Mrs B because he was coming to the hospital to see another patient.

It is clear that Ms C attempted to provide appropriate maternity care for Mrs B during a rapid and painful labour and under trying circumstances. My midwifery advisors commented on the difficulty of maintaining continuity of care to Mrs B, who was very distressed and required a lot of support, and at the same time frequently leave the room to fetch equipment and make telephone calls.

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My first midwifery advisor concluded that it might have been prudent for Ms C to telephone Dr E again when she was becoming concerned about the baby's heart rate, and Dr E still had not arrived.

Mr A and Mrs B believe that the delay in obstetric intervention caused the baby's death. I am unable to reach that conclusion. The time and cause of her death has not been established, although it is clear that signs of foetal distress were missed.

In my opinion, having dismissed Dr D, Ms C had a duty to obtain specialist obstetric assessment as soon as possible. When Dr E did not arrive within a reasonable time, it would have been prudent to contact him again. By not doing so Ms C failed to provide midwifery services with reasonable care and skill and breached Right 4(1) of the Code.

Opinion: No breach – Ms C

In my opinion Ms C did not breach Rights 4(1) and 6(1)(b) of the Code in relation to the following matters:

Right 6(1)(b)

Adequate information
Mrs B had the right to information that a reasonable consumer in her circumstances needed in order to make an informed choice. This included all the relevant information about her labour and delivery options.

Recommendation to attend secondary care clinic
It is clear that Mrs B's age and the baby's position placed her at risk during labour and delivery. She had three of the risk factors identified by the hospital's guidelines for consultation with an obstetrician.

Mrs B and Ms C discussed a referral because of the baby's abnormal lie. Mrs B agreed to a referral to Dr F, but he was unavailable. They discussed referral again. Mrs B said she was not told she was high risk, simply that her delivery would be no different from her previous two. Mrs B said that Ms C called her to say that the clinic visit was probably unnecessary; she could not get the obstetrician she wanted and another obstetrician might talk her into having a hospital midwife as her LMC.

Ms C referred Mrs B to an obstetrician during her previous pregnancies but since then the clinic had changed. Ms C explained the role of the clinic and said that sometimes maternity care could be transferred to hospital staff. Ms C also pointed out that the obstetrician Mrs B saw at the clinic would not necessarily be the one who would deliver her baby.

Mrs B had had some disagreement with Dr D and she was aware that the other obstetricians performed abortions. Mrs B had copies of Dr F's letters, from 1994 and 1995, in which he noted the risks of an unstable lie. Ms C was comfortable with no obstetric input antenatally

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as long as Mrs B was aware of the risks, as Dr F's advice had indicated no changes in antenatal care, but only in delivery. She and Mrs B discussed his advice on a number of occasions. The plan was to seek immediate specialist advice on arrival at the delivery suite.

On the balance of probabilities I am satisfied that Mrs B was aware of the reasons why a referral was required and of the risks, from both the documented discussions with Ms C and from her previous consultations with Dr F. My midwifery advisors said that it was not unreasonable to continue to manage Mrs B on the basis of Dr F's previous advice, provided that Mrs B agreed to that course of action. When Mrs B decided not to attend the secondary care clinic, she did so on the basis of adequate information. Accordingly, in my opinion Ms C did not breach Right 6(1)(b) of the Code

Consultation with an obstetrician during antenatal admission
Mrs B understood that Ms C would seek the advice of an obstetrician if, when she commenced labour, the baby remained in an oblique lie. Ms C had two opportunities to consult an obstetrician before Mrs B's labour established but failed to do so. The question is whether Ms C required specific consent from Mrs B to seek obstetric advice.

Mrs B was a very experienced mother who held strong views on maternity care. She did not have a scan until very late in her pregnancy and was reluctant to see three of the four obstetricians available in the public health system.

An ultrasound on 9 June 1999, when Mrs B was 38 weeks' gestation, confirmed the baby lying in the slightly oblique position (the same as her last two pregnancies) and she was admitted to hospital the following day. On 11 June Mrs B asked about a Caesarean section and Ms C told her that it was unlikely because she was 10 days early. However, it is clear from Ms C's documentation that they discussed an obstetric assessment and induction of labour which could be performed "within the next few days". Mrs B said that she "would think about it". Mrs B did not authorise Ms C to discuss the matter further with an obstetrician and went home without an obstetric assessment.

