Midwife, Ms C

A Report by the

Health and Disability Commissioner

(Case 03HDC15086)

Parties involved

Mrs A	Consumer
Mr A	Husband of consumer
Mrs B	Consumer's mother
Ms C	Provider/Independent midwife
Ms D	Second independent midwife
Ms E	Maternity Clinic midwife
Ms F	Maternity Clinic midwife
Ms G	Managing Director, Maternity Clinic
Dr H	Mrs A's general practitioner
Dr I	Obstetric Registrar

Complaint

On 9 October 2003 the Commissioner received a complaint from Mrs A about the standard of care provided to her by Ms C, independent midwife. The issues investigated by the Commissioner arising from Mrs A's complaint were identified as follows:

Whether Ms C, independent midwife, provided services of an appropriate standard to Mrs A in May 2003, including whether Ms C:

- *adequately managed Mrs A's labour on 21 May 2003, in particular the:*
  - *provision of pain relief*
  - *assessment of the progress of labour*
  - *rupture of the uterine membranes*
  - *insertion of the intravenous canula*
  - *transfer to secondary services*

- *communicated adequately with Mrs A about the:*
  - *progress of her labour*
  - *management of the labour*
  - *circumstances of her transfer to secondary services*

- *provided Mrs A with appropriate postnatal care.*

An investigation was commenced on 2 February 2004.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Information reviewed

- Information received from
  - Mrs A
  - Mrs B
  - Ms D
  - Ms E
  - Ms G, Managing Director, Maternity Clinic
  - Ms C
  - Ms F
- Mrs A's antenatal records and clinical records from the maternity clinic and the public hospital
- Ambulance CAD Incident report
- Expert advice was obtained from Ms Teryll Muir, independent midwife.

Information gathered during investigation

Background

Antenatal care
Mrs A consulted her general practitioner, Dr H, on 16 September 2002. Dr H confirmed that Mrs A was in the 5th week of her first pregnancy, examined her and noted the baseline recordings of weight, blood pressure and blood glucose level. Mrs A had an ultrasound scan on 1 November, which was normal, and Dr H assessed the progress of Mrs A's pregnancy in the 9th and 13th weeks. On 10 January Dr H referred Mrs A to a public hospital antenatal clinic. Dr H noted:

> "Please can [Mrs A] be registered for antenatal clinic. She now lives in [an area] which is under [the public hospital]. She is gravida 1 [first pregnancy], 22/40 [22 weeks] pregnant and has not chosen LMC [Lead Maternity Carer] yet. She is anxious and prefers hospital and specialist input and not keen on midwife only."

Mrs A informed me that she initially engaged a public hospital midwife to be her LMC, but this midwife was not able to transfer Mrs A to the maternity clinic. Mrs A's preference was to spend her postnatal period at the maternity clinic, so she informed her first midwife that she would find another midwife who had an access agreement with that facility.

Ms C, an independent midwife, was recommended to Mrs A by a friend. When Mrs A first spoke to Ms C she asked whether she could deliver at the public hospital and transfer to the maternity clinic for her postnatal care, because she wanted to be close to medical services in case anything went wrong. Ms C explained to Mrs A that the maternity clinic is a birthing and postnatal facility, not a hospital, and does not provide emergency medical services. She reassured Mrs A, telling her that "everything would be fine". Mrs A recalls being told that

if the circumstances altered she would be able to get to hospital and have an epidural within 15 minutes.

Mrs A and her husband visited the maternity clinic and were happy with the facilities provided. Mrs A suffers from a mild spinal scoliosis (curvature of the spine) and wanted to avoid having an epidural anaesthetic. She told Ms C that she would prefer to use the birthing pool for comfort and would try nitrous oxide gas (Entonox) as pain relief.

Mrs A engaged Ms C as her LMC on 27 February 2003 when she was in the 27th week of her pregnancy. Ms C saw Mrs A five times during the antenatal period and found that the pregnancy was progressing normally.

Labour 20–21 May 2003

Mrs A went into labour at 3am on 20 May 2003. Her labour gradually became stronger over the day. She was in contact with Ms C by telephone (they spoke once). Ms C visited Mrs A at home at 12.20am on 21 May to assess her progress, and found that the contractions had become more intense and frequent – occurring every two to three minutes and lasting between 30 and 60 seconds. The foetal heart rate was heard at 130 beats per minute (bpm), which was within normal limits. Ms C conducted a vaginal examination on Mrs A and found that the cervix was thin and well effaced (stretching to accommodate the birth of the baby's head) and was dilated to 4–5cm. Ms C estimated that the baby was at station 0. (See Appendix A for an explanation of "station".) Mrs A asked to be transferred to the maternity clinic.

At 1.15am Mrs A was admitted to the maternity clinic, accompanied by her husband Mr A. Her contractions were occurring more frequently at this time and she used the birthing pool to ease their intensity. Ms C listened to the foetal heart rate, which ranged from 130 to 142 bpm.

Mrs A stayed in the pool for the next 1½ hours, using nitrous oxide gas for pain relief when her contractions became more painful, and dozing between contractions. Ms C monitored the foetal heart rate at 2am, 3am and 3.45am and found that it remained within normal limits. While Mrs A was in the pool her parents arrived to provide support.

At 4.50am Mrs A got out of the pool. Her contractions were very painful and she recalls that she requested pethidine at this time for additional pain relief. Mrs A informed me that this was refused "on the grounds that it was dangerous for my baby". Ms C said she does not recall Mrs A asking for pethidine, but agreed that had it been requested she would have refused to give it at this stage in the labour, "as it can interfere with the baby's breathing".

