Midwife, Ms C

A Report by the

Health and Disability Commissioner

(Case 05HDC18619)

Parties involved

Ms A	Consumer
Mr A	Complainant/Ms A's husband
Mr B	Ms A's brother
Ms C	Provider/registered independent midwife
Dr D	Obstetrician and gynaecologist
Ms E	Ms C's lawyer
Ms F	Charge midwife

Complaint

On 21 December 2005 the Commissioner received a complaint from Mr A about the services provided to his wife, Ms A, by midwife Ms C. The following issues were identified for investigation:

The appropriateness and adequacy of the antenatal care Ms C provided to Ms A.

The appropriateness and adequacy of the care Ms C provided to Ms A in relation to the labour and birth of her baby.

An investigation was commenced on 17 March 2006. The investigation has taken 16 months to complete, in part because of disputes in relation to interview transcripts and the complexity of the investigation.

Information reviewed

Information from:

- Ms C
- Ms E/Lawyer representing Ms C
- Ms A
- Mr B
- Mr A
- Duty Consultant at the Hospital
- Dr D
- Ms A's General Practitioner
- Ms F/Charge Midwife
- The District Health Board (The DHB)

Independent expert midwifery advice was obtained from Ms Kay Faulls.

Overview

In February 2005, Ms C became Ms A's Lead Maternity Carer. Ms A (aged 22 years) was approximately eight weeks pregnant and her baby was due in August 2005. In the last month of her pregnancy, Ms C referred Ms A to hospital, owing to concern about fetal movement and Ms A's blood pressure. Ms C's assessment, including a CTG,[1] was that the pregnancy was proceeding normally, and Ms A was discharged home.

Two days later, following the onset of abdominal pain, Ms A was admitted to hospital by Ms C for a further assessment. On this occasion Mrs A was discharged home following an injection of pethidine, to await the establishment of labour. Later that day, Ms A was readmitted in labour, and gave birth at 6.15pm to a still-born baby, Baby A. Due to the amount of skin peeling it is thought that Baby A had been dead for approximately 24 hours prior to delivery.

Information gathered during investigation

Antenatal care
On 16 February 2005 Ms A and her partner, Mr A, attended their general practitioner, who recommended that they contact independent midwife Ms C for the management of Ms A's pregnancy.[2]

According to the Maternity Information Booklet (the booklet),[3] Ms C assessed Ms A for the first time on 7 February 2005 (although this date is now accepted as being incorrect). Ms C recorded that Ms A was "well". Ms C assessed Ms A a further eight times[4] until 29 July, and noted "well" for six appointments, "well scan" for another (18 April), and a partly illegible comment, "… daily", for another (26 May).

On the pages labelled "Careplan", the issues of antenatal care (such as education plan, diet and exercise and specialist referral) are dated as being discussed on 20 February 2005.

On 13 July 2005 the "notes" section of the Booklet records:

[1] Cardiotocograph (CTG): an electronic recording of the fetal heartbeat and (if in labour) the mother's contractions.

[2] Ms A's pregnancy was confirmed in December 2004.

[3] See Appendix 1. The booklet was provided to Ms A by SAMCL Ltd, a company that aims to support health professionals in the provision of optimal maternity care.

[4] 20 February, 10 March, 18 April, 26 May, 9 June, 2, 13 and 22 July.

> "Discussed about labour signs, pain relief options given. Fetal movement monitoring discussed. Discussed — diet and exercise."

On 22 July 2005, the "notes" section of the Booklet records:

> "Birth plan. Husband will be with her. Baby's movement."

On 29 July, Ms C assessed Ms A during a routine antenatal care visit. Ms C stated that she advised Ms A how to recognise the signs and symptoms of labour, and when to contact her. Ms C also stated that she discussed the labour and birth plan, which included a discussion of pain relief. The issues of labour and birth are documented on the careplan as being discussed on 29 July 2005, with the additional note "Pain relief — pethidine, epidural, panadol, warm showers".

Ms C recalls that Ms A "appeared in good health, she was experiencing good fetal movements and the fetal heart [rate] was fine". Ms C stated that she checked the fetal heart rate with a "battery operated sonicaid".

Mr A disputes that there was any discussion about pain relief options prior to the labour. Ms A does not recall any discussion about an epidural or a birth plan.

Mr A stated that on 31 July, Ms A experienced lower abdominal pain and pinkish bleeding, and he reported this to Ms C by telephone. He stated that Ms C said that they were not to worry and the pain was due to the baby moving into position for the birth. Mr A stated:

> "That was not a serious bad pain, it was just felt like, the moment she saw a little bit of blood, really scanty blood, we were alarmed, something's happening, because her tummy was quite big … so, at the end of July we were ready, at the moment we saw bleeding so everybody has said you know that's the first sign, that's when we called her."

Ms C has no recollection of any such discussion. She stated that if she had received a call from Ms A regarding abnormal bleeding or abdominal pain she would have referred Ms A to hospital. Ms A herself cannot recall having any particular concerns at that time.

Saturday

On a Saturday in the last month of her pregnancy, Ms A visited Ms C for a routine check-up. Ms C recorded Ms A's blood pressure as 140/90, which was higher than her normal reading. Ms C also stated that Ms A had complained that "the baby was moving slower than normal". Ms C decided to admit Ms A to hospital to perform a CTG and a further check of her blood pressure. Ms C's lawyer, Ms E, stated:

> "[Ms C] checked the fetal heart rate which appeared to be normal. However, in order to make sure and to reassure the complainant, [Ms C] advised that she would take her to the hospital."

Mr A and Ms A's brother, Mr B, who was living in the same house, recall that Ms C was also concerned about the fetal heart rate. Ms A stated that Ms C was unable to hear the baby's heartbeat, but did not say why.

First hospital admission — Saturday
When Ms A, accompanied by her husband and Mr B, arrived at the delivery suite of the hospital, Ms C performed a CTG at 8.30pm. There are differing recollections about this incident, with Ms A, Mr A and Mr B recalling only a single lengthy CTG recording being produced, while Ms C recalls two recordings being made from two machines.

Ms C informed me that the CTG machine in that room was faulty and "was having trouble picking up the fetal heart beat". Ms C explained that the CTG machine was not printing a proper trace as it was producing an intermittent straight line. After persisting for about 10 minutes, Ms C consulted the Charge Midwife, Ms F.

Ms C informed me that she obtained another CTG monitor, which was a new machine and looked "completely different" from the older machines. She explained that the newer machines were "slimmer" and "easier to use". This necessitated changing the belt attached to the machine. She said "the results from the second machine showed a normal CTG graph" and "did not indicate any cause for concern". Ms E, on behalf of Ms C, stated:

> "[Ms C] noted that the CTG graph showed that it was reactive, with good variability, with accelerations and nil deceleration. The CTG indicated that everything was normal."

Ms C advised me that there was a printout from the first machine she used, but she did not keep it as she considered it was inaccurate, owing to the machine being faulty. (Ms C cannot recall whether the first machine she used had the ability to print the date and time). Ms C's clinical records make no reference to any difficulties with initially obtaining a CTG reading. Ms E stated:

> "[Ms C] acknowledges in hindsight that the printout should have been kept and she should have made the appropriate notes about the faulty machine."

Mr A was present with his wife while Ms C was performing her assessment. He does not recall a second CTG being used, and informed me that a lengthy and erratic CTG recording was produced over a period of over 45 minutes. It has subsequently gone missing from the medical file. Mr A stated:

> "The fetal heart beat was not showing normal. The heartbeat will suddenly go down (almost zero). [Ms C] was not sure why it was showing like that. [Ms C] also told us that [Ms A] was getting little labour pains. [Ms A] instead kept reiterating that the belt is hurting very badly on [her] lower abdomen. [Ms C] told us that it is not normal and she has not seen such plot (CTG) earlier. She reiterated that similar sort of behaviour was being observed at home when she was listening

> to [the] fetal heartbeat. She went out to talk to [the] consultant. Came back and told us she is going to talk to registrar."

Mr B said that a second CTG machine was not used. He recalls that the graph he saw was "definitely" over a metre long and looked like an "earthquake graph".

Ms A also recalls that Ms C used just one CTG machine. Ms A could not see the graph, but recalls that it was "very big" as it was taken over approximately one hour. Ms A stated that Ms C said that the CTG graph had not been plotting because the baby had been moving around, but that it was difficult for her to feel the movement because she was nearing the end of her pregnancy. Ms A indicated that she felt Ms C's explanation was somewhat contradictory.

Ms F, the Charge Midwife at the hospital Delivery Suite at the time, recalls advising Ms C of a fault in the CTG machine in that room. She told Ms C to try an alternative machine. Ms F stated:

> "The fault was a crackly static noise and, from recent communication with biomedical engineering, no fault was found with the ultrasound lead (cardio transducer)."

Ms F advised me that machine X[5] was the only machine with this fault. CTG machine X was also the only available machine that did not automatically print the day and date onto the tracing, and that used the type of paper found in the clinical notes. Ms C has handwritten the date and time (Saturday and 8.30pm) on the CTG tracing for Saturday. (The CTG reading on Ms A's medical file clearly came from CTG X.) Ms C initially wrote Monday, but amended this to Saturday when she realised her error.

The Chief Medical Officer at the Hospital, informed me:

> "The CTG machines are allocated to rooms in [the] delivery suite. The principle is that they stay in the rooms that they are allocated to. Occasionally, the mobile machines are moved from room to room if required.
>
> The CTG machine X was stationed in Room 14."

In response to my provisional opinion, Ms E, on behalf of Ms C, reiterated that Ms C had changed the CTG machine. However, she suggested that the problem Ms C reported to Ms F was not the static noise but that she was not getting a proper trace. Ms E suggests that in fact the second machine Ms C used was model X, and that the first machine she used was a different machine with a different fault.

[5]Machine X was subsequently recertified after having its annual check on a few days later. Two damaged button covers were replaced on that date, but no fault with the ultrasound function was identified. The button covers are cosmetic and were replaced because they were worn.

The Chief Medical Officer, however, informed me that in reviewing the documentation where faults were recorded there were no other machines in the unit at the time thought to have a fault.

Ms C commented that Ms A did not like the CTG belt because it was "tight", but that this was necessary to obtain a reading. Ms C also informed me that she checked Ms A's pulse, which indicated that the CTG machine was recording the baby's pulse, not Ms A's pulse.[6]

Ms C rechecked Ms A's blood pressure, which had fallen to 130/80, and tested Ms A's urine for protein (which was negative). Ms C said that she then contacted the consultant on call, Dr G, because it was hospital policy to inform a consultant about any hospital admission. Ms C initially informed me that she was "100% certain" that she consulted Dr G. Ms C stated that Dr G advised her to contact the registrar if she had any concerns, but "otherwise to send [Ms A] home and monitor her blood pressure over the next couple of days".

Ms C's clinical notes are as follows:

> "20.30 Attended delivery suite with a history of BP 140/100 and slightly reduced fetal movements.
>
> 21.06. CTG reactive, good variability with accelerations nil decals. BP 130/80. MSU nil protein. Consultant informed to discharge her and monitor BP."

CMDHB advised that Dr G was not on duty on Saturday. Dr G does not recall any conversation with Ms C. The consultant on duty on Saturday has no recollection of any discussion with Ms C. He stated:

> "I would have asked midwife [Ms C] whether [Ms A] has any symptoms of high blood pressure and whether the baby felt normal size for the gestation.
>
> …
>
> In the presence of a normal CTG and now normal BP [blood pressure] at 21.06, it was quite appropriate to discharge [Ms A] and then monitor her BP some time in the next 2 days to confirm that it was normal. This would be my standard practice."

Ms C now accepts that she must be mistaken about the consultant to whom she spoke on Saturday, since Dr G was not rostered that day.

Ms C stated that she contacted the registrar "in an abundance of caution". However, the registrar was busy with rounds and could not come immediately. Neither of the registrars on duty on Saturday evening can recall a conversation with Ms C.

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[6] Ms C's clinical notes make no reference to her checking the maternal heartbeat.

Mr A informed me that Ms C said the registrar was asking for "unnecessary things" like blood tests, and admission to the pre-natal unit. He stated:

> " [Ms C] instead of waiting for the registrar took [a] urine test, BP [blood pressure] and declared that everything is normal."

Ms A and Mr A recall that Ms C was angry when she returned from consulting the hospital doctors. She stated:

> "When she returned after her conversation with doctor she was very angry. Doctor said you know I'll finish the round and then I'll come … she [Ms C] was very tired so she didn't want to wait there. Then she check[ed] the [blood] pressure and pressure was down and she checked the baby's heartbeat [with her sonicaid]."

Ms C stated that she told Ms A and Mr A that "they could wait for the registrar if they preferred but that everything appeared to be OK". Ms A and Mr A decided to go home, and they were discharged from hospital — with the plan that Ms C would monitor Ms A's blood pressure over the next few days.