I am satisfied that Mrs B knew what her delivery options were and, if she remained in doubt, had the opportunity to advise Ms C that she wished to consult an obstetrician before she went home on 11 June. Ms C was prudent to seek Mrs B's permission before involving the secondary team. In these circumstances, Ms C did not breach Right 4(1) of the Code by failing to consult an obstetrician.

Right 4(1)

Consultation with an obstetrician once labour commenced
Mrs B's baby remained in the oblique position when she went into labour on the afternoon of 14 June. Ms C examined her and advised her to remain at home. Ms C did not consult the obstetrician in the hour of so following this examination and before Mrs B's admission to hospital. Ms C did not plan for the rapid progress and intensity of Mrs B's labour.

Ms C and Mrs B followed their birth plan of early epidural anaesthesia. Ms C knew that an obstetrician would expect to assess Mrs B before authorising an epidural but had known of

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circumstances in the past where this rule was not strictly adhered too. My midwifery advisors confirmed that this occurs. As a result, when Mrs B went into labour the obstetrician on call was unprepared for her arrival, delivery or any complications.

Ms C consulted Dr D before Mrs B arrived at the hospital. She told him that Mrs B was in strong labour and would need an epidural. My second midwifery advisor advised that Mrs B's labour commenced rapidly and painfully; that Ms C could not have predicted this; and that her attempts to obtain obstetric assessment were timely. I am guided by this advice.

In my opinion it would have been prudent for Ms C to discuss Mrs B's management with an obstetrician after she examined her that afternoon. However, in the circumstances, Ms C's actions were reasonable and she did not breach Right 4(1) of the Code.

Ms C's observations
When Mrs B's contractions commenced on the afternoon of 14 June Ms C performed a vaginal examination and found that Mrs B's cervix was not dilated. This was confirmed by subsequent examination. Even though Mrs B doubts Ms C's findings I have no reason to believe that the observations or advice were incorrect.

Wait before seeing an obstetrician
Ms C referred Mrs B to Dr D before her arrival at the hospital. The hospital was very busy; Dr D was the only obstetrician on duty, and he was attending five other women in labour. My second midwifery advisor said that Ms C made a timely and appropriate referral. I accept this advice.

Ms C's response to Mrs B's pain
Mrs B had developed fear of the pain of labour and believed an anaesthetist and obstetrician would be immediately available upon her admission. However, there were other demands on hospital resources that night.

Some of the delay in obtaining pain relief was attributable to Dr D's insistence on an obstetric assessment before authorising the epidural. Mrs B would not consent to the assessment and Dr D had little option but to refer her for epidural nerve block. Ms C contacted the anaesthetist immediately. When the epidural was administered it was not as effective as expected and Mrs B required additional top-ups.

Mrs B experienced some delay before her pain was effectively controlled. However, Ms C took all reasonable steps to secure pain relief for her and any delays were not of Ms C's making.

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Opinion: No breach – Dr D

In my opinion Dr D did not breach Right 4(1) of the Code.

Dr D's response to situation
When Ms C told Dr D that Mrs B was coming into hospital in very strong labour it was the first time he heard about her. Dr D was alarmed because Mrs B had not attended the secondary care clinic, had no delivery plan and faced very real risks at delivery. He was on call in a very busy maternity unit and might not always be immediately available if she, or the baby, got into difficulties.

Dr D advised me that his conversation with Ms C occurred at about 7.30pm before Mr A and Mrs B arrived at the hospital at 7.55pm. He admitted he was "concerned and disappointed" that Ms C had not recognised the risks and sought specialist obstetric assessment, especially since Mrs B had been in hospital a few days before. My obstetric advisor considered it reasonable for Dr D to have expected Mrs B to attend the secondary care clinic during her antenatal period, to have talked through the risks involved with labour and delivery, and to have planned for each eventuality before labour began.

Ms C asked Dr D to authorise an epidural. Mrs B had no observations or CTG recorded. Dr D asked to be informed when these observations had been taken. My obstetric advisor indicated that it is reasonable for an obstetrician to rely on a recent assessment from the midwife before authorising an epidural once labour has commenced and is progressing normally. However, this was not the situation with Mrs B. She was in extreme pain and faced a number of potential risks. Dr D was expected to approve and implement a plan of care that he might oppose on clinical grounds. Once he approved the epidural he would have assumed responsibility for Mrs B.