Ms C performed another vaginal examination on Mrs A when she got out of the pool, and found that her cervix was almost fully dilated at 9cm (full dilatation is 10cm), and the baby was at station +1. However, there was some uterine membrane in front of the baby's head, and Ms C suggested to Mrs A that the progress of labour would be assisted if the membrane was ruptured. Mrs A stated that she preferred to leave matters to take a natural course. The foetal heart rate was heard in the range of 138–142 bpm.

Ms C recorded the foetal heart rate again at 5.38am and 6.15am. At 6.30am Mrs A requested a further vaginal examination as she felt that she had made no progress towards delivery of her baby. On examination Ms C found that there was a small lip of cervix remaining and, although there was a small amount of clear liquor draining, the uterine membrane was intact and bulging through the cervical opening. Ms C discussed the situation with Mrs A and again advised her that if the membrane was ruptured it would assist progress. Mrs A agreed to the procedure.

Mrs A informed me:

> "[Ms C] and her partner kept making me go and sit on the toilet to push. By now I could hardly move [I was] in so much pain. I felt very degraded and disrespected."

There is discrepancy in the information about the number of midwives present during Mrs A's labour. Mrs A believes that Ms C's midwifery partner arrived at 5am to assist with the labour and delivery and that this person was different from the one she had been introduced to during her pregnancy. Ms C noted that her midwifery partner, Ms D, arrived at the maternity clinic at 8.40am. No other midwives are recorded as having arrived or attended.

Mrs A stated that she felt that she was not being listened to and that the midwives were suggesting that it was her fault that the baby was not being delivered, because she was not pushing hard enough. She said, "All three midwives were determined for me to give birth at [the maternity clinic]." Mrs A stated, "The head midwife of [the maternity clinic] said, 'If you think we're treating you rough, you wait until you get to [the public hospital]'." Mrs A took exception to this comment.

In relation to this issue Ms F, senior maternity clinic midwife on duty, stated:

> "My practice is at all times professional and I would never comment like this. The comments were supposed to have been made at 7.00am. Handover occurs at 6.45am. I would have been gone by 7am.
>
> [Ms C] had called her partner in, so we [the maternity clinic midwives] would not have been called in until either transfer or an emergency occurred. I am an advocate for all women and I would not have stood by if I felt she was not being listened to. I do not recall meeting this woman or her husband at any time during their labour at [the maternity clinic]."

Ms C informed me:

> "At 0700hrs [Mrs A] had started involuntary pushing with contractions. It was therefore reasonable to assume at 0730hrs that her cervix would be fully dilated. In order to progress the labour at that time I suggested that it might help to sit on the toilet for a few contractions. In my experience I have found this to be an open position that can help to bring the baby down. My records show that she was on the toilet for 15 minutes from 0730–0745hrs. There were other times however when I asked her to go to the toilet to pass urine."

Ms C assessed the foetal heart rate at 7am and found no abnormality. At 7.45am she recorded, "[Mrs A] feels that she has had enough … wants to transfer for epidural." Ms C telephoned the public hospital and spoke with one of the on-call consultant obstetricians. Later Ms C was unable to identify the obstetrician with whom she spoke, but she informed him that although Mrs A was progressing well there had been a persistent cervical lip for an hour and she was distressed and tired. The obstetrician advised Ms C to commence Mrs A on intravenous fluids and believed that she would deliver shortly. Ms C informed me that dehydration can slow the progress of labour; intravenous fluids are a rapid method of rehydrating, and can resolve a persistent lip of the cervix.

Ms C introduced an intravenous line for Mrs A at 8.15am. Mrs A believes that Ms C did not site the intravenous needle correctly, as shortly after insertion her hand and arm started to swell, and the needle was re-sited later at the public hospital. The clinical records written by Ms C at 8.15am state that she took blood for cross-match and commenced 2000mls of Plasmolyte, that Mrs A pushed with her contractions at this time, which produced thin meconium-stained liquor, and that an ambulance was called.

The foetal heart rate was recorded as being between 120 and 128bpm at 8.30am.

Ms D informed me that she is unable to recall the circumstances of Mrs A's labour in any detail. She stated that when she arrived at 8.40am to assist Ms C, she was told that Mrs A was "exhausted and had had enough" and was transferring to the public hospital.

Ms C reassessed the foetal heart rate at 9am and 10am and found that it remained within normal range.

Ambulance transport
Mrs B, Mrs A's mother, informed me:

> "At about 5am [Mrs A] asked for an ambulance to take her to [the public hospital]. [Ms C] told her that it was too late to order an ambulance. I don't recall her giving an explanation why. We presumed the baby was close to arriving. Still no progress.
>
> [Ms C] got [Mrs A] to stand up and move around a number of times. … Again the ambulance was asked for about 7am. We were told, either by [Ms C] or the head midwife (I think her name was [Ms E] that one had been ordered but that it would not arrive until 10am as the traffic was very heavy. The head midwife told [Mrs A] that [the public hospital] would be brutal with her, especially if she had to have a Caesar. She seemed very severe, and told [Mrs A] to push harder, and said they wanted to have this baby delivered before the ambulance arrived."

Ms C recalls that at 8.15am she asked a maternity clinic midwife to call an ambulance. She assumed that the maternity clinic midwife then made the call, as this is standard practice when transferring clients from the maternity clinic to the public hospital. Ms C stated:

> "As it was not an emergency situation and it was rush hour I was not unduly concerned when the ambulance did not arrive. I had explained to [Mrs A] that there could be a delay and encouraged her in the meantime to push with contractions.
>
> … At 1000 hours I rang the ambulance service to enquire the whereabouts of the ambulance. They had no record of our request so I asked for one to be ordered immediately."

Ms D stated that while they were waiting for the ambulance to arrive she and Ms C kept encouraging Mrs A. She said that Ms C was waiting for the ambulance to arrive, and it was her impression that the ambulance was first called about the same time that Ms C telephoned her, about 8am. Ms D has the impression that she was there for only about an hour before Mrs A transferred. She remembered that they assisted Mrs A to the toilet.