Sunday

Ms A remained concerned at the lack of movement from the baby, but had been told by Ms C that this was because of the increasingly limited space for the baby to move around in. Ms A informed me that the last time she felt the baby move was on Saturday. Ms A commented:

> "I woke up in the morning, next day [Sunday] at the normal time. I told my husband that you know normally I can feel that how many times you know baby's moving around. At that time I told my husband that there's no movement at all. It's like he's sleeping. Baby's sleeping very long time. Then I tapped on both sides and still no movement. And I was feeling heavier down below. Since morning I was a little bit stressed but I didn't have much pain. The pain was started Sunday night. It was a mild pain you know like a slight sore. So midwife told me that that pain was due to pressure."

Mr A commented that Ms A experienced increasing discomfort on Sunday, and did not particularly feel like walking. Mr A stated:

> "Things were just going on, we got up in the morning and we went for another spree of shopping that day I remember and my wife was not willing to walk that day at all, she was saying no I'm not feeling like walking, too difficult to walk, so walking changes a bit, she did not want to get outside and go. So that was one thing that I remember for the day. Later that evening we went to one of her [Ms A's] relative's place where she did complain, you know I haven't felt baby moving today but we just took it so light, because [Ms C] said that the head blocks the baby movement and having seen, you know midwife the night before, she didn't warn us or raise any concern."

Monday

First home assessment

On Monday at approximately 2am, Ms A had severe abdominal pain and contacted Ms C. Ms A described the pain (which began around 11pm) as "unbearable" by 2am and "lower abdominal". She recalls that it was similar to pain she experienced with the CTG machine belt.

Ms C recalls that she was contacted around 2.30am by Mr A, who reported that his wife had developed lower abdominal pain. At Ms C's suggestion, Mr A took Ms A to Ms C's home, which was nearby. Ms C documented performing a vaginal examination at 3am and recorded[7] that Ms A was in early labour. The cervix was not dilated and Ms A was experiencing pressure pain. Ms A's blood pressure was normal. Ms C noted that she "heard" the fetal heart. Ms A specifically recalls that Ms C checked the fetal heart rate, but not her own. Ms C also recorded "[Ms A] stated that she had good FM [fetal movement]".

Ms C stated that Ms A told her the pain was "bearable" and was occurring every 20 minutes. She suggested that Ms A take Panadol for the pain, and contact her if it got worse. Ms A said that she took the Panadol as directed, but was unable to sleep through the night.

Mr A stated that Ms A started bleeding "red blood" at 6am. Ms A said that she was "scared" and described the bleeding as "a very heavy flow" with "big clots" which became smaller after she passed urine. She stated that her undergarments were "full of blood" and she felt "really feeble". This was reported by Mr A by telephone to Ms C, who advised that the bleeding was a normal sign of early labour, and that she would visit at 10am.

In contrast, Ms C is "definitely certain" that she was not contacted at 6am — and there is no documentation of any contact. Mr A subsequently provided a copy of his mobile phone bill, confirming that he telephoned Ms C on Monday at 7.05am. The call lasted one minute.

Second home assessment

Ms C stated that she visited Ms A at her (Ms A's) home at approximately 10am on Monday, to "see how things were going". Ms E, Ms C's lawyer, stated:

> "Ms C decided as she had not heard from the complainant, to drop by on her way to doing some antenatal visits."

Ms A commented that, after the vaginal examination, Ms C's gloves were "full of blood" but she cannot recall seeing any further clots at that stage.

[7] Ms C did not record her assessment of Ms A in her contemporaneous clinical notes. She retrospectively documented her assessment (at 10.30pm on Monday). Ms C explained that she made retrospective clinical records as she was unable to fully document what occurred at the time.

Ms C stated that Ms A informed her that the pain was worsening. She performed a further vaginal examination, and concluded that Ms A's cervix was 2cm dilated and she was in early labour. Ms C observed "a small amount of brownish coloured discharge", which she considered was a "show", and explained this to Ms A.

Ms C commented that it is relatively common for first-time mothers to mistake a "show" for bleeding. Ms C also commented that Ms A was not wearing a pad, which is normally worn when any bleeding arises.

Ms C considered that Ms A's pain was due to early labour pains — but was worse than normally expected at that stage of labour. She claims that she consulted obstetrician Dr D to discuss Ms A's pain (while Ms A had a shower). Ms E stated:

> "It is not usual for someone who is only 2cm dilated to be admitted to hospital. Accordingly, [Ms C] considered it appropriate to consult with [Dr D] about what to do about the pain and whether [Ms A] should be admitted to hospital. … [Ms C], at the request of [Ms A], requested permission to provide some pain relief. [Dr D] advised that [Ms A] could be taken to [Hospital], pethidine administered and she could then return home until such time as labour was established."

Ms A stated that she felt unwell and experienced further bleeding in the shower, which she described as "normal bleeding", without clots. (Mr A reported that his wife was bleeding in the shower with clots.) Mr A recalls telling Ms C that his wife had been "drip-bleeding" in the shower.

Ms C explained that she was still at the house when Ms A finished her shower — during which time she had been consulting with Dr D — and she was not informed of any bleeding in the shower.

Ms C's retrospective clinical notes record:

> "I saw her at home at 10am for an antenatal check. Small show present she was having irregular contractions becoming stronger … Discussion of progress with consultant [Dr D]. Admitted to delivery suite."

Mr A disputes that Ms C remained at their home while Ms A had a shower. He states:

> *"We do not recall [Ms C] having a phone conversation with [Dr D] in front of us. [Ms C] advised us to have a shower and reach hospital, in the meantime she will complete a post-natal visit."*

Dr D has no recollection of being contacted prior to Ms A's hospital admission.

First hospital assessment

At 11.30am on Monday Ms A was admitted to Hospital. Ms C stated that the baby's head was half-way down the pelvis and engaged. She felt that Ms A was not yet in established labour and there were no apparent problems. Ms C explained that she did

not perform a further vaginal examination as this had already been done at home. A further CTG recording was taken, which Ms C considered was normal.

Ms E informed me that Ms C checked Ms A's pulse on "[Saturday and Monday]" to ensure the CTG machine was detecting the fetal pulse rather than the maternal pulse. At interview, Ms C could not remember whether she also took Ms A's pulse manually during Ms A's first hospital assessment. She explained that her standard practice was to take the maternal pulse only if there was concern that the pulse being detected was not the baby's. Ms C's contemporaneous clinical notes make no reference to her checking the maternal pulse.

Ms C advised that she contacted Dr D again to discuss the administration of pethidine and Ms A's discharge. Ms C recorded:

> "CTG reactive with good variability, with accelerations and nil decal[erations]. [Dr D] informed [Ms A] can have pethidine and go home."

Dr D stated that he was first contacted around 11.30am by Ms C from the Delivery Suite of the Hospital. He informed me:

> "I was informed that [Ms A] was in very early labour and was quite distressed and that all her observations including [CTG] were normal. [Ms C] intended to give her sedation (pethidine injection) and sending her home to establish in labour. As I was in a clinic which is at a different site and was not able to attend, my advice was that as an LMC she could do whatever she intended but if she felt that secondary care was needed then she needed to contact the on duty medical staff who were on site, and they could attend."

Dr D subsequently advised me that he now believes the baby had in fact died by this stage, as the degree of maceration (skin peeling) at post-mortem indicated the baby had died approximately 24 hours before the delivery. He commented:

> "The transducer (instrument from the CTG machine put on the mother's abdomen to record baby's heart rate) will pick up any regular fluctuating signals wherever it is placed. In [Ms A's] case it was picking up the mother's pulse. The maternal large vessels (aorta) pulsates and this is transmitted to the mother's abdomen to the transducer. Normally it would be easy to differentiate the mother's pulse (around 80 beats per minute) from the fetal heart rate (110–160 beats per minute) but as [Ms A] had [a] haemorrhage behind her placenta, her heart rate was higher (around 130) which is shown in the monitoring that you have enclosed."

After consulting Dr D, Ms C administered 100mg pethidine (25mg intravenously, 75mg intramuscularly) to Ms A, who fell asleep for approximately 15 minutes. When Ms A awoke she reported excessive wetness and bleeding. Ms C noted in her contemporaneous clinical records that Ms A's membranes ruptured at 12.30pm with

"clear liquor". (This notation was made at approximately 3pm after Ms A had returned to the delivery suite.)

Ms A recalls that Ms C "checked" and told her that her "waters had broken", but did not perform any further observations. According to Ms C, Ms A felt better after sleeping and was then discharged.

Ms C commented:

> "While discharging a patient within one hour of being administered pethidine is not normally recommended, it is hospital policy not to keep the patient in hospital if they are not in established labour. This is due to a shortage of beds in the hospital and that it is generally unnecessary for the patient to be in hospital until they are in established labour."

Dr D also commented that he was not on call and is unsure why Ms C chose to speak to him. Ms E informed me:

> "There is no formal arrangement in place, however, he is the consultant that [Ms C] normally deals with. [Dr D] is [of the same ethnicity] and speaks [the same language]. As [Ms C's] clients are predominately [of this ethnicity] and speak [this language], she considers [Dr D] has a comprehensive understanding of these patients' needs, particularly from a cultural perspective."

Second hospital assessment — delivery

Ms A advised me that her pain increased as the pethidine wore off. The bleeding also continued, and she recalls it being "watery" with "tiny clots". At 2.30pm, Mr A contacted Ms C to advise that Ms A's pain had increased and she was very distressed. Ms C advised them to go to hospital as she believed that Ms A "was progressing into established labour".

Ms C assessed Ms A on arrival at the hospital and "conducted intermittent fetal heart monitoring" which, on admission, was recorded at 3pm as 130 to 140 beats per minute. Ms C explained that she did not perform continuous monitoring as she felt "there were no indicators of any concerns present", and Ms A had previously found the CTG machine belts uncomfortable. She recorded that Ms A was 5cm dilated and was using Entonox for pain relief.

At 4pm, Ms C administered a further 25mg pethidine intravenously because Ms A was becoming more distressed. Ms C said that she offered to arrange an epidural, but it was refused. Ms A stated that an epidural had not been discussed previously (see page 3 above). Mr A declined an epidural for Ms A, as he had been told by a relative about the possible side effects.

Mr A and Ms A stated that an epidural had not been discussed previously (see page 3 above). Ms C informed me (at interview) that she had "probably" previously discussed epidural options as this is her usual practice.

Mr A was concerned that every time she "checked [Ms A] for dilation", Ms C would get "heaps of blood and clots" on her gloves. Ms A stated that her bleeding continued and she had "tiny clots". Mr B was outside the room, and commented that Mr A informed him of "some heavy bleeding". However, Ms C advised him that the bleeding was normal.

Ms C informed me that "a little bit of blood and mucus is not uncommon", particularly after a vaginal examination. She acknowledged that some bleeding occurred, but it was associated with the vaginal examination. She stated that "[t]here were no blood clots on the gloves during labour". If there had been clots present, she would have been concerned and contacted the consultant.

At interview, Ms C explained that she monitored the fetal heart rate after each contraction. It was steady at 120–130, and "sometimes more like" 140 beats per minute (bpm). She described this as a standard range with accelerations. Ms C specifically recalls checking Ms A's pulse at "about half-past three" when an IV luer was inserted to provide fluids to Ms A, as she was becoming dehydrated.[8]

Ms C cannot recall whether she checked the maternal pulse in the final stages of labour. Ms C commented that "there's not really much time for pulse-taking" during the "fast" stage of labour. There is no reference to the maternal heart rate in the contemporaneous or the retrospective clinical records of the delivery.

At 4.30pm and 5pm, Ms C recorded in the contemporaneous clinical notes that the fetal heart rate was 120–130 bpm. Ms C also recorded observations on a partogram chart.[9] The partogram chart combines key observations (such as maternal and fetal heart rate, blood pressure, temperature and contractions) on one chart, and provides an overview of what is occurring. The partogram records the fetal pulse as 150 bpm at 3pm, 3.30pm, 4pm, 4.30pm, 5pm and 5.30pm. The partogram also records the maternal heartbeat as 80 bpm with a rise to 90 bpm around 4.30pm. (There is no partogram recording of the maternal heart rate after 5pm.)

Ms C's contemporaneous clinical notes record that Ms A commenced "pushing" around 5pm. Ms C's retrospective clinical notes record:

> "[Ms A] progressed well in labour. She was fully dilated and 17.15 commenced pushing. Fetal heart heard after each contraction witnessed by family no decels heard no meconium present."

[8] Ms C's contemporaneous clinical notes record that intravenous fluids were provided to Ms A at around 4.10pm. Her retrospective clinical notes indicate that fluids were provided after her consultation with Dr D (at 5.30pm).

[9] See Appendix 3.

Ms C stated that "the pushing was ineffective and [Ms A] was tiring". She contacted Dr D for advice at 5.30pm. Ms C stated that Dr D advised that he was in a clinic, and said that he would arrive by 6pm.