Dr D wanted to be satisfied that Mrs B and her baby were able to tolerate the additional risks involved with epidural anaesthesia. My obstetric advisor noted that epidural analgesia poses risks to the baby, which can be tolerated if the baby's oxygen supply is adequate. However, "a baby who is already compromised will not cope with further interruptions to its oxygen supply". Furthermore, Mrs B's extreme pain may have been a sign of placental abruption or uterine rupture, both of which are obstetric emergencies, heralded by alterations in foetal heart rate.

It is clear that Mrs B's pregnancy was very high risk and she needed to be carefully monitored. In Ms C's experience, Mrs B would consider only one form of pain relief and, once the epidural was effective, she would consent to any examinations. If Mrs B needed to have a forceps assisted delivery or Caesarean section, the epidural nerve block would be of benefit. Ms C said that Dr D would not listen to her and in her view was very angry. She knew that epidurals had been authorised in the past before these observations were taken.

I accept that it is probable that Dr D was angry with Ms C. He was also very worried about Mrs B and her baby and was anticipating a complicated delivery involving another woman for whom he was responsible. He needed to plan accordingly. My obstetric advisor said

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that she would have criticised Dr D if, in these circumstances, he had not requested the CTG trace and simply ordered the epidural. I accept this advice.

In my opinion Dr D attempted to provide obstetric services with reasonable care and skill and did not breach Right 4(1) of the Code.

Dr D's departure from the delivery suite
When Mrs B arrived at the public hospital she was in extreme pain, screaming and "hitting her leg in pain". She expected that an anaesthetist would be on hand to administer an epidural and was relieved when she saw the epidural equipment outside the delivery room door. She became distressed when Ms C told her that Dr D refused to authorise the epidural until she had a 20 minute CTG trace and obstetric assessment. She allowed Dr D to perform a brief vaginal assessment but refused to allow him to rupture the membranes artificially until after she had the epidural.

Mr A said that Ms C told them Dr D was angry with them because Mrs B had not attended the clinic. Mr A and Mrs B stated that Dr D shouted at them that their baby could die, pulled off his gloves and threw them in the bin as he stormed out of the room. Ms C told them she would contact another obstetrician. Clearly Mrs B was upset by Dr D's actions.

Dr D said that he did not discuss Mrs B's non-attendance at the clinic in front of her and denies that he was angry with them. He was trying to explain to Mrs B that her baby was in real danger. He denies pulling off his gloves in an angry fashion but admits to being very worried. Faced with Mrs B's continued refusal he approved the epidural before he had completely satisfied himself about her or her baby's suitability for the procedure.

Dr D returned to complete his assessment after surgery but Ms C refused him entry. Whether Mr A and Mrs B dismissed Dr D or Ms C advised them that she would contact another obstetrician is not clear.

I am satisfied that Dr D intended to continue caring for Mrs B but was prevented from doing so. It is my opinion that Dr D made reasonable attempts to provide obstetric services in the particularly difficult circumstances of this case and did not breach Right 4(1) of the Code.

Dr D's attempt to perform a vaginal examination
Ms C told Dr D that Mrs B was in painful labour and wanted to have an epidural as soon as she arrived. Dr D did not initially authorise the epidural. He asked Ms C to complete the normal obstetric assessment and 20 minute CTG tracing. Ms C said that she could not do that because Mrs B was in so much pain. Dr D found Mrs B was very distressed. He thought he could complete a quick assessment with Ms C's help. When this failed he authorised the epidural.

My obstetric advisor said that Mrs B's pain could have been a sign of an impending emergency and that Dr D was correct in attempting to assess her labour and likely cause of her pain. Dr D did not refuse to authorise an epidural but attempted to assess her baby's

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ability to tolerate the procedure. I accept this advice. In my opinion Dr D's actions were reasonable in the circumstances and did not breach Right 4(1) of the Code.

Dr D's records
Dr D attempted to perform an obstetric assessment, which included a vaginal examination. On vaginal examination he found Mrs B's membranes bulging. The only way he could come to that conclusion was by vaginal examination. I can find no evidence to support Mrs B's claim that Dr D did not perform a vaginal examination.

Other comments

Availability of equipment
My midwifery advisors indicated that the services provided to Mrs B were not of an appropriate standard but that it is extremely difficult for a midwife to provide continuity of care while constantly leaving the room to obtain equipment or use a telephone.

It is clear to me that the demands on the hospital that night were exceptional and that the rapidity with which Mrs B's labour progressed and the severity of her pain caught everyone by surprise.

Ms C's absences from the delivery room contributed to the delay in delivering appropriate care, and exacerbated the situation. She was unable to stay with Mrs B, offering support and calming her through her distress. Her absences interrupted foetal heart monitoring and delayed Dr D's assessment.