Mrs A informed me that the midwives told her that the arrival of the ambulance at the maternity clinic was delayed because there was a problem with rush hour traffic, and she was not an emergency. While her recollection supports Ms C's explanation, Mrs A believes this was not the truth. Mrs A believes that the ambulance was not called at all until just before 10am.

The morning shift maternity clinic midwife, Ms E, informed me that she did not enter the room where Mrs A was labouring, but recalled being asked by Ms C to telephone for an ambulance. Ms E stated:

> "I arrived on duty at 0645 hours on the 21st May 2003 and was informed that [Ms C] had a lady in labour.
>
> At approximately 0930 hours [Ms C] requested an ambulance as her lady was transferring to [the public hospital] for failure to progress. There was no urgency in her voice so a normal call was made rather than a 111 call. I made the call at 0945 hours (from memory). The ambulance service replied they would be there as soon as possible but it would be about 20 minutes. She replied that this was fine.
>
> The ambulance arrived at approximately 1000 hours. I remember this time as I was at morning tea when I was called to assist with the transfer."

The ambulance CAD Incident report provided to the Commissioner recorded that the telephone call from the maternity clinic to order an ambulance to transport Mrs A to the public hospital was received at 9.56am. The ambulance arrived at the maternity clinic at 10.13am, and completed transporting Mrs A to the public hospital at 10.53am.

The public hospital

The public hospital records show that Mrs A was admitted at 10.50am. She was reviewed by Dr I, obstetric registrar, at 11.10am. Dr I took a history from Ms C and Mrs A and on examination found that Mrs A was "exhausted". Meconium (foetal faecal staining of the liquor, which can be an indicator of foetal distress) was noted and a foetal scalp monitor applied to monitor the baby's well-being. Dr I ordered an epidural anaesthetic, intravenous

fluids and maternal blood samples for typing and cross-match in the event that Mrs A needed surgical intervention. A continuous CTG (cardiotocograph) was commenced to monitor the baby's heartbeat and Mrs A's uterine contractions, and the paediatricians were informed of Mrs A's admission.

At 12.20pm, when the epidural had been sited and Mrs A was more comfortable, Dr I reviewed her. He performed a vaginal examination and found that she was at station 0, and that there was a thin anterior cervical lip present. Dr I noted that he discussed Mrs A with an obstetric consultant, who recommended a short trial of Syntocinon to augment labour. Mrs A's temperature was noted to be within normal limits at 37°C. Dr I's plan was to review Mrs A after an hour.

At 1.30pm Ms C recorded that she had handed over the care of Mrs A to the public hospital midwifery team, and left the hospital.

Ms C informed me:

> "My role as independent midwife when transferring to secondary services is to consult and review the case. [Mrs A] was reviewed by the registrar on admission who confirmed that a cervical lip had persisted and the baby changed to a ROT position [right occipital transverse lie i.e. baby positioned head down facing the mother's left flank]. I stayed as support to the client and provide the midwifery care as long as I am able. I do not provide epidural care so if this is required I request a hospital midwife to give the epidural top-ups. [Mrs A] had an epidural inserted at 1210hrs and once she was comfortable I took a lunch break at 1245hrs.
>
> If I have been working for more than 12 hours I consider it safe practice to hand over to another midwife. At that time I will always ensure that my client is comfortable and that decisions regarding care are in place before I hand over, which I did in this case to the hospital midwife. I had been caring for [Mrs A] since 0030hrs and I left at 1330hrs. This was done in full consultation with [Mrs A], her support persons and the staff at [the public hospital]."

Delivery

Mrs A was reassessed by Dr I at 2.30pm. He performed a vaginal examination and found that her cervix was fully dilated. Mrs A was encouraged to push with her contractions. Dr I noted that he would check Mrs A again in 20 minutes.

At 3.15pm Dr I noted that the baby was progressing well and was at station +2, but Mrs A was exhausted. A Ventouse suction cup was applied to the baby's head, and Mrs A's baby was delivered with the next contraction, at 3.20pm.

Postnatal care

At 6.30pm Mrs A's temperature was found to have risen to 37.7°C. She was commenced on intravenous antibiotics and at 7.30pm was admitted to a ward at the public hospital.

At 8.10am on 22 May 2003 Mrs A was assessed as suitable for transfer back to the maternity clinic.

Re-admission to the maternity clinic
Mrs A was re-admitted to the maternity clinic at 10.15am on 22 May. Ms C contacted the maternity clinic and informed the staff that she was attending a compulsory study day and would not be able to visit Mrs A that day. The maternity clinic midwives agreed to monitor Mrs A. Ms C also spoke to Mrs A and explained the situation to her.

At 11.30am Ms E contacted Ms C to ask whether she wished Mrs A's intravenous antibiotics to be continued. Ms C advised that this was not necessary, and Ms E removed the intravenous luer.

At 10.30am on 23 May Ms C visited Mrs A at the maternity clinic. Mrs A recalled that Ms C informed her at that visit that if she had transferred earlier to the public hospital her baby would have been delivered by Caesarean section. Mrs A replied that she would rather have had a Caesarean section than "go through what I did". Mrs A recalled that Ms C responded, "No you wouldn't" and went on to tell her that there was a likelihood that her baby had suffered a neck injury from the Ventouse. Ms C informed me that she "debriefed" Mrs A regarding her labour and delivery. She could not recall a discussion about a Caesarean section. She told Mrs A that on 26 May she would call to see her, with a student midwife, at her home.

Follow-up care
Mrs A was discharged home from the maternity clinic on 25 May 2003 and had been informed that Ms C's back-up midwife was available if needed until Ms C visited at 1pm on 26 May. Mrs A's mother telephoned Ms C on the evening of 25 May and cancelled the visit scheduled for the following day. Mrs A transferred to the public hospital Midwifery Service for her postnatal care.