Dr D stated:

> "[Ms C] contacted me again at 17.30hrs on [Monday] because [Ms A] was fully dilated and had been pushing since 17.00hrs but was not progressing in labour. I was also informed that all her observations were normal and that the baby's heart rate trace was also normal. [Ms C] had started her on intravenous fluids as she felt that she was dehydrated. Once again as I was not available to see [Ms A] I advised [Ms C] that she should consult the hospital specialist if she felt secondary care was needed … I explained that if there were no concerns then I could attend after my clinic finished which would be after [6pm]."

Ms C stated that after she contacted Dr D the situation improved, and Ms A was "doing better pushing". Ms C said that she contacted Dr D again at 5.50pm, and advised him that he was no longer required, but Dr D replied that he was on his way and would come in. (There is no reference in the clinical records to Dr D being contacted again. However, Ms A confirms that Dr D was contacted by Ms C and told he was no longer required.)

Ms C advised me that Dr D arrived at 6pm. (Ms C's clinical notes indicate that Dr D arrived between 6pm and 6.15pm.) Dr D stated that he arrived at 6.10pm. He informed me:

> "I found that [Ms A] was making good progress and the baby's head was crowning (very close to delivery). [Ms C] was doing the delivery. Once the head was delivered [Ms C] had difficulty delivering the baby's shoulders and this is when I took over at [Ms C's] request."

Ms C's retrospective notes record:

> "Head crowning [Dr D] arrived. Mum now pushing better. No decels noted … proceeded to normal vaginal delivery of male infant."

Ms C stated that she initially thought the baby was pink and normal, but it did not start to breathe or cry. Ms E stated:

> "The baby was taken to the resuscitation table and the emergency procedures were initiated with the ringing of the emergency bell. Both [Ms C] and [Dr D] were completely stunned as there had been no indications that anything was wrong.
>
> The neonatal team arrived, along with the Charge Midwife. Attempts at cardiac massage and resuscitation failed. The paediatric team announced that the baby was stillborn and a comment was made that the baby could have been dead for a while before delivery (as much as 24 hours) as indicated by the extent of the skin peeling.

> [Ms C] was surprised and concerned at that comment and she recalls saying to the Charge midwife and to [Dr D] that she could not believe it as she had a normal CTG and had a fetal heartbeat. She remembers asking the question 'how can this be?'."

Ms A stated:

> "[T]he midwife was in shock, she said how is it possible, I was listening to the heartbeat of the baby."

Dr D stated:

> "The baby was stillborn but paediatricians were in attendance. After delivering the baby I delivered the placenta which had a large, retroplacental clot (500ml of clotted blood) which I felt was the cause of the fetal demise."

Mr A recalls that the baby appeared "really white" when it was born, but became purple. Dr D commented that "the skull and head [of the baby] felt soft and there was skin peeling which are signs of a dead baby. … [The baby was] grey, mottled, pale, all indicating a dead baby." Mr A stated:

> "[Ms C] kept on saying it seems that the baby passed away in the canal, when [Ms A] was not able to push and I kept on saying, because that's the only thing we could think, before that you were hearing heartbeat and … we don't remember hearing the heartbeat once [Ms A] started pushing, started pushing, so we never heard the heartbeat, so she said baby must have passed on, passed away between that time."

As noted above, Ms C recorded further retrospective clinical notes at 10.30pm. Ms C recorded Ms A's postnatal pulse as being 80 beats per minute.

Ms A was transferred to the ward at 10.40pm. Ms A's family stayed with her until 11.30pm. She then slept through the night. On Tuesday at 8.30am nursing staff recorded Ms A's pulse at 116 bpm. At 11am Ms A was reviewed by Dr D, who authorised a transfusion of three units of blood. She was discharged from hospital on Wednesday.

The pathology report for Baby A revealed an anatomically normal male infant, with evidence of "widespread maceration" [peeling of skin]. The cause of death was noted to be a clinically silent retro-placental haemorrhage. The report stated:

> "At delivery, there was a large retroplacental blood clot of approximately 500mls. The infant showed evidence of early maceration [peeling of skin].
>
> Postmortem examination showed an anatomically normal male infant with widespread evidence of maceration. The findings were consistent with an acute asphyxial event in-utero. No evidence of infection was identified."

On 25 August 2005, Ms A and Mr A met with Dr D to discuss what had occurred. Mr A recalled Dr D explaining that the baby had been dead for "at least 24 hours" (indicated by the extent of the maceration). Dr D told Mr A that the fetal heart rate heard on the monitor was either an "artefact" or the maternal pulse. Dr D recorded "pregnancy normal good care by LM [Ms C]". He also recorded:

> "Problems discussed
>
> [Saturday] BP [blood pressure] up, FHR [fetal heart rate] down. Husband says FHR dropped several times — no record on CTG in file. Was not seen by medical staff for increased blood pressure as midwife wanted to go home. Was reassured — blood pressure became normal and CTG was normal.
>
> Bleeding and constant pain
>
> Had fresh bleeding on Sunday night and had excruciating constant pain on [Sunday] night. Seen by LM [lead maternity carer] who examined, did VE [vaginal examination] and listened to FH [fetal heart] and explained — early labour — cervix 2cm dilated.
>
> Monitoring
>
> Explained that FHR on monitor was artefact or maternal pulse recording."

Mr A stated that Dr D was unaware of Ms A's bleeding and abdominal pain, as Ms C's clinical records made no reference to them. In addition, Dr D did not have reference to the lengthy CTG recording taken on Saturday, as this had been disposed of by Ms C.

Altered records

Mr A informed me that the maternity information booklet (which Ms C had taken with her after the delivery) was returned altered, with "false entries" of visits made while he and his wife were overseas,[10] and incorrect information (particularly in relation to the epidural).

The hospital sent me a copy of the pages of the booklet taken for the purposes of the morbidity and mortality review[11] — before additional information was subsequently added by Ms C. These pages are the "maternity record" and the "antenatal visit information record".

The original antenatal visit information record has maturity calculations entered in the first two consecutive columns, indicating that two initial undated visits occurred. No

[10] Mr A and Ms A were overseas from 2 to 14 February 2005. Mr A also believes there was no visit to Ms C on 20 February 2005. This was a Sunday and the initial visits occurred at the GP's clinic, which was closed on a Sunday.

[11] See Appendix 2 for original booklet pages.

other information is entered with respect to these two initial visits. Ms C has subsequently dated the first two visits as occurring on 7 and 20 February 2005, and has also added blood pressure recordings, weight (60kg on 7 February) and the comments "well".

The amended antenatal visit information record also has the comment "well" added for the day of her first hospital admission. In addition, a visit dated Sunday, the following day, has been added. The added entry includes a blood pressure reading and a note (partly illegible) stating "some contractions". Neither Mr A nor Ms A has any recollection of seeing Ms C on the Sunday. At interview, Ms C stated that "[t]hey never called me on Sunday".

The original maternity record has no recording in the column concerning allergies, whereas the amended book has the note "nil". The original maternity record makes no reference to Ms A's previous pregnancy, whereas the amended book records a termination of pregnancy in 2003. The original maternity record also has no record of Ms A's initial weight, whereas it has been subsequently noted in the maternity record section of the booklet as 60kg.

Ms C accepts that the appointment recorded on 7 February 2005 was incorrect. However, she is certain that the number of appointments she recorded is correct. Ms E, acting on behalf of Ms C, stated:

> "[Ms C] explains that she may well have got this date wrong as it was written retrospectively and from her memory. [Ms C] accepts that such record keeping practices are unacceptable and recognises that documentation is a weakness of her practice."

In all other respects, Ms C states that the maternity information booklet provides an accurate record of her care.

Independent advice to Commissioner

The following expert advice was obtained from Ms Kay Faulls:

> "I, Kay Beverley Faulls, have been asked to provide an opinion to the Commissioner on case number 05HDC18619, and I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.
>
> I am a New Zealand Registered General and Obstetric Nurse 1976 and Registered Midwife 1978.

I worked at Christchurch Women's Hospital, Christchurch both as a midwife in birthing suite 1981–1983 and as Charge midwife in a 20–bed antenatal and postnatal ward, 1986–1989.

I have worked as an Independent Midwife and Lead Maternity Carer since 1992, caring for 40–50 women and their families per year.

I have been involved with the Midwifery Standards Review Committee, Canterbury and West Coast Region, New Zealand College of Midwives (NZCOM) from1993–1997.

I am the Midwifery member of the Resolutions Committee, Canterbury and West Coast Region (NZCOM) Inc from 2002 till present day.

I have been an Expert Advisor for the New Zealand College of Midwives Inc since 2005.

I am familiar with the use of cardio-toco-graph monitoring equipment and the Hewlett Packard machine, model X used at [the Hospital].

Expert Advice to Health and Disability Commissioner

Complaint: [Ms C]

Your Ref 05/18619

In your professional opinion, were the services provided to [Ms A] by Midwife [Ms C] appropriate?

"In my professional opinion some of the services provided by midwife [Ms C] to [Ms A] were appropriate, others were not.

The Midwives Handbook for Practice ISBN0–476-011728, updated version published by the New Zealand College of Midwives — 2005 Christchurch is written for midwives, women and the general public, and identifies the beliefs that midwives hold about midwifery.

Contained within this handbook are:

1. Definition of a midwife
2. The scope of Practice of the midwife
3. Standards for Midwifery Practice
4. Decision Points for Midwifery Care.

I have used this handbook as the basis for my professional opinion.

Standard Two of the Midwives Handbook states:

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

Amongst the criteria the midwife **develops a plan for midwifery care together with the woman and documents decisions and her midwifery actions.**

[Ms A] states in her interview with [the Commissioner's staff] that there was no antenatal discussion on a birth plan or pain relief in labour. Certainly there is no available documentation to support decisions made between [Ms C] and [Ms A] and the subsequent midwifery action undertaken.

I was provided with the original green covered **Maternity Information Booklet** provided to [Ms A] by [Ms C]. This contains all the documentation of the midwifery care provided by [Ms C].

On the pages labelled 'Careplan' it is not sufficient to date issues discussed without outlining the discussion. There is no documentation as to a comprehensive 'plan of care'.

There are two entries in the green Maternity Information Booklet dated 13/7 and 22/7 that some issues were discussed, including labour signs, pain relief options, fetal movement, monitoring, diet and exercise, birth plan but this is not supported by either [Ms A] or [Mr A].

Standard Three of the Midwives handbook states:

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

Amongst the criteria in this standard the midwife **documents her assessments and uses them as the basis for ongoing midwifery practice.**

I can find no evidence of comprehensive assessments done by [Ms C]. Certainly there were a number of antenatal visits by [Ms C] to [Ms A] during the pregnancy but it is inadequate to write 'well' at each visit without further explanation.

Standard Five of the Midwives handbook states:

Midwifery care is planned with the woman.

The midwife **provides access to a variety of information sources, ensures the care plan is woman-centred and involves and respects the woman's significant others in care as desired by the woman.**

There is no supporting documentation to know if [Ms A] read or was given any information on pain relief in labour. The New Zealand College of Midwives (Inc.) also publishes a leaflet titled 'Labour Pains — Making choices', NZCOM 2003.

This is a valuable resource for women and midwives offering information on pain relief in labour. There is no documentation to suggest [Ms A] read this leaflet.

There is no documentation to support the claim that epidural analgesia was discussed with this family in any depth or form prior to [the day of the birth].

This standard also states the midwife **sets out specific midwifery decisions and actions in an effort to meet the woman's goals and expectations and documents these.**

This does not appear to have been done.

Standard Six of the Midwives handbook states:

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

The midwife **ensures assessment is ongoing and modifies the midwifery plan accordingly.**

As there was no midwifery plan in place for [Ms A] this standard has not been met.

Standard Seven of the Midwives handbook states:

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

The midwife **clearly documents her decisions and professional actions.**

[Ms C] provided frequent antenatal visits to [Ms A]. It appears recordings of blood pressure, urinalysis and fetal heart were documented. There are some written comments as to what was discussed but these are too brief to be of value.

There are a number of discrepancies between the original green Maternity Information booklet and the photocopy of the same booklet taken by hospital staff on [the day of the birth]. There appears to have been additional information added after the photocopying was done.

The portion of the report above answers questions one to five of the required expert advice.

Question Six of the Expert Advice Required asks — **were there any signs of fetal distress or concern that [Ms C] should have detected prior to [Ms A's] hospital admission on [Saturday]?**

There does not appear to be any documentation to show [Ms C] was informed of the lower abdominal pain and very scanty bleeding, pinkish, reported by [Ms A] on 31st July.

Question Seven of the Expert Advice Required asks **'Did [Ms C] take adequate steps to monitor the fetal heart rate and other vital signs during [Ms A's] hospital admission on [Saturday]?'**

I have reviewed both a photocopy and the original recording of the cardio-toco-graph undertaken by [Ms C]. It shows a sixteen (16) minute recording of a fetal heart rate of 140–180 beats per minute. It shows one acceleration to 180 beats per minute and no decelerations.

This cardio-toco-graph does not have time and date printed on it by the machine. A handprinted time and date is shown. This sixteen (16) minute recording appears to be in conflict with both parents' recollection of a much longer piece of recording paper not included in any information provided to me.