The hospital advised that it is the responsibility of the LMC to check that all equipment is available, and that there was no need for Ms C to constantly leave the room to obtain equipment and midwifery help as there was a call bell system in the room. Staff were available to assist Ms C, had she used the bell to summon help.

Shared care between LMC and secondary care clinic
The likelihood that Mrs B would need secondary intervention in the form of assisted delivery or Caesarean section was high. The DHB established its secondary care clinic as a part of antenatal care for women such as Mrs B, yet she did not attend the clinic.

Women considered at risk are referred to the clinic by the LMC for assessment and the LMC contacts the secondary team for advice on labour management and delivery. Once a woman is referred to the clinic she may be referred back to the LMC to continue antenatal care until the commencement of labour, or sooner, depending on the circumstances. A woman may be transferred into the care of the secondary care team if the obstetrician considers it necessary. There is a perception that in this situation the LMC must relinquish midwifery care of her client and that the woman loses her right to choose her LMC. This perception is incorrect. Ms C advised me that she has referred women to the secondary services clinic in the past who have had a specialist obstetric assessment and been referred back to her for continuing antenatal care.

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Dr F advised me that the hospital is facing increasing numbers of women, such as Mrs B, who present in established labour in difficulties. The obstetrician, who has had no involvement during the antenatal period, or prior warning of impending delivery, is expected to take responsibility for managing her labour and delivery. The secondary care clinic was established to bring an obstetrician into the picture to better manage women at risk. Doubtless all the maternity care providers involved in this case are deeply saddened by the outcome.

Issues raised by obstetric advisor

Clearly, Mrs B expected that, as in her previous two pregnancies, there would be shared care between her midwife and obstetrician. However, this case demonstrated that the maternity team failed to work towards common goals.

My obstetric advisor, and the obstetricians at the hospital, suggested that once an obstetrician authorises epidural anaesthesia, responsibility for care of the mother and baby passes to the obstetrician. This is problematic where there has been no consultation or agreed plan with the LMC.

It is clear that Ms C, Ms H, Ms I, and my midwifery advisors do not agree with the way the hospital implemented the HFA guidelines for referral to secondary services. Ms H and Ms I informed me the LMC could no longer provide services once she has referred her patient to the secondary care clinic, even if it is the woman's choice to remain with the LMC. The midwives consider that the LMC (midwife) retains responsibility for providing services, but that responsibility is shared with the secondary care team. It is clear that there was a misunderstanding between Ms H and Ms I, and possibly Ms C, about the hospital's policy. The purpose of referral to secondary care clinic during the antenatal period is to begin dialogue about the most appropriate way to manage a woman's labour and delivery if she is assessed as likely to require specialist obstetric intervention. Shared care can only work where each member of the team – obstetrician, LMC and parents – discuss and agree upon appropriate arrangements.

Duty to co-operate

My obstetric expert advised that Dr D was correct in ordering a 20 minute CTG tracing and assessing Mrs B before ordering an epidural. Mrs B was high risk and had not been seen by a specialist antenatally. My midwifery experts advised that although it would have been best practice for Dr D to request a 20 minute CTG tracing and examine Mrs B abdominally and vaginally before the epidural was inserted, the extent of her pain made this almost impossible. Dr D was informed of the problem and could see that Mrs B was in obvious distress. Ms C said that Dr D would not listen to her and was intent on carrying out his assessments before the epidural. Mr A and Mrs B said that Dr D was angry with them, shouted at them and told them their baby might die. They stated that he tore off his gloves and stormed out of the room. From this point the relationship between Mr A and Mrs B and Dr D, and between Ms C and Dr D, deteriorated.

I accept that Dr D was technically correct in requiring the CTG tracing and in attempting to assess Mrs B, and that his paramount duty was to ensure safe and effective obstetric care for his patient. However, the communication breakdown that occurred was unfortunate and

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may well have been avoidable. It should be possible to achieve a compromise, even in a difficult case such as this, without placing a woman or her baby at risk.

Actions

Ms C is now overseas, is no longer practising midwifery, and has not provided a forwarding address. In these circumstances, there is no point in recommending any actions for Ms C to implement.

Further actions

- A copy of this opinion will be sent to the Nursing Council of New Zealand and the Medical Council of New Zealand.
- A copy of this opinion, with identifying details removed, will be sent to the New Zealand College of Midwives, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, and the Maternity Services Consumer Council, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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