Additional information

Ms C
Ms C informed me:

> "My personal philosophy relating to labour and birth is to support women to, as far as possible, achieve the birth that they want. I encourage all my clients to write a birth plan (as [Mrs A] did) and I make every effort to support and encourage the woman to achieve the birth she had planned (within the boundaries of safe and ethical practice). At all times I monitor the progress of the labour and the health of the baby. I work within section 88 guidelines and the NZ College of Midwives Standards of Practice."

The Maternity Clinic
Ms G, Managing Director, the maternity hospital, informed me:

"Our clinical manager was not present with this case; she was in fact on study leave this day, 21 May 2003. The coordinator, […], a senior midwife, has left our employment. … I have spoken with [her] … and she does not recall ever assisting [Ms C] with a labour or birth; she does not recall being called downstairs to assist with any clinical intervention that day (the coordinator is based on the second floor).

…

The facility responsibilities are clear in our service specification. We are required to provide the facility suitable for birthing and the associated hotel services. We are also required to have in place policies and procedures that meet the minimum standards required for certification. [The maternity clinic] is certified under the Health and Disability Services (Safety) Act 2001. LMCs are required to be familiar with our policies and procedures and abide by them.

[The maternity clinic] is obliged to provide relief for LMCs and to attend and assist an LMC in an emergency situation. In reality, for many, our input is a lot greater. For some, [Ms C] included, [maternity clinic staff] may not attend the client until she is transferred to a postnatal room, or, as in this case, when an administrative task related to clinical activity is required such as calling an ambulance. Any attendance to a woman in labour is with the woman's permission.

The clinical manager is responsible for ensuring that all policies and procedures are followed and that when an incident occurs the appropriate process is followed for resolution. Since this time [the maternity clinic] has instituted a regime where any client admitted, whether attended by [the maternity clinic] or not, will have a clinical note commenced and the fact of not interacting with the client recorded."

Responses to Provisional Opinion

Ms C

Ms C forwarded a response to my provisional opinion through her legal representative who provided the following additional information:

- Ms C also carried out a foetal heart rate assessment at 9:30am;
- the foetal heart rate assessments were one minute in duration, with some listening also during a contraction;
- Ms C increased the frequency of foetal heart rate monitoring after the discovery of meconium-stained liquor;
- Ms C's usual practice is to carry out maternal assessments when she transfers a woman from a primary facility, and this occurred when Mrs A was admitted to the public hospital;

- Ms C was able to assess Mrs A's condition through touch, observation and by asking questions as to how she was feeling. There was no indication of hypertension or other pathology;
- Ms C stands by her recollection of when she requested an ambulance;
- medical research shows that the appearance of meconium during labour does not indicate foetal distress, provided the foetal heart rate remains normal;
- there is no specific intermittency recommended for foetal heart rate monitoring in professional guidelines;
- medical research indicates that there is little need for routinely repeated maternal observations in an apparently normal labour;
- taking maternal observations may be "best practice" but it is not unreasonable if such observations are not taken in every case.

Ms C's legal representative advised me that, upon reflection, Ms C has undertaken to adopt "best practice" in relation to monitoring and assessment and will be more vigilant in following up a delay in ambulance services."

Mrs A

Mrs A did not respond to my provisional opinion.

Independent advice

The following expert advice was obtained from Ms Terryll Muir, independent midwife.

"Background
[Mrs A] contacted [Ms C] to be LMC midwife for her labour and birth. [Ms C] visited [Mrs A] antenatally on the:
22/02/03 29 weeks
25/03/03 32 weeks
15/04/03 35 weeks
01/05/03 37 weeks
06/05/03 38 weeks
13/05/03 39 weeks

The frequency of the visits has been within accepted guidelines and each of the antenatal visits has been appropriate.

20/05/03
0300 hours: [Mrs A] started labour, at 40 weeks' gestation.
1800 hours: The labour established.
2400 hours: [Mrs A] contacted [Ms C] to inform her that the contractions were 2½ minutes apart and lasting one minute.

21/05/03
0030 hours: [Ms C] visited [Mrs A] at her home, performed a vaginal examination and found that [Mrs A] was 4-5cm dilated. The contractions were 1:2-3minutes, lasting 30-60 seconds. The fetal heart rate (FHR) was 130 bpm. [Mrs A] wanted to go to [the maternity clinic].

The assessment is adequate, [Ms C] has determined the labour appropriately and has determined [Mrs A's] general state. I agree that [Mrs A] was in established labour and that it was appropriate to go to [the maternity clinic].

0115 hours: [Mrs A] arrived at [the maternity clinic] and got into the pool for pain relief. FHR- 130-142.
0200 hours: FHR 138-142
0300 hours: Contractions stronger 1:2minutes, lasting 60seconds. FHR 138-142. [Mrs A] is using gas (entonox) for pain relief.
0345 hours: FHR 128-134. [Mrs A] is relaxed, breathing with contractions and sleeping between contractions.

The management of pain at this stage of the labour is appropriate. [Ms C] has encouraged [Mrs A] to use water (which was discussed antenatally), breathing techniques and entonox.

The LMC is responsible for all primary care from the time of established labour, which includes initial assessment of the women and regular monitoring of the progress of the woman and baby (Section 88).

Enkin: Monitoring progress of Labour:

'Adequate attention must be paid to her (the woman's) physical condition. In most circumstances this will include at least, assessment of her BP, pulse and temperature. Although such assessments have become traditional, there is little agreement to how frequently they should be performed ... In the presence of suspected abnormality such assessments should be made as frequently as necessary … It is questionable whether any useful purpose is served by routinely repeated observations of these parameters in healthy women in apparently normal labour.'