To be of any clinical value it is usual to have **a continuous cardio-toco-graph recording of 20 to 30 minutes available to be seen.**

[Ms C] makes no comment as to palpation of [Ms A's] uterus, especially as [Ms A] remembers complaining of lower abdominal pain when the cardio-toco-graph belts were attached to her abdomen.

It is also documented that there have been 'slightly reduced fetal movements' but does not say for how long. I would expect, given that there is a 'Count to 10' baby movement chart in the green **Maternity Information Booklet** provided by [Ms C] to [Ms A], that this should have been commenced.

[Ms C] did document a blood pressure of 130/80 and MSU — nil proteinuria.

[Ms C] did take reasonable steps to monitor the fetal heart and other vital signs on [Saturday].

Question Eight of the Expert Advice Required asks '**was it appropriate for [Ms A] to be discharged on [Saturday]?'**

It was appropriate for [Ms A] to be discharged on [Saturday] although no formal follow-up appears to have been organised only that 'blood pressure to be monitored' is documented in the hospital notes.

Question Nine of the Expert Advice Required asks **'Did [Ms C] provide an appropriate standard of care in relation to [Ms A's] first hospital admission on [Monday], including whether it was appropriate to discharge [Ms A] after the administration of pethidine on [Monday]?'**

It is usual Midwifery Practice once pethidine has been administered, especially intravenously, to monitor the fetal heart and the blood pressure and pulse of the mother. There is no clear documentation in the hospital records that this was done.

There is also no documentation as to the spontaneous rupture of the membranes prior to discharge at 12.30pm on [Monday]. There is no record of the fetal heart recording being taken or documented prior to discharge.

There is also no mention made of the timing of uterine contractions — the length, strength and frequency of the contractions is not documented.

According to the Midwives Handbook for Practice **The second decision point[12] in labour — when the woman wants intermittent support from midwife information shared should include:**

Check blood pressure and pulse.

Assess contractions, lie presentation and descent of baby.

I am very concerned that there was no mention of fetal heart rate being listened to after the pethidine was administered or after the spontaneous rupture of membranes.

It would have been prudent midwifery practice to keep [Ms A] at the hospital for at least one hour after the pethidine was administered especially in light of the membrane rupture.

Question Ten states: '**Please comment on the standard of care provided to [Ms A] by [Ms C] during the labour on [Monday], including whether [Ms C] took adequate steps to monitor the baby's vital signs.'**

The documentation of [Ms A's] labour is not comprehensive or clear — the clinical notes written in retrospect contain more information.

[Ms C] states that the baby's heart was heard after every contraction but this is not documented in the hospital notes apart from on the partogram. There is a rate of 140–150 beats per minute documented on the partogram, yet in the other notes [the contemporaneous clinical records] it is documented as 120–130 beats per minute.

[Ms C] did provide [Ms A] with further pain relief, both Entonox and pethidine and also intravenous fluids for hydration.

[12] The decision points in the *Midwives Handbook for Practice* identify those times when there ought to be an assessment during pregnancy and childbirth.

[Ms C] did provide an adequate standard of care, given that she believed this to be a 'low risk' labour. However information and documentation aspects of the care were inadequate.

Question Eleven asks: **please comment on whether the CTG machine readings (and [Ms C's] hand-held device) may have been detecting an artefact pulse or the maternal pulse.**

I am unable to comment on this as the length of the CTG recordings available to me was insufficient. I have examined the original CTG recording and am still no clearer whether this is artefact as stated by [Dr D] or indeed the fetal heart.

It is possible that [Ms C] was hearing [Ms A's] pulse and not the fetal heart when she listened with her handheld device.

'**Although continuous electronic fetal monitoring gives a substantially more accurate measurement of the fetal heart rate, the interpretation of fetal heart traces is open to great variation. Tracings are often interpreted differently, not only by different obstetricians, but also by the same obstetrician at a later date. The problem with electronic fetal heart monitoring is not its ability to measure but in its interpretation.'**

Chapter 31. Page 192 A guide to effective care in pregnancy.

Murray Enkin, Marc J.N.C.Keirse and Iain Chalmers.

Oxford University Press, first published 1989.

Question Twelve asks '**did [Ms C] appropriately document her care?'**

[Ms C] did not document her care appropriately.

The green Maternity Information booklet provided to [Ms C] by South Auckland Maternity Care Ltd[13] is an inadequate forum to provide women with all the information they are entitled to so they may make informed decisions and choices during their pregnancy.

After discussion with [the HDC Office] on 27 February 2007, I am enclosing a copy of the notes used by midwives who belong to the Midwifery and Maternity Provider Organisation.

These notes were developed by midwives to use in accordance with the standards of practice set out by the New Zealand College of Midwives (Inc). They provide a

[13] Now trading as SAMCL Ltd.

venue for midwives to comprehensively document the care they give to pregnant woman and their families. They also comply with the contractual agreement outlined by the Ministry of Health Notice Pursuant to Section 88 of the New Zealand Public Health & Disability Act 2000.

Summary

[Ms C's] documentation is not of an adequate standard for a New Zealand Registered Midwife.

Not only does this lack of documentation fall below the standard expected of a midwife it also fails to meet [Ms C's] contractual agreement with the Ministry of Health. As an independent self-employed midwife, [Ms C] has entered an agreement with the Ministry of Health to provide midwifery services under Section 88 of the New Zealand Public Health & Disability Act 2000.

A 'Care Plan' means the process by which the Lead Maternity Carer ([Ms C]) and the woman ([Ms A]) develop a plan of care for the woman and her baby and the documentation of this plan throughout the individual clinical notes pertaining to the woman.

This care plan should cover, as a minimum:[14]

(a) schedule and location of visits for pregnancy care;
(b) how continuity of care will be achieved;
(c) how to access the Lead Maternity Carer in urgent situations;
(d) cultural safety requirements;
(e) education plan during pregnancy and following birth;
(f) referral to other midwifery, medical social and diagnostic services;
(g) smoking cessation options;
(h) screening for infectious diseases;
(i) assessment of risk of family violence;
(j) location of birth and other services including booking in to a facility or arrangements for home birth;
(k) presence of others at birth;
(l) birth environment and position for birthing;
(m) options and preference for monitoring, intervention and treatments;
(n) handling of placenta;
(o) breastfeeding or other feeding arrangements;
(p) likely stay in the Maternity facility and planning to go home;
(q) requirements for postnatal care;
(r) risk of postnatal depression and support options;

[14] Appendix III of the maternity services notice under section 88 of the New Zealand Public Health and Disability Act sets out the minimum requirements for a care plan.

(s) advice regarding contraception and sexuality; and
(t) referral to Well Child provider and the timing of this.

I believe that [Ms C's] professional peers would view this lack of documentation and therefore the midwifery services provided by [Ms C] with moderate to severe disapproval.

(References)

New Zealand College of Midwives (2002). Midwives Handbook for Practice.

Enkin, Keirse and Chalmers (1994). A Guide to Effective Care in Pregnancy and Childbirth, Oxford University Press.

New Zealand College of Midwives (2003). Labour Pains — Making Choices.

Ministry of Health. Maternity Services Notice pursuant to Section 88 of the New Zealand Public Health & Disability Act 2000. This notice is issued by the Crown and is effective from 1 July 2002.

Documents enclosed with this report

Midwifery and Maternity Provider Organisation Maternity Notes

MMPO Ltd 1998

New Zealand College of Midwives (2003). Labour Pains — Making Choices."

Further expert advice
Ms Faulls further advised that she "is certain" that the CTG recording of Saturday was that of the baby and not the mother. She informed me that, clinically, it was of just sufficient length to provide a reasonable reading of the baby's heart rate. Ms Faulls stated that it was appropriate to discharge [Ms A] on Saturday. However, better follow-up should have occurred with checking of blood pressure and fetal heart rate the next day, together with the number/frequency of movements/contractions. Optimally, [Ms C] should have carefully documented the nature of [Ms A's] pain (contraction pain is intermittent, whereas pain from a haemorrhage is ongoing). Ms Faulls also commented that [Ms C] was not alert to the significance of the lower abdominal pain [Ms A] was experiencing. The pain, combined with the report of reduced fetal movements, was probably a sign of fetal distress.

Overall, Ms Faulls considered that [Ms C] provided reasonable care on Saturday as there were no overt signs of fetal distress, in what was considered to be a low-risk labour.

Ms Faulls also commented that the lack of documentation has made it hard to assess certain aspects of clinical care. For example, to document a "show" rather than "blood

stained liquor" provides very little clinical detail. There is no documentation of the report from [Ms A] of bleeding on 31 July, and Ms Faulls is therefore unable to conclude that this occurred. As noted above, the precise nature of abdominal pain is not documented.

Ms Faulls considered that the death of the baby probably occurred on Sunday and was an unexpected incidental event in an otherwise healthy child. The retroplacental clot ceased the supply of blood to the baby from the placenta. It is very hard to say whether the baby would have survived if this had occurred in hospital.

Ms Faulls commented that the pulse readings for Monday may have been the maternal pulse. Maternal pulses are normally 80–100, but if the haemorrhage had already occurred then the pulse may have been higher.

Ms Faulls further commented that the partogram appears to have been "manufactured" as there could not have been a maternal and fetal pulse if the baby was dead, and the fetal heart recordings are too regular. Ms Faulls stated that, in light of the issues of credibility, including the apparent fabrication of the partogram, she was "entirely comfortable" with the Commissioner adopting a more critical approach than she had in her report.

Responses to provisional opinion

Ms C
On behalf of Ms C, Ms E emphasised that the death of Baby A was a tragic event that was caused by a clinically silent large retroplacental clot and not Ms C's care. Ms E submitted that Ms C appropriately assessed Ms A's bleeding and abdominal pain, and suggested that the Commissioner's presumption that in light of the stillbirth it was possible that there was abnormal bleeding and clots is incorrect, as the haemorrhaging was behind the placenta and was concealed.

Ms E reiterated that Ms C's care was appropriate given the symptoms that she observed directly and those that were reported to her. Ms E also commented that there were differing accounts of bleeding and reports of bleeding to Ms C, and that on three occasions Mr A's and Ms A's accounts contradict each other. Ms E suggests that if Ms A had reported heavy bleeding to Ms C, and there were clots on her gloves during the examinations, Ms C would have recognised this as a cause for serious concern. Ms C has over 20 years' experience in obstetrics and over eight years' experience as a midwife, and knows how to recognise and take the appropriate action with antepartum haemorrhaging. Ms E suggested that it is inconceivable that Ms C would simply ignore such serious symptoms if they had been observed by her or reported to her. Ms A was appropriately assessed as a low-risk labour, and there were no signs of fetal distress.

Ms E submitted that Ms C cannot be criticised for her interpretation of the CTG recording on Monday owing to the inherent unreliability of CTG recordings, which can only ever be used as a guide. She stated:

> "As Ms Faulls points out (and as was discussed during [Ms C's] interview), the interpretation of fetal heart traces is open to great variation and can be interpreted differently by different obstetricians, or even the same obstetricians at a later date."

Ms E suggests that an abnormal trace has a 50% false positive rate (ie, 50% of fetal heart rate abnormalities do not signify fetal compromise), and that a low baseline FHR (around 100 bpm) in a fetus at full term is not necessarily an indication of abnormality.

Ms E emphasised that the fetal demise would not necessarily have been detected if a comprehensive check had been undertaken after the administration of pethidine (on Monday). As this was a low-risk labour, Ms C's reliance on the CTG reading was reasonable in the circumstances. Even if Ms C had compared the maternal pulse with the CTG trace, this may not have resulted in the fetal demise being detected as it can be difficult to distinguish between the two. Ms E suggested that it is not routine to compare maternal pulse with the CTG trace during the course of a normal labour and a low-risk pregnancy.

Overall, Ms E submitted that there is no basis in law to disregard Ms Faulls' view that Ms C provided an appropriate standard of care. Ms E submitted that the Commissioner is not qualified to make judgements on medical matters or clinical judgements without receiving expert advice, and can only disregard expert advice where such advice is illogical or unreasonable. She also noted Ms Faulls' expertise and experience and that there was "no expert medical evidence" supporting the Commissioner's view. Ms E submitted that given the Commissioner's role to act independently and objectively, it was not open to refuse to accept independent expert advice without providing a reasonable basis for doing so.

Ms E further submitted that while Ms C's documentation of her care was poor, there was no deliberate intention to mislead. Ms C was "extremely distressed" by what occurred and "her judgement was clouded". Ms E stated that Ms C has taken significant steps to rectify that area of her practice of her own accord and also following the competence and midwifery standards reviews that she has undertaken. Ms C now makes a conscious effort to ensure that all matters raised or discussed are documented in her notes, and supplements the notes with a diary in which she records all telephone conversations at the time they occur.