There is no record of any blood pressure assessment, any temperature or pulse taken. While the labour and birth may have appeared normal at this stage, there is an expectation that an initial set of observations will be done. They were not. The monitoring of [Mrs A's] labour was outside of accepted guidelines.

New Zealand College of Midwives (NZCOM) *Midwives Handbook for Practice* 2002. Labour:
'Continue regular assessment of the woman and baby and progress of labour.'

Myles: *Textbook for Midwives*:
'The fetal heart rate is assessed intermittently or continuously.'

How often assessments are done is left to the midwife to decide and depends on how the labour is progressing and the condition of the mother and baby. It is generally accepted to listen to the fetal heart rate ½ hourly during established labour for at least 15 seconds, and to consider continuous monitoring if any abnormality is noted.

The fetal heart rate has been listened to at 0030hrs; 0115hrs; 0200hrs; 0300hrs; 0345hrs. The FHR has been listened to at 45-60 minute intervals. The labour was progressing well and both mother and baby appear well, the frequency can be left to the midwife to decide. The monitoring of the FHR is within acceptable limits.

0450 hours: [Mrs A] was experiencing considerable discomfort and got out of the pool. [Ms C] performed a further vaginal examination to assess the progress of [Mrs A's] labour, and found that she was 9cm dilated and the baby's head was at station +1. [Ms C] discussed performing an ARM, but [Mrs A] decided against the procedure. FHR 128-142. [Mrs A] was using a semi-reclined position on the bed. Good support from [Mr A] and [Mrs B]. Using rescue remedy for pain relief.

The management of pain at this stage of the labour is appropriate. [Ms C] has encouraged [Mrs A] to use positioning, family support and homeopathy. As [Mrs A] was 9cm dilated and in what is termed as 'transition', it would be normal to expect [Mrs A] to feel that she wasn't coping but with good support it would also be acceptable to expect her to manage without the need of any medication.

0538 hours: FHR 126-128. [Mrs A] relaxed, breathing with contractions, using entonox, feeling lots of pressure.
0615 hours: FHR 121-126. [Mrs A] working hard with contractions. Using breathing techniques and homeopathy for pain relief.

The management of pain at this stage of the labour is appropriate. [Ms C] has encouraged [Mrs A] to use breathing techniques, homeopathy and entonox.

NZCOM *Midwives Handbook for Practice*.

'The third decision point in labour –
Continue regular assessment of the woman and baby and progress of labour.'

Myles: *Textbook for Midwives*:
'It is usual to record the pulse rate every 1-2 hours during early labour and 15-30 minutes when labour is more advanced.'

There is still no record of any blood pressure assessment, any temperature or pulse taken. The monitoring of Mrs A's labour was outside of accepted guidelines.

NZCOM *Midwives Handbook for Practice*.
'The third decision point in labour –
Continue regular assessment of the woman and baby and progress of labour.'

Myles: *Textbook for Midwives*:
'The fetal heart rate is assessed intermittently or continuously.'

The fetal heart rate has been listened to at 0450hrs; 0538hrs; 0615hrs; it is accepted practice that the FHR will be listened to at ½ hourly intervals during established labour and more frequently if there is any concern. The FHR has been listened to at 40-50 minute intervals. As the labour was progressing well and both mother and baby appear well, the frequency can be left to the midwife to decide. The monitoring of the FHR is within acceptable limits.

0630 hours: [Mrs A] felt that she was not progressing. [Ms C] performed a vaginal examination and found that there was a small lip of cervix. [Mrs A] consented to an ARM, and when [Ms C] performed the procedure a moderate amount of thin meconium-stained liquor drained. FHR 120-124.

[Ms C] performed the ARM for slow progress, which was an appropriate thing to do. Sometimes an ARM will produce instant results, however, it is common to wait for 1-2 hours to see results.

'Amniotomy is the artificial rupture of the fetal membranes resulting in drainage of liquor. It is commonly abbreviated to ARM (Bennett & Brown, 1999). A policy of early amniotomy leads to a reduction, on average, of between 60 and 120 minutes in the duration of labour … Given the evidence … It is highly likely that amniotomy would enhance progress in prolonged labour as well'.
(Enkin et al., 1996)

0700 hours: [Ms C] noted that [Mrs A] was starting to make small pushes with her contractions. FHR 120-122.
[Mrs A] says she requested transfer at 0700 hours. Progress had been good up until 0500 hours, and it had slowed since then. It does sometimes take a while for the last bit of cervix to subside, although this can also be a sign of problems. As the membranes were intact it was reasonable for [Ms C] to perform an ARM prior to considering transfer. The presence of meconium on its own was not a reason to transfer.

'Fetal distress occurs when the fetus suffers oxygen deprivation and becomes hypoxic. Severe hypoxia may result in the baby being stillborn or he may be asphyxiated at birth and suffer brain damage (Bennett & Brown, 1999). Signs of fetal distress are: fetal tachycardia; fetal bradycardia or fetal heart decelerations related to uterine contractions and meconium stained amniotic fluid. If fetal distress is more than transient, a midwife would be expected to speed up the delivery of the baby.' (Bennett & Brown, 1999)

'The presence of meconium should prompt more intensive fetal surveillance.'
(Enkin et al., 1996)

The FHR had been listened to more frequently since the meconium liquor was noticed. Ms C had listened at 30-minute intervals. This was within acceptable limits but since an abnormality had been diagnosed it would be important for [Ms C] to rule out fetal distress as a cause of the meconium liquor. The FHR had not been listened to enough to rule out fetal distress.

0730 hours: FHR 120-122. [Mrs A] exhausted. [Ms C] suggested that [Mrs A] try sitting on the toilet during some contractions.
Upright positions do aid descent of the fetal head and to get [Mrs A] to sit on the toilet for a few contractions is an appropriate thing to do.

'Women who adopt upright positions to give birth generally have shorter second stages.'
(Gupta, J., Hofmeyr, G., 2003)

One of the skills of the midwife is to encourage the woman to choose a position that is comfortable and facilitates the birth of the baby. A midwife will encourage a woman to change positions if progress is not being made.

0745 hours: [Mrs A] stated that she wanted to transfer to [the public hospital]. [Ms C] performed another vaginal examination and found the lip of cervix remained. [Ms C] contacted the consultant at [the public hospital], who advised her to commence IV fluids.

[Ms C] has responded to [Mrs A's] wishes. It had been 1 hour since the ARM with no progress, there was meconium liquor present, and transfer was appropriate. The baby did not appear to be distressed, however [Mrs A] was distressed. It was appropriate for [Ms C] to discuss the transfer with a consultant at [the public hospital] and to follow any instructions that were suggested.

0815 hours: An IV line was inserted. IV fluids were commenced and bloods taken. Thin meconium was noted in the draining liquor when [Mrs A] pushed with her contractions. [Ms C] noted that she called an ambulance to transfer [Mrs A] to [the public hospital].

Intravenous lines are often very painful to insert. It must have been put in correctly for the IV fluids to run. I do not see anything inappropriate in the care given.

0830 hours: FHR 120-128
0840 hours to 0930hours: [Mrs A] was encouraged to push with her contractions.
0900 hours: FHR 123-130
0930 hours: FHR heard, actual rate not recorded.
0935 hours: [Ms E], midwife at [the maternity clinic], called for an ambulance at [Ms C's] request.
0956 hours: [ambulance service] logged a request for ambulance call.
1000 hours: [Ms C] noted, 'Still waiting for ambulance.'
A [maternity clinic] midwife stated that she made the call about 0935 hours at the request of [Ms C]. The ambulance records show that there was only one telephone

call requesting an ambulance, which was made at 0956 hours. The discrepancies are unexplainable. The two midwives are either both mistaken or the ambulance system is faulty. On the balance of probabilities the ambulance system is the most likely to be correct, which would mean that [Ms E] was incorrect in her estimation of the time and that [Ms C] did not call the ambulance when she stated at 0815 that she had. It only took the ambulance 15 minutes to arrive once the call was made. [Ms C] has been waiting for 1 hour and 45 minutes, this is a long time to wait for transfer, and 2 hours 15 minutes without any progress being made. The transfer has not been managed appropriately. [Ms C] should have called for an ambulance when [Mrs A] asked her to at 0745 hours. If [Ms C] phoned for the ambulance at 0815 hours, then if it hadn't arrived by 0900 hours she should have phoned to check on the estimated arrival time. To have not called the ambulance until 0935 hours without this being agreed to by [Mrs A] is inappropriate care.

1013 hours: The ambulance arrived at [the maternity clinic].
1050 hours: [Mrs A] was admitted to [the public hospital]. She was assessed as 'exhausted' and having made no progress for two hours. A vaginal examination found that the baby's head was at station -1, confirmed the presence of an anterior lip, caput and meconium. A scalp electrode was applied and [Mrs A] was prepared for an epidural. The consultant advised a short trial of Syntocinon.
1330 hours: [Ms C] handed over care to the [the public hospital] team and went home.
1430 hours: The obstetric registrar performed a vaginal examination and found that [Mrs A] was fully dilated and the baby's head at station +1 to +2. [Mrs A] was encouraged to push and the registrar planned to review her again in 20 minutes.
1515 hours: The registrar noted that [Mrs A] was exhausted. The baby's head was at station +2, and the CTG showed variable decelerations. Delivery via forceps or ventouse was discussed with [Mrs A]. The baby was delivered at 1520hours by ventouse.

[Mrs A] was detained at [the public hospital] overnight because the paediatric team would not release the baby until 0900hours on 22/05/03. [Mrs A] then transferred to [the maternity hospital]. [Ms C] telephoned [Mrs A] at [the maternity hospital] on 22/05/03 to inform her that she would not see her that day as she had a compulsory study day, but had asked the [the maternity clinic] midwives to take over the post-natal care.

NZCOM *Midwives Handbook for Practice*. Standard Ten:

'The midwife participates in on-going midwifery education and professional development.'

Section 88 of the New Zealand Public Health & Disability Act 2000, states:

'4.5.1 The LMC will be responsible for ensuring that the following services are provided:

(b) a daily visit while the woman is receiving Inpatient Postnatal Care, unless agreed otherwise with the woman and the Maternity Facility;'

It is expected that midwives will participate in ongoing education. It was appropriate for [Ms C] to go to the study day. It was appropriate for [Ms C] to have alternative cover for the day.

NZCOM *Midwives Handbook for Practice*. First point in the postnatal period:

'This timing provides an opportunity for the midwife to reflect on the birth experience with the woman and assess the health and well-being of the woman and her newborn baby.'

I would have expected [Ms C] to call to visit [Mrs A] following the study day.

NZCOM *Midwives Handbook for Practice.* Standard Two:

'The midwife develops a plan for midwifery care together with the woman.'

NZCOM *Midwives Handbook for Practice*. The First decision point in pregnancy:

'The midwife discusses the role of NZCOM Midwifery Standards Review.'

I would have expected Ms C to pre-warn her clients of planned study days.

[Ms C] saw [Mrs A] at [the maternity clinic] on 23/05/03 and told her that as the following two days were her days off, she had arranged for another midwife to be available if [Mrs A] needed any assistance.

Section 88 states:

'4.5.1 The LMC will be responsible for ensuring that all of the following services are provided:

(e) One Home Visit within twenty-four hours of discharge;'

Midwives are entitled to days off just like any other person. It was appropriate for [Ms C] to still have her days off, if she changed them every time a woman delivered she would never have any time off. [Mrs A] had just had her first baby, she would need daily support when she went home. It would be expected that [Ms C] would arrange another midwife to visit [Mrs A] not just to be available.