Ms E argued that at no time had Ms C misled the Commissioner in terms of the additions to her notes, and argued that this distinguished Ms C's actions from the defendant in Director of Proceedings v Martin (Decision No 58/Med05/15D NZHPDT, 31 August 2006). Ms C advised the Commissioner of her own accord that she had made additions to her notes and that her documentation was below acceptable standards. Ms E also suggested that it is acceptable practice to make additions to

patient notes, as long as the time and date of the additions is made clear (which Ms C failed to do). Ms E accepts that Ms C also made errors failing to record the date the alterations to the clinical records were made; recording information from her memory that was inaccurate (such as the date of certain visits); and failing to adequately record her care. These were serious shortcomings. However, Ms E explained that Ms C made the amendments after the baby's death as she appreciated that the most complete set of information possible would be required as a result of the death. Her motivation was to provide a more full picture of her care, as she realised that her contemporaneous notes were sparse and did not provide a full picture.

Ms E submitted:

> "[Ms C] was shocked at the outcome, she was extremely distressed and made a very poor decision to make additions to her notes, without recording the date those additions were made. She did not understand at the time the importance of recording the date the additions were made. However, she did not act deceitfully in her responses to the Commissioner's investigation."

SAMCL Ltd

The SAMCL Ltd Chief Executive commented that SAMCL does not accept Ms Faulls' view that the booklet is "inadequate" for the comprehensive documentation of maternity care. SAMCL is very aware of the need for the midwives to keep appropriate records. This has been the subject of several articles in its fortnightly newsletter, which has emphasised the importance of not just ticking boxes but recording contents of discussions, decisions made and date and time as appropriate. The Chief Executive explained that the antenatal record books are provided to SAMCL midwife members for their use and are intended to be the medium in which the midwives may, if they choose, record their notes. The actual notes remain the responsibility of the midwife.

SAMCL also advised that in May 2006 it commenced a review of the maternity antenatal record forms. This included reviewing five different antenatal record books from within New Zealand and several from overseas. The best was considered to be the antenatal record developed in Birmingham as part of the Manners Project for the English National Health Service. SAMCL has already taken steps to draft revised records based on that record, tailored for New Zealand conditions. It is anticipated that the new record will be available in September 2007.

Code of Health and Disability Services Consumers' Rights

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

RIGHT 4
Right to Services of an Appropriate Standard

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

RIGHT 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 …

Other relevant standards

The New Zealand College of Midwives *Midwives Handbook for Practice* (2002)

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

Opinion: Breach — Ms C

The stillbirth of Baby A was a tragic event that has had a huge impact on Mr A and Ms A. It seems fairly certain that Baby A's death was a result of retroplacental haemorrhage, a condition that is difficult to detect. This report does not determine whether his death was caused by Ms C's care (an issue that is not for the Commissioner to determine) but whether her care was of an appropriate standard.

Antenatal care

Under Right 6(1) of the Code, Ms A was entitled to the information that a reasonable consumer in her circumstances would expect to receive, including information about pain relief and labour delivery options. The provision of adequate information is an integral component of antenatal care, as it gives the mother the opportunity to carefully

consider her options prior to birth and delivery, and to formulate a plan in conjunction with her midwife and her partner or any support person.

Right 4(2) of the Code entitled Ms A to care from Ms C that met professional standards. Giving adequate information about pain relief and labour delivery options, and developing an appropriate care plan in consultation with the mother, is required by the Maternity Services Notice issued under section 88 of the New Zealand Public Health and Disability Act 2000, and under relevant standards in the *Midwives Handbook for Practice*.

It is not disputed that Ms A declined an epidural during her labour and elected to receive pethidine to relieve the pain associated with childbirth. Mr A advised me that he had heard from a relative about side effects that can be associated with an epidural. Neither Ms A nor Mr A can recall any discussion with Ms C about pain relief. Ms A also cannot recall any particular discussion about a birth plan. At interview Ms C could not recall specifically discussing pain relief, but stated that it was her usual practice to do so.

Ms C documented brief reference to a birth plan on 22 July 2005, stating "husband will be with her". Pain relief options are documented as being discussed on 13 July with the note "pain relief options given". The issues of labour and birth are bracketed on the care plan as being discussed on 29 July 2005, with the additional note "Pain relief — pethidine, epidural, panadol, warm showers".

My midwifery advisor, Ms Faulls, commented:

> "[Ms A] states in her interview with [the Commissioner's staff] that there was no antenatal discussion on a birth plan or pain relief in labour. Certainly there is no available documentation to support decisions made between [Ms C] and [Ms A] and the subsequent midwifery action undertaken.
>
> …
>
> There is no supporting documentation to know if [Ms A] read or was given any information on pain relief in labour. The New Zealand College of Midwives (Inc.) also publishes a leaflet titled 'Labour Pains — making choices', NZCOM 2003. This is a valuable resource for women and midwives offering information on pain relief in labour. There is no documentation to suggest [Ms A] read this leaflet.
>
> There is no documentation to support the claim that epidural analgesia was discussed with this family in any depth or form prior to [the day of the birth]."

Ms Faulls drew particular attention to Standard Two of the *Midwives Handbook for Practice*, which emphasises that there should be informed choice and consent "throughout the childbirth experience".

As noted above, there is no indication from the documentation that labour and birth were discussed other than in a perfunctory manner. Overall, I am inclined to the view that although some references were made to pain relief there was insufficient information provided to Ms C about pain relief options. There also appears to have been minimal discussion about any particular birth plan.

Accordingly, Ms C breached Right 6(1) of the Code by failing to provide Ms A with the information she could reasonably expect to receive in her circumstances.

Standard of care — hospital admissions and delivery

Under Right 4(1) of the Code, Ms C had the right to services provided with reasonable care and skill. Overall, I consider that the care provided by Ms C in relation to Ms A's labour and delivery was unsatisfactory, and constituted a breach of Right 4(1).

On Saturday, Ms C referred Ms A to hospital to perform a CTG recording and check her blood pressure. Mr A and Ms A also recall that Ms C was concerned about the fetal heart rate. Ms C advised me that Ms A had reported that the baby was moving more slowly, and she referred her to hospital to check that the fetal heart rate was normal, and to reassure Ms A and Mr A.

There are differing accounts of whether Ms C used one or two CTG machines. This issue cannot be determined by reference to the available documentation. All that the documentation proves is that at least one 16-minute tracing was recorded. This has been confirmed as being recorded by machine X, being the only machine that used the type of paper that the CTG tracing was printed on. It is also the only machine that did not automatically record the date and time. Whether this was the only reading taken, or whether it was the first or second reading, is impossible to tell.

Ms C asserts that she used two different machines because the first machine she used was faulty. Ms A, Mr A and Ms A's brother, Mr B, who were present, recall only one machine being used and state that a lengthy graph was produced. Ms C, in response to my provisional opinion, suggested that she first used another unidentified machine that had a fault, and then transferred to machine X. However, Ms F, Charge Midwife, informed me that Ms C was using X when Ms F advised her to change machines. The Chief Medical Officer from the Hospital advised that the only known machine with a fault at the time was X, and that it was in room 14 when it was used by Ms C and Ms A.

Ultimately I am unable to reach a conclusion as to whether one or two machines were used and whether the tracing that is on the file is the first or second recording. Ms Faulls, my expert advisor, commented that the CTG tracing that is available shows a 16-minute recording of a fetal heart rate of 140–180 beats per minute with one acceleration to 180 beats per minute and no decelerations. Ms Faulls commented that she "is certain" that the CTG recording of Saturday was that of the baby and not the mother. Although she advised that to be of any clinical value it is usual to have a continuous cardiotocograph recording of 20 to 30 minutes available to be seen, she

considered that, clinically, the 16-minute tracing was just of sufficient length to provide a reading of the baby's heart rate.

Ms Faulls noted that Ms C also rechecked Ms A's blood pressure, which had fallen to 130/80, and tested Ms A's urine for protein (which was negative).

Ms C stated that she spoke to the hospital consultant and registrar prior to discharging Ms A. However, none of the hospital doctors concerned can recall speaking to Ms C. The on-duty consultant commented that it would have been entirely appropriate to discharge Ms A in the presence of a normal CTG reading and normalised blood pressure.

Ms Faulls advised that it was appropriate for Ms A to be discharged. However, Ms Faulls also identified several shortcomings in Ms A's care at this point. First, she was critical of Ms C's failure to palpate Ms A's uterus, especially as Ms A remembers complaining of lower abdominal pain when the cardiotocograph belts were attached to her abdomen.

Secondly, Ms Faulls advised that the "Count to 10"[15] fetal movement chart should have been commenced.

Thirdly, Ms Faulls advised that Ms A's blood pressure and the fetal heart rate should have been checked the next day, together with the frequency of any contractions and baby's movements.

Optimally, Ms C should have carefully established the nature of Ms A's lower abdominal pain. This was probably a sign of fetal distress, along with the report of reduced fetal movements. However, Ms Faulls noted that there were no overt signs of fetal distress, in what was appropriately considered to be a low-risk labour.

Monday — hospital admissions and delivery
On Monday, Ms C reviewed Ms A (at approximately 3am and 10am), prior to referring her to hospital. Ms C's retrospective clinical notes record that she saw Ms A at her (Ms C's) home at 3am in early labour. The fetal heart rate was apparently checked with the sonicaid (at 3am) and good fetal movement was noted as being reported by Ms A. The documentation of good fetal movement is in stark opposition with Ms A and Mr A's statement that fetal movement had not been felt since Saturday.

Ms C performed vaginal examinations at 3am and 10am and did not register any particular concerns about bleeding. Ms C noted at 10am that a small "show" was present with irregular contractions, and thought it likely that Ms A had confused the

[15] The "Count to Ten" baby movement chart provides a daily record of how long, from 9am in the morning, it takes for the mother to notice 10 movements. The booklet states that the midwife should be contacted immediately if fewer than 10 movements are detected over a 12-hour period.

"show" with bleeding. In contrast, Ms A recalls being concerned that Ms C's gloves were "full of blood".

Ms A recalls that she was experiencing an unbearable degree of pain at that time. (Dr D, in his discussion with Ms A and Mr A on 25 August 2005, obtained a description of "fresh bleeding" and "excruciating constant pain".)

Ms C considered that the pain was normal, occurring approximately every 20 minutes, and caused by pressure associated with early labour.

There are conflicting accounts of whether Ms C was contacted at around 6am and advised of the development of bleeding with associated clots, and whether Ms C was informed of further bleeding by Ms A while she was in the shower.[16] Ms C has no recollection (or record) of receiving any communication from Mr A at 6am, nor of being told of further bleeding in the shower. However, Mr A's mobile phone account confirms that he telephoned Ms C at 7am that morning. I also note Ms E's submission that an experienced midwife would undoubtedly be concerned if clots arose in these circumstances. It is also possible that the "clots" may have been "mucous" associated with the vaginal examination. Overall, I am unable to determine whether the bleeding associated with Ms A's labour was of a normal quantity or quality.

While Ms C stated that she consulted Dr D about Ms A at this point, Dr D has no recollection of Ms C contacting him until after Ms A's admission to hospital. Mr A and Ms A also do not recall Ms C remaining at their house after her 10am assessment and contacting Dr D.

Ms A was admitted to the delivery suite at 11.30am. Ms C felt Ms A was not yet in established labour, and there were no apparent problems. She considered the CTG recording that she obtained to be normal. Ms C cannot recall whether she took the maternal pulse on this occasion, and explained that her practice was to do so only if there was some cause for concern.

Ms Faulls commented that the "interpretation of fetal heart traces is open to great variation". She examined the original CTG recordings obtained on Monday and stated:

> "I am still no clearer whether this is artefact as stated by [Dr D] or indeed the fetal heart."

In contrast, Dr D was clearly of the view that the CTG recording of Monday represented the maternal pulse. He explained:

[16] Mr A and Ms A provided slightly different accounts of further bleeding while Ms A was in the shower. Mr A recalls that there was bleeding and clots. Ms A recalls that she had bleeding without clots.

> "The transducer (instrument from the CTG machine put on the mother's abdomen to record baby's heart rate) will pick up any regular fluctuating signals wherever it is placed. In [Ms A's] case it was picking up the mother's pulse. The maternal large vessels (aorta) pulsates and this is transmitted to the mother's abdomen to the transducer."

Ms C consulted Dr D by telephone about Ms A. Dr D recalls being advised that Ms A was in early labour with normal observations, and that Ms C intended to give her pethidine prior to sending her home to establish labour. Dr D is unsure why Ms C chose to speak to him that day, as he was not on call (see Other comments, below).

Ms A fell asleep briefly after the administration of pethidine. When she awoke she reported excessive wetness, and Ms C checked and told her that her "waters had broken". Ms C then discharged her without any further assessment. Ms C has explained that she discharged Ms A after the administration of pethidine, as hospital policy is that patients generally should not be in hospital unless they are in established labour.

Ms Faulls considered that it would have been prudent midwifery practice to keep Ms A at the hospital for at least one hour after the pethidine was administered, particularly following the rupture of her membranes. Ms Faulls was "very concerned" that it appears that the fetal heart rate was not listened to after the administration of pethidine or the spontaneous rupture of membranes. She stated:

> "It is usual Midwifery Practice once pethidine has been administered, especially intravenously, to monitor the fetal heart and the blood pressure and pulse of the mother. There is no clear documentation in the hospital records that this was done.
>
> There is also no documentation as to the spontaneous rupture of the membranes prior to discharge at 12.30pm on [Monday]. There is no record of the fetal heart recording being taken or documented prior to discharge.
>
> There is also no mention made of the timing of uterine contractions — the length, strength and frequency of the contractions is not documented."

Ms Faulls noted that the *Midwives Handbook for Practice* describes the "second decision point in labour"[17] as an opportunity for the further assessment of the woman in labour. This includes checking the blood pressure and pulse, contractions, and presentation and descent of the baby.

Second admission and delivery

Ms A was admitted to hospital in established labour at approximately 3pm. Again, there are different accounts of Ms A's bleeding. Ms A and Mr A recall the presence of

[17] The "second decision point" is the time in early labour when the woman needs intermittent support from the midwife.

clots associated with quite heavy bleeding. Ms C's clinical notes record that Ms A was "quite distressed" but make no reference to bleeding. Ms C informed me that the amount of bleeding was normal for this stage of labour.

Ms C did not undertake any CTG recordings of the fetal heartbeat. Ms C stated that she conducted intermittent fetal heart recordings (with her sonicaid) as "there were no indicators of concern present". She specifically recalls checking Ms A's pulse around 3pm. She commented that "there's not really much time for pulse-taking" during the later stages of labour.

Ms Faulls observed:

> "[Ms C] states that the baby's heart was heard after every contraction but this is not documented in the hospital notes apart from on the partogram."

At 4.30pm and 5pm, Ms C recorded in the clinical notes that the fetal heart rate was 120–130 bpm. However, the partogram recorded the fetal pulse at 150 bpm at 3pm, 3.30pm, 4pm, 4.30pm, 5pm and 5.30pm. The partogram records the maternal heartbeat as 70–80 bpm. There is no recording of the maternal heart rate after 5pm. The last fetal heart rate recording is at 5.30pm.

Ms Faulls commented that the fetal heart rate recorded on the partogram appeared to be "manufactured", owing to its regularity. This issue is discussed further below. Ms Faulls stated that maternal pulses are normally 80–100 bpm but if the haemorrhage had already occurred the pulse would have been higher. Ms Faulls stated that there could not have been a fetal and maternal pulse as the baby was undoubtedly dead.

This was a low-risk pregnancy. However, the available information shows that there were clear signs of possible fetal distress or demise, which Ms C failed to be alert to and to act on. Furthermore, aspects of the documentation of Ms A's care by Ms C have significantly undermined her credibility. These matters are discussed in further detail below.

Conclusion

I accept that there were no overt signs of fetal distress on Saturday. I also note Ms Faulls' view that Ms C took reasonable steps to monitor the fetal heart rate on Saturday. There are, however, several aspects of her care at this point that are concerning. The CTG tracing was barely of an adequate length, and Ms C did not take steps to ascertain the cause of Ms A's abdominal pain. In addition, she failed to institute a fetal movement count or arrange to check on Ms A the following day.

Ms Faulls and Dr D expressed the view that the death of the baby occurred on Sunday and was an unexpected event in an otherwise healthy child. Dr D considered that the degree of maceration (described in the post-mortem report as "widespread") indicates that the baby had died approximately 24 hours before the birth. Therefore, it seems certain that the baby died prior to Ms A's first hospital admission on Monday. This is

entirely consistent with Ms A's report that she did not experience any fetal movement from Sunday onwards.

Ms C has noted a visit in the antenatal visit record as occurring on Sunday, with blood pressure readings taken. However, it is common ground that no visit occurred on this date. This incorrect entry further undermines Ms C's credibility.

Clearly, if there was any suggestion that Ms A's bleeding, pain or fetal movement was anything other than ordinary, further investigation, including secondary referral, should have occurred. This did not happen. Ms E submitted that it is "highly improbable" that if "heavy bleeding" was reported to Ms C she would not have recognised this as cause for concern. However, I am not satisfied that Ms C gave adequate consideration to Ms A's symptoms.

The care provided during the hospital admission that morning was less than adequate. I note advice by my advisor that Ms C's interpretation of the CTG recording for Monday was adequate (although the baby had died at this point, and the CTG is likely to have recorded the maternal pulse). However, my advisor was "very concerned" that following the administration of intravenous pethidine, there is no evidence to suggest that Ms C conducted a comprehensive assessment of mother and baby. If a comprehensive check had occurred at this point, and specialist referral had been made, it is likely that the fetal demise would have been detected.

Ms Faulls said that, overall, the care provided to Ms A was adequate. However, she also made a number of significant criticisms of Ms C's care and noted difficulties in assessing elements of the care provided because of the poor documentation. It is not Ms Faulls' role to resolve evidential conflicts. Having addressed these evidential matters and considered all the available information, I conclude that there were significant deficiencies in Ms C's care. In these circumstances I am not satisfied that the care provided to Ms A was of a reasonable standard.

As Commissioner, I am expected to form an independent opinion on the reasonableness of the care provided, even where I have received expert advice to suggest that it may have been acceptable or commonplace. I do not accept Ms E's submission that I have substituted my own views for that of my expert. Rather, I have formed my own conclusions on the reasonableness of the care after carefully considering Ms Faulls' report (which I have not disregarded), her further comments, and all the available information, including the significant factual discrepancies and apparent attempt by Ms C to provide a more satisfactory account of her care. I note that my advisor is critical of many aspects of Ms C's care. This approach is supported by the decision of the Full Court of the High Court in *Ambros v Accident Compensation Corporation*,[18] where their Honours stated at paragraphs 18–19:

[18] *Ambros v Accident Compensation Corporation* (HC Auckland CIV 2004-404-3261), 21 March 2005, Harrison and Heath JJ).

> "In assessing whether diagnosis or treatment has been adequate the issue is whether, objectively assessed, the appropriate standard of care was applied. That is for the Court to determine from primary facts after receiving assistance (where necessary or appropriate) from experts. It is not a question for the experts to determine themselves.
>
> Judges have a positive duty to analyse all the evidence (whether factual or expert opinion) to ensure it is reliable. That is the approach adopted in all areas involving allegations of negligence against professionals . . ."

In addition, while I accept that there can often be a legitimate range of responsible opinion and practice, I am also conscious of my responsibility, as an independent guardian of patients' rights, to distinguish between mediocre and good practice.

The following aspects of Ms C's care (as identified by my expert) in my opinion support a finding that the care she provided fell below the appropriate standard:

- failure to establish the nature of Ms A's lower abdominal pains on Saturday;
- failure to commence the "Count to 10" fetal movement chart on Saturday;
- failure to check fetal heart rate and maternal blood pressure on Sunday;
- failure to listen to the fetal heart rate after the administration of pethidine or the spontaneous rupture of membranes on Monday;
- discharge of Ms A following the administration of pethidine without waiting at least one hour; and
- failure to monitor and record fetal heart, and maternal blood pressure and pulse on Monday.

Overall, I consider that the care provided by Ms C to Ms A was inadequate; I do not consider the care provided can be described as reasonable given the number of serious concerns identified about her care. In addition, I am particularly concerned by Ms C's apparent attempts to reconstruct events to show her care in a more satisfactory light. For these reasons, I conclude that Ms C breached Right 4(1) of the Code.

Documentation of care and care planning

Under Right 4(2) of the Code, Ms A had the right to midwifery care from Ms C that met professional and ethical standards. This investigation has revealed numerous examples not only of poor documentation but also of documentation that has been amended or added to retrospectively. This aspect of Ms C's care is very concerning.

My expert advisor, Ms Faulls, considered that Ms C's documentation of Ms A's care was not of an appropriate professional standard. She was particularly critical of Ms C

for failing to develop a care plan for Ms A in the maternity information booklet (the booklet). The booklet[19] documents the antenatal care plan, and records the decisions made between midwife and mother along the course of the pregnancy. As such, the booklet contains the complete record of the antenatal care provided to Ms A by Ms C in her capacity as lead maternity carer.

The pages of the booklet labelled "Careplan" contain the three broad headings "antenatal" (dated by Ms C 20 February) "labour and birth" (dated 29 July), and "postnatal" (dated Saturday and Wednesday), as well as a "general" section (undated with the comment "antenatal classes discussed"). Under each of these headings is listed a variety of different issues to be discussed and a plan to be formulated. There are no comments written by Ms C on the care plan (apart from the additional note on 29 July about pain relief). Otherwise, the items requiring discussion and planning have been grouped together by brackets and dated. There is an "additional notes" section, which records that labour and birth were discussed on 13 July, and on 22 July a brief note was made about the birth plan.

There is no documentation to show that agreement was reached between Ms C and Ms A about how to proceed with her pregnancy and birth. Ms C's notes make only general reference to these matters being covered, and neither Ms A nor Mr A recalls any discussion of a birth plan or pain relief prior to the labour. Ms Faulls considered that the documentation of the options of antenatal care and pain relief was "too brief" to be of value. Overall, Ms Faulls advised that Ms C failed to document and develop an appropriate care plan for Ms A. She commented:

> "On the pages labelled 'Careplan' it is not sufficient to date issues discussed without outlining the discussion. There is no documentation as to a comprehensive 'plan of care'."

Ms Faulls drew attention to Standard Five[20] of the *Midwives Handbook for Practice,* which states that "Midwifery care is planned with the woman" and stipulates that midwifery decisions and actions should be documented. (The criteria for Standard Two[21] also require that the midwife develops a documented plan.) Ms Faulls commented that Ms C did not comply with the criteria for Standard Six that the

[19] See Appendix 1.

[20] The criteria for Standard Five include that the midwife provides access to a variety of other information sources, ensures the care plan is "woman-centered", involves and respects the woman's significant others in care as desired by the woman, and sets out specific midwifery decisions and actions in an effort to meet the woman's goals and expectations and documents these.

[21] Standard Two of the *Midwives Handbook for Practice* state: "The midwife upholds each woman's right to free and informed choice and consent throughout the childbirth experience."

midwifery plan was regularly updated,[22] as "there was no midwifery plan in place". Ms Faulls stated:

> "Not only does this lack of documentation fall below the standard expected of a midwife it also fails to meet [Ms C's] contractual agreement with the Ministry of Health. As an independent self-employed midwife, [Ms C] has entered an agreement with the Ministry of Health to provide midwifery services under Section 88 of the New Zealand Public Health & Disability Act 2000."[23]

According to the booklet, Ms A was assessed by Ms C on 10 occasions between 7 February and 29 July (inclusive). On eight of those occasions, Ms C wrote "well" in the booklet and recorded standard observations. On 18 April she noted "well scan", and on 26 May she noted a brief illegible comment.

Ms Faulls advised that although Ms C provided frequent antenatal visits to Ms A, and recorded blood pressure, urine analysis and fetal heart rate, the documentation of her assessments was inadequate. She stated:

> "I can find no evidence of comprehensive assessments done by [Ms C]. Certainly there were a number of antenatal visits by [Ms C] to [Ms A] during the pregnancy but it is inadequate to write 'well' at each visit without further explanation."

Ms Faulls considered that Ms C did not comply with Standard Three[24] of the *Midwives Handbook for Practice*, which states:

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

Ms Faulls considered that the follow-up documented on the occasion of Ms A's discharge on Saturday was of limited value, and was concerned that the precise nature of her abdominal pain was not documented. Furthermore, there was insufficient documentation during Ms A's initial hospital admission on Monday, particularly in relation to the rupture of her membranes, and any observations taken following the administration of pethidine. In addition, while the retrospective clinical notes contain more information, the documentation of Ms A's labour was "not comprehensive or

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[22] The criteria for Standard Six include that the midwife ensures that assessment is ongoing and modifies the midwifery plan accordingly. Standard Six states: "Midwifery actions are prioritised and implemented with no midwifery action or omission placing the woman at risk."

[23] The Maternity Services Notice issued under section 88 of the New Zealand Public Health and Disability Act sets out the terms and conditions for the provision of maternity services. The notice (Part C, 4.1(c) requires the lead maternity carer to "commence and document" a care plan, covering as a minimum the items listed in Appendix 3 (as listed by Ms Faulls on page 23).

[24] The criteria for Standard Three include that the midwife documents her assessments and uses them as the basis for ongoing midwifery practice.

clear". The poor quality of Ms C's documentation has made it difficult to assess certain aspects of her clinical care.

Ms Faulls noted that there are discrepancies between the original booklet and the photocopy of the booklet taken by hospital staff on Monday. Comparison shows that the date for the visits of 7 and 20 February were retrospectively inserted — together with blood pressure records, weight, and the comments "well". The original booklet has maturity calculations recorded for two visits but no date or remarks added. Also added is a visit dated Sunday — which all parties, including Ms C, state did not occur.

In addition, the amended book has a note added to the cover page that this was Ms A's second pregnancy, that an earlier pregnancy had been terminated in 2003, that she had reported no allergies, and that her initial weight was 60kg.