I would also expect [Ms C] to pre-warn her clients of planned days off.

> [Ms C] made an appointment to visit [Mrs A] at her home on 26/05/03, but [Mrs A's] mother telephoned [Ms C] on the evening of 25/05/03 to cancel the visit and inform her that [Mrs A] had transferred to another provider."

Additional advice

Ms Muir was asked to consider the additional information provided by Ms C in response to my provisional opinion. Ms Muir provided the following additional advice:

> "In reply to your recent correspondence, which includes a response from [Ms C's legal representative] the legal advisor for the NZ College of Midwives, I would like to make the following comments:
>
> **Extent of brief**
>
> The original brief I received in this case was to advise the commissioner whether [Mrs A] received an appropriate standard of care from [Ms C]. The complaint was given to me, some particular questions asked and some additional questions asked such as whether there are any other professional or ethical issues that I believe were relevant.
>
> I believe that this is completely appropriate, a woman would know if she felt unhappy with the care she received but would not generally be knowledgeable enough to know which part of her care was of a reasonable standard and which was not. It would be unfair to the woman to not be able to look at the care in its entirety.
>
> **Facts upon which expert advise based**
>
> *A midwife is to clearly document all of her assessments, decisions and professional actions (Standard seven, NZCOM handbook for practice).*
> [Ms C's] notes should contain adequate information for me to see what the assessment and monitoring of the foetal heart rate was following the meconium liquor becoming apparent. In this instance [Ms C] should not have needed an opportunity to provide full information, it should already have been in the notes. I do acknowledge that there are times when midwives are unable to document thoroughly but they are usually in situations of emergency or when labour progresses very fast. The labour progress in this case was quite slow, there was ample opportunity for the notes to have been 'full'.
>
> **Foetal Heart rate**
>
> [Ms C] has acknowledged that her notes did not fully show her actions but has said that she did listen to the foetal heart rate for a full minute immediately following contractions, this does show a better assessment of the foetal heart rate than was indicated by the notes. However, in the presence of meconium I do not believe that once every half-hour is frequent enough to rule out foetal distress. To be absolutely sure the baby is healthy the foetal heart rate should be listened to more frequently.

The quote from Enkin is quite correct. Slight staining of meconium in the liquor rarely indicates foetal distress but rather than ignoring it, foetal distress should be ruled out first and then the normality assumed. The appearance of meconium is correctly quoted as being frequently associated with healthy babies 'provided the foetal heart rate remains normal'. In this instance to be sure that the foetal heart rate was normal [Ms C] would need to listen to the foetal heart rate more than once every half an hour in order to rule out foetal distress.

Maternal assessment

It is clearly stated in the Midwifery Council Scope of Practice and the NZCOM handbook for practice that midwives are to identify complications/deviations from normal. The Midwifery Scope of Practice has been adapted from the Nursing Council Scope of Practice, which was legally binding to midwives when this case initiated. There are many ways to do this, one is by taking maternal and foetal observations.

I stand by my original comment that it is reasonable for an initial set of maternal observations to be taken in the majority of labours. I do not believe this is 'best practice' but 'reasonable practice' that every woman can expect. No one can predict accurately when an apparently normal labour will change to become abnormal. The cases where observations are sometimes not taken are those labours that progress so quickly that other things take priority.

During the rest of labour the midwife will use her professional judgement to decide on the frequency. I agree that there are many labours in which no observations apart from the initial set would be required. I do not believe that to be the case in this labour.

There are many instances in this case that warranted further observations. [Mrs A] spent some of her labour in a pool, the maternal temperature should have been taken in this instance. The labour progress was slow and [Mrs A] became distressed, [Mrs A] had a 15 hour early labour, she was in established labour for 7¼ hours before going to the hospital where she laboured for another 3¾ hours before reaching transition. [Mrs A] was in transition from 0450 hours until 1430 hours when full dilation was confirmed, this was almost 10 hours. Maternal observations would have been a good indication of how [Mrs A] was coping with the labour and the results used to plan her care. The temperature and pulse rate would be advantageous to show whether signs of dehydration existed. Dehydration can cause labour contractions to become irregular and progress to slow.

It does appear that the observations were normal upon arrival at [the public hospital]. It is worth noting that [Mrs A] had been given two litres of intravenous fluids by then. There were no observations done prior to or during the insertion of the IV fluids. It is not reasonable to use hindsight as an excuse for not providing adequate assessments during labour, what is expected is that a midwife will give a reasonable standard of care to all women that she cares for. I believe that there were

indications in this labour that warranted recognition that observations of both mother and baby were taken.

Ambulance transfer

I have no further comment on this, an error has occurred somewhere in the timing of events. [Ms C's] acknowledgement that she should have followed up the transfer sooner clearly shows that she has recognised a misjudgment of practice and has initiated restorative actions (Standard seven, NZCOM handbook for practice) in order to improve her practice.

[Ms C's] Assurance

Every midwife is to continually evaluate her practice (Standard eight, NZCOM handbook for practice). [Ms C] has shown a willingness to improve her practice by stating that she intends to record maternal and foetal observations more thoroughly in future.

I stand by my original comments that taking baseline observations of mother and baby and repeating these when specific situations occur is 'reasonable practice' not 'best practice'."

Code of Health and Disability Services Consumers' Rights

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

RIGHT 4
Right to Services of an Appropriate Standard

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

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

RIGHT 6
Right to be Fully Informed

3) Every consumer has the right to honest and accurate answers to questions relating to services …

Other Standards

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

"**Decision points for midwifery care**

> The third decision point in labour – when the woman wants continuous support from a midwife
>
> This point is the full realisation of the working partnership between the woman and the midwife.
>
> …
>
> Continue regular assessment of the woman and baby and progress of labour.
>
> If the woman or the midwife feels that progress is not being made, mother and baby should be reassessed regularly for factors that may indicate additional care should be considered."