Mr A and Ms A were overseas on 7 February. Ms C agrees that she made a mistake in recording a visit on 7 February, as the additional entries were written "retrospectively", but is certain that she is correct about the number of visits documented. Mr A believes that there was no visit on Sunday 20 February.

My advisor also raised concerns about the partogram, purportedly recording fetal and maternal heart rate during labour. She considered that the partogram appeared "manufactured". I concur with that view. The fetal heartbeat is consistently recorded as 150, yet that is not what is recorded in the clinical record. The maternal heartbeat is also consistently 70–80 bpm. Ms C does not record any maternal heartbeats in the clinical record. As already discussed, given that Baby A had died the day before, there cannot have been two heartbeats.

Ms E has not responded directly to the issue of whether the partogram was manufactured, nor has she explained why there were two sets of heartbeats recorded. However, Ms C has accepted that her errors in failing to record the date the alterations to the clinical records were made, recording information from her memory that was inaccurate (such as the date of certain visits) and failing to adequately record her care, were serious shortcomings.

Ms E submits that Ms C had not attempted to mislead the Commissioner and had made amendments and alterations in order to provide a more complete picture of her care, as she realised that her contemporaneous notes were sparse and did not provide a full picture. Ms E stated that Ms C did not understand at the time the importance of recording the date the additions were made. Ms E therefore submits that Ms C did not act deceitfully in her responses to the Commissioner's investigation.

Conclusion

In my view, Ms C's documentation was significantly below the expected standard. The record of the care Ms A received from Saturday is lacking in detail and, in parts, internally contradictory (such as the discrepancy between her clinical notes and the partogram about the fetal heart rate) and indicative of a suboptimal standard of care

(such as the lack of record of any observations after the administration of pethidine). In addition, numerous aspects of the care recorded contradict the recollections of Ms A and Mr A, particularly in relation to bleeding, pain and fetal movement — or whether Ms C was contacted at 6am on Monday. I find the account provided by Ms A and Mr A more credible than Ms C's.

The alterations made to the maternity booklet are a further illustration of Ms C's poor documentation practices. Comparison of the two versions of the booklet shows that significant clinical information was retrospectively added by Ms C. I doubt that Ms C would have been able to recall detailed clinical observations such as weight and blood pressure readings from memory, and can only conclude that these recordings were retrospective estimates. In addition, Ms C has added a visit for Sunday. It is common ground that no visit or telephone contact occurred on that date.

There is also no evidence of an appropriate care plan being developed by Ms C, in partnership with Ms A. There is no evidence that comprehensive assessments occurred, with modification of the care plan as required. As Ms Faulls has observed, there was effectively no care plan.

The documentation of a mother's care must be illustrative of clear and specific planning between the mother and midwife of the pregnancy, birth, and other associated issues. Standard Seven of the *Midwives Handbook for Practice* states:

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

The criteria for Standard Seven include that the midwife clearly documents decisions and professional actions. Ms Faulls concluded:

> "I believe that [Ms C's] professional peers would view this lack of documentation and therefore the midwifery services provided by [Ms C] with moderate to severe disapproval."

Ms C failed to comply with her professional obligations to comprehensively document Ms A's care. The poor documentation has made it difficult to ascertain precisely what occurred by reference to the clinical notes. A further example of this is the confusion surrounding the CTG tracing undertaken on Saturday. If proper documentation had been kept, this confusion might have been resolved.

I am particularly concerned about the manner in which Ms C amended or altered her clinical notes after the tragic death of Baby A, and manufactured the partogram. Ms E suggests that Ms C completed the partogram retrospectively with the intention of providing a "full picture" of what occurred. However, the fabrication of such a vital observation cannot be described as an attempt to provide a "fuller picture". In circumstances where there was only one heartbeat that was consistently around 120–130bpm, I can only conclude that Ms C's intention was to demonstrate that she had

taken steps to differentiate the fetal and maternal heartbeats. While her judgement was clearly "clouded", this is no excuse.

There are also a significant number of instances where Ms C's recollection of events has subsequently been shown to be incorrect. I note that these have all occurred in a manner that, if proven correct, would have made the care she provided more acceptable.

In *Director of Proceedings v Martin*[25] the Health Practitioners Disciplinary Tribunal discussed the significance of amending or altering clinical records. At paragraph 156 the Tribunal stated: "No health professional should mislead the Commissioner or any other person about their records." The Tribunal considered that amending the clinical records and misleading the Commissioner about this was the most culpable misconduct in that case. While Ms C's actions are different from those of the defendant in *Martin* as she has admitted that she made retrospective amendments and alterations, I am concerned about her motivation for doing so. Ms C admitted to the inaccuracies and amendments only when they were specifically put to her. The alterations and additions to the notes give the impression that Ms C provided better care than she in fact did, which suggests that she was trying to mislead. Amending and adding to the clinical record is not consistent with professional standards, and Ms C's apparent attempt to provide a more satisfactory documentary account of her care has significantly undermined her credibility.

In these circumstances Ms C breached Right 4(2) of the Code.

Other comments

Contacting hospital doctors
Ms C was "100%" certain that she contacted the on-call consultant, Dr G, on Saturday, as it was standard practice to notify the consultant of admissions. However, Dr G was not on duty and has no recollection of speaking to Ms C. As noted above, Ms C now acknowledges that she was mistaken. Consequently, the on-duty consultant was not made aware of the admission.

More significantly, on Monday Ms C contacted Dr D at approximately 11.30am to discuss Ms A's pain. Ms C contacted Dr D again at 5.30pm when Ms A was having difficulty with pushing. (Dr D agreed to attend after his clinic. Ms C stated that she later advised Dr D that he was no longer required, but he was on his way and came in.)

[25] Decision No 58/Med05/15D NZHPDT, 31 August 2006.

Dr D informed me that he was not on call, and is unsure why Ms C chose to contact him. On both occasions, Dr D advised Ms C to contact the hospital specialist if she felt secondary care was needed.

Ms C was sufficiently concerned about Ms A to request advice on Saturday, and assistance on Monday, from Dr D. Ms C advised me that she normally deals with Dr D as he is also of the same cultural descent, as are the majority of her clients (including Ms A and Mr A). Notwithstanding any cultural factors, Ms C had an obligation to promptly contact hospital specialists[26] if Ms A required secondary care. Clearly, Ms C should have contacted the on-call consultant rather than Dr D on Monday.

Template for care plan
My investigation has highlighted considerable concern about Ms C's documentation practices. Ms Faulls expressed concern about the adequacy of the maternity information booklet used by Ms C to record Ms A's maternity care and suggested that it did not provide an optimal template for the recording of maternity care.

SAMCL Ltd does not consider that the maternity notes booklet used by other providers necessarily provides a better template for the recording of maternity care, or that its booklet is inadequate. SAMCL is undertaking a comprehensive review of its maternity antenatal record form, which it expects to be completed in September 2007. It will continue to highlight awareness amongst SAMCL midwives of the need for comprehensive documentation of maternity care. In the circumstances, I do not consider any further recommendation is required.

Actions taken

Ms C
Ms C informed me that she has reviewed her practice and now keeps more detailed records and documentation.

Midwifery Council of New Zealand
In light of concerns about her competence, which arose from a previous HDC investigation,[27] in February 2006 the Midwifery Council of New Zealand (the Council) decided to undertake a review of Ms C's competence to practise. In March 2006, following the notification of Ms A's complaint, the Council gave consideration to

[26] Appendix 1 of the Maternity Services Notice issued pursuant to Section 88 of the New Zealand Public Health and Disability Act 2000 sets out the guidelines for consultation with obstetric and specialist services.

[27] This investigation involved the death of a baby shortly prior to birth in June 2003. The investigation was finalised in November 2005. Ms C was found to be in breach of the Code in relation to her documentation, care planning and information about labour options, especially pain relief.

whether Ms C should be suspended pending the outcome of the competence review. The Council decided that Ms C did not pose a risk of serious harm to the public and decided not to suspend her.

The Council identified particular concerns about Ms C's high caseload and the impact that had on her practice, interpersonal communications with her colleagues, and not meeting the "legal requirements" for independent practice. In August 2006, the Council issued an order following the competence review, which required Ms C to undergo a special midwifery standards review in 2006 and 2007. The Council requested that both these reviews paid particular attention to:

- caseload numbers
- evidence of standards of care to women
- clinical outcomes
- interpersonal communications with colleagues and secondary care teams
- documentation
- client feedback.

Ms E advised me that the first midwifery standards review was completed in October 2006, and the panel considered that there had been a "significant improvement" in the standard of Ms C's documentation.

Follow-up actions

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

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

- A copy of this report, with details identifying the parties removed, will be sent to the Maternity Services Consumer Council and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

The Director of Proceedings has issued a disciplinary charge in relation to Ms C's inadequate monitoring of Ms A during labour, and the considerable additions Ms C made to the clinical records after the events.

APPENDIX 1

Antenatal Visit Information Record

Date	Urine Prot.	Urine Sug.	Wt. kg.	Oed.	B.P.	Maturity Calc.	Maturity Clin.	Hgt/Girth	Presn.	Posn.	Descent 0 1 2 3 4	F.H.	Remarks, discharge, prescriptions etc.	Next date	Name
7/2	—	—	60	—	100/90	8	—	—	—	—		—	well.	4/52	
10/2	/			—	100/70	12.	—	—	—	—	—	—	Well	4/52	
10/3	—	.		—	95/64	17	—	—	—	—	—	✓	Well.	4/52	
18/5	~~N~~	~~N~~			107/60	25	—	—	—	—	—	✓	Well. scan.	2/52	
26/5	N	N	66.	—	107/60	28	—	—	—	—	—	✓	Re daly	7/52	
9/6.	N	N	65	—	103/70	29⁵	—	—	—	—	—	✓	well.	2/52	
2/7	N	N		—	100/70	33²	—	—	—	—	—	✓	well.	2/52	
13/7	N	N	—	—	107/76	35.	—	—	—	—	—	✓	Well. H.V	1/52	
22/7	N	N	—	—	106/70	36³	—	—	—	C	D0	✓	well. H.V	1/52	
29/7	N	N	—	—	110/70	37³	—	—	—	L	D1	✓	Well. H.V	1/52	
6/8			—	—	140/90	38⁴	—	—	—	L	D1	✓	well H.V	1/52	
7/8			—	—	138/80		—	—	—	L	D1	✓	E/L ob or some contractions review		

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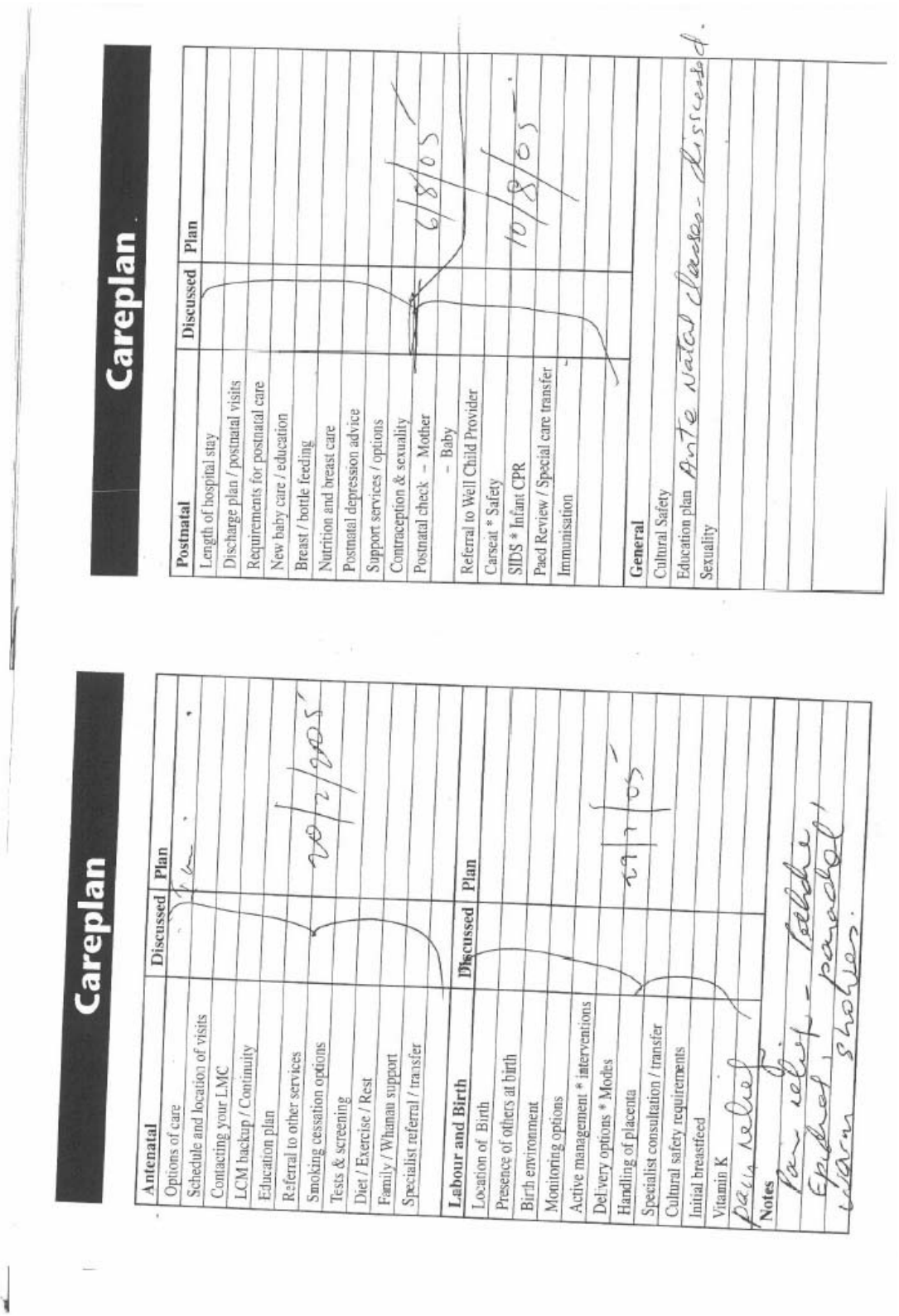

Careplan

Antenatal	Discussed	Plan
Options of care		
Schedule and location of visits		
Contacting your LMC		
LCM backup / Continuity		
Education plan		
Referral to other services		
Smoking cessation options	20/7/2005	
Tests & screening		
Diet / Exercise / Rest		
Family / Whanau support		
Specialist referral / transfer		
Labour and Birth	**Discussed**	**Plan**
Location of Birth		
Presence of others at birth		
Birth environment		
Monitoring options		
Active management * interventions		
Delivery options * Modes	29/7/05	
Handling of placenta		
Specialist consultation / transfer		
Cultural safety requirements		
Initial breastfeed		
Vitamin K		
Pain relief		
Notes		

Careplan

Postnatal	Discussed	Plan
Length of hospital stay		
Discharge plan / postnatal visits		
Requirements for postnatal care		
New baby care / education		
Breast / bottle feeding		
Nutrition and breast care		
Postnatal depression advice		
Support services / options		
Contraception & sexuality	6/8/05	
Postnatal check – Mother		
– Baby		
Referral to Well Child Provider		
Carseat * Safety		
SIDS * Infant CPR	10/8/05	
Paed Review / Special care transfer		
Immunisation		
General		
Cultural Safety		
Education plan	Ante natal classes - discussed.	
Sexuality		

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Date	Gest.	NOTES	Signature

Date	Gest.	NOTES	Signature
13/7		Discussed admit	
#		La bour / signs	
		pain relief options	
		given.	
		Effective movement	
		monitoring ongoing	
		Discussed - shift	
		end date.	
22/7		Birth Plan -	
#		Husband will be	
		with her.	
		Baby movement.	

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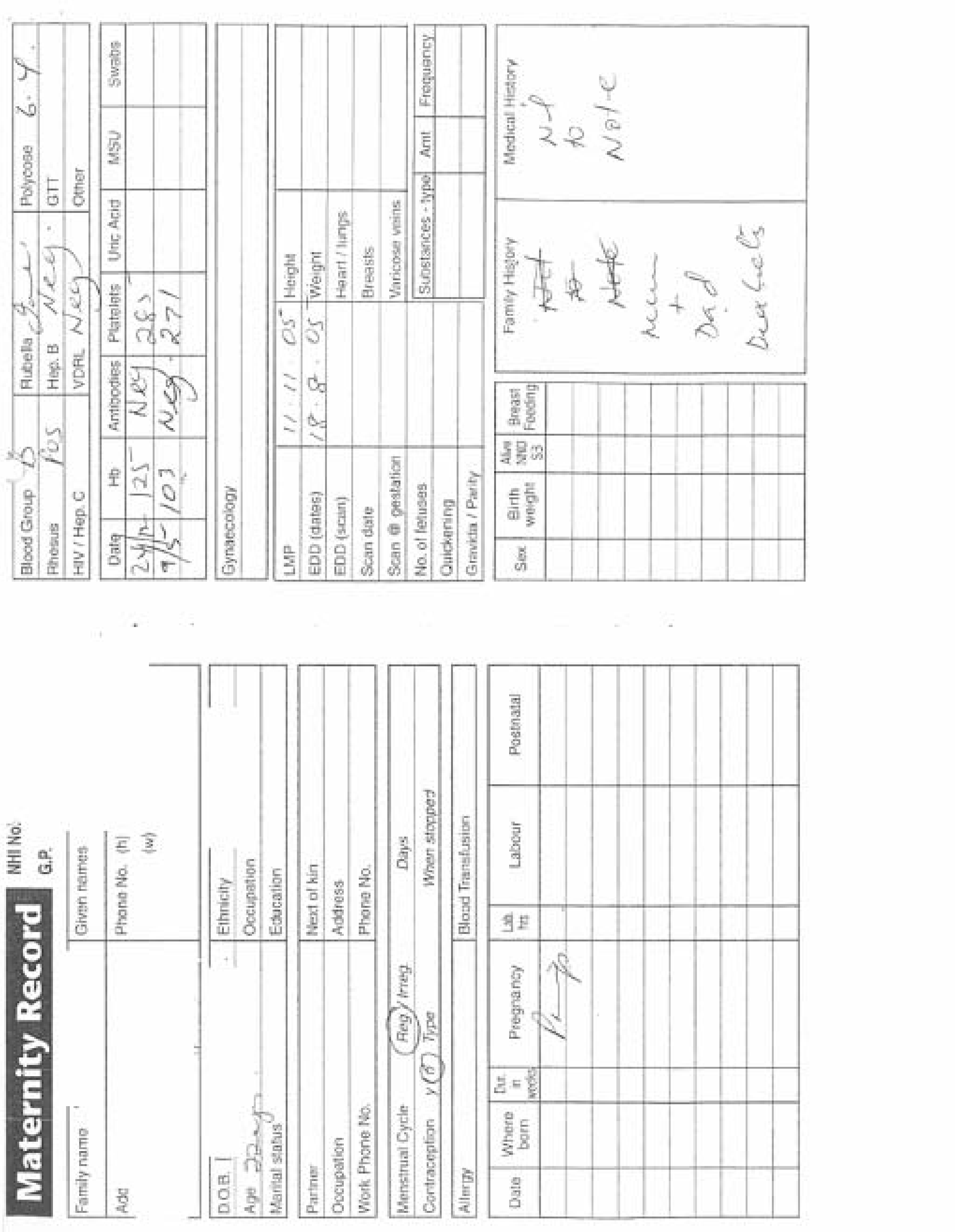
APPENDIX 2



Maternity Record

NHI No:

G.P.

Family name | Given names

Add | Phone No. (h) (w)

D.O.B. | Ethnicity

Age 32 [illegible] | Occupation

Marital status | Education

Partner | Next of kin

Occupation | Address

Work Phone No. | Phone No.

Menstrual Cycle (Reg) Irreg. Days

Contraception Y (N) Type | When stopped

Allergy | Blood Transfusion

Date	Where born	Dur. in weeks	Pregnancy	Lab. hrs	Labour	Postnatal
			[illegible]			

Blood Group B | Rubella [illegible] | Polycose 6.9

Rhesus Pos | Hep. B Neg | GTT

HIV / Hep. C | VDRL Neg | Other

Date	Hb	Antibodies	Platelets	Uric Acid	MSU	Swabs
24/1 [illegible]	125	Neg	283			
9/5	103	Neg	271			

Gynaecology

LMP 11.11.05 | Height

EDD (dates) 18.8.05 | Weight

EDD (scan) | Heart / lungs

Scan date | Breasts

Scan @ gestation | Varicose veins

No. of fetuses | Substances - type | Amt | Frequency

Quickening

Gravida / Parity

Sex	Birth weight	Alive NND SB	Breast Feeding

Family History: ~~Not to Note~~ Mum + Dad Diabetic

Medical History: Nil to Note

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Antenatal Visit Information Record

Date	Urine Prot.	Urine Sug.	Wt. kg.	Oed.	B.P.	Maturity Calc.	Maturity Clin.	Hgt/Girth	Presn.	Posn.	Descent 0 1 2 3 4	F.H.	Remarks, discharge, prescriptions etc.	Next date	Name
						8									
						12.									
10/3	—			—	73/64	17	–	–	–	–	–	✓	well.	4/52	
18/8	N	N			105/60	25	–	–	–	–	–	✓	well.	2/52	
26/5	N	N	66.	–	107/68	28	–	–	–	–	–	✓	Fe daily	3/52	
9/6.	N	N	65	–	108/70	29^5	–	–	–	–	–	✓	well.	2/52	
2/7	N	N		–	105/70	33^2	–	–	–	–	–	✓	well.	2/52	
13/7.	N	N	–	–	103/76	35	–	–	–	–	–	✓	well.	[illegible]/52	
20/7	N	N		–	100/70	36^3	=	=	–	C	40	✓	well.	1/52	
27/7	N	N	–	–	110/70	37^3	=	=	–	L	D1	✓	well.	1/52	
6/8			–	–	140/90	38^4									

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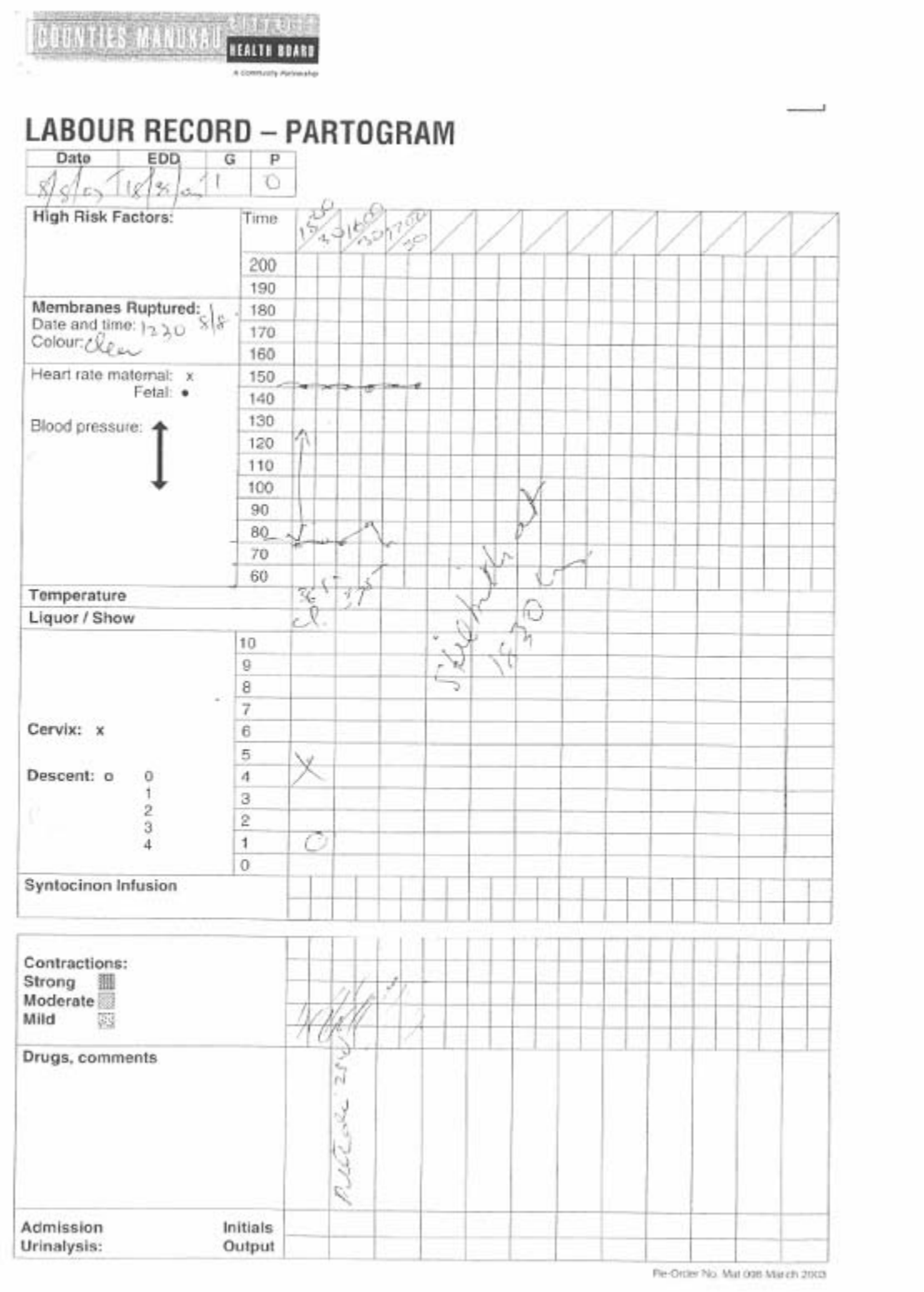
Appendix 3



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