Opinion: Breach

Rights 4(1) and 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code) state that every consumer has the right to have services provided with reasonable care and skill, and in compliance with professional standards. Right 6(3) of the Code states that every consumer has the right to honest and accurate answers to questions relating to services. Mrs A's complaint raises the question whether Ms C provided midwifery services of an appropriate standard, particularly in terms of her monitoring of the labour and transfer of Mrs A to hospital.

Maternal assessment
Mrs A's labour became established at 6pm on 20 May 2003. At midnight she contacted Ms C, her midwife, to inform her of her progress. Mrs A's contractions were occurring every 2½ minutes, and lasting one minute. Ms C visited Mrs A at her home at 12.30am and, following an examination to assess the status of her labour, advised her to transfer to the maternity clinic.

My independent midwifery expert, Ms Muir, advised that Ms C's initial assessment of Mrs A, and the decision to transfer to the maternity clinic, were appropriate. I accept that advice.

Mrs A arrived at the maternity clinic at 1.15am. Ms C initially assessed the status of Mrs A's labour and monitored the foetal heart rate. However, there is no record that Ms C

performed an assessment of Mrs A's blood pressure, pulse rate or temperature on admission or at any other time during the early part of the labour. Ms Muir stated:

> "There is no record of any blood pressure assessment, any temperature or pulse taken. While the labour and birth may have appeared normal at this stage, there is an expectation that an initial set of observations will be done. They were not. The monitoring of [Mrs A's] labour was outside accepted guidelines."

At 6.30am Ms C ruptured Mrs A's uterine membrane to assist the progress of labour and, by 7am, Mrs A was beginning to push with her contractions. My midwifery expert advised that there was "still no record of any blood pressure assessment, any temperature or pulse taken", and this was "outside of accepted guidelines".

In response to my provisional opinion, Ms C argued that it is not necessary to take maternal observations in every case, and that to do so is to apply a standard of "best practice". Ms C informed me that she relies on touch and observation of behaviour to determine any deterioration in the mother's condition, and that Mrs A's observations were normal when she was transferred to secondary care.

Ms Muir advised me that in the majority of cases an initial set of observations should be recorded so that any abnormalities can be identified as the labour progresses. This is a requirement of reasonable practice. The frequency of subsequent assessments throughout the labour is a matter of professional judgement.

I agree that it is important to establish baseline information about a labouring mother's blood pressure, pulse and temperature. While I acknowledge that Ms C monitored Mrs A's progress through touch and observation throughout her labour, it is difficult to measure the degree of any deterioration without baseline observations. In my opinion, Ms C's failure to take or record Mrs A's initial observations was unacceptable.

Foetal heart rate assessment

At 8.15am Ms C commenced Mrs A on intravenous fluids on the advice of the public hospital on-call obstetrician. At this time Mrs A began to push with her contractions, and a small amount of thin meconium was noticed in the draining liquor. Ms C reassessed the foetal heart rate at 8.30am, 9am, 9:30am and 10am, and found it to be within normal range. She did not note the duration of these assessments but, in response to my provisional opinion, advised me that she assessed the foetal heart rate for one minute immediately after a contraction, with some listening during the contraction.

My expert advisor explained that after the meconium was noticed in the liquor it was important for Ms C to rule out foetal distress as a cause. Foetal distress occurs when the foetus suffers from oxygen deprivation. Signs of foetal distress are alterations to the foetal heart rate related to uterine contractions and meconium stained amniotic fluid (liquor). Ms Muir advised that while the duration of Ms C's foetal heart rate assessments may have been better than indicated in her clinical notes, the assessments should have been carried out

more frequently. In Mrs Muir's view, half-hourly assessments were not adequate when possible indications of foetal distress were present. I accept this advice.

Ms C's failure to record Mrs A's blood pressure, temperature and pulse at the beginning of established labour, and to adequately monitor the foetal heart rate after meconium was noted, was unacceptable. In my opinion, Ms C failed to provide Mrs A with services with reasonable care and skill and in compliance with the standards expected of her profession, and therefore breached Rights 4(1) and 4(2) of the Code.

Ordering ambulance transport

Mrs A complained that when she asked Ms C at 10am why the ambulance she initially requested at 7.45am to transfer her to the public hospital was taking so long, Ms C told her that it was delayed because of rush-hour traffic. Mrs A believes she was not told the truth about the non-arrival of the ambulance, and that the ambulance was not ordered when she initially asked for one, to ensure that her baby would be delivered at the maternity clinic.

There is discrepancy in the information gathered from Mrs A, Mrs B, the ambulance service, Ms C and Ms E, about the placement of the call ordering the ambulance to convey Mrs A to the public hospital. Mrs B recalled that her daughter first asked to be transferred at 5am and repeated her request at 7am. Mrs A recalls asking to transfer around 7am. Ms C recorded in the notes that Mrs A stated that she "had had enough" and asked to be transferred at 7.45am. She recalled asking one of the maternity clinic midwives at 8.15am to make the call, and that when she became concerned about the delay she herself made the call to the ambulance service at 10am. However, Ms E, the morning shift midwife, recalled being asked by Ms C to call for an ambulance at about 9.45am. The ambulance records show that only one call was placed, at 9.56am.

I agree with my expert advisor that it is unlikely that the ambulance service records are inaccurate. It is possible that Ms C did ask an unidentified maternity clinic midwife to call for an ambulance at 8.15am (as she says) and this was not done; it is also possible that Ms C omitted to ask for an ambulance to be ordered.

My midwifery expert advised that Ms C should have called for the ambulance when asked to do so by Mrs A at 7.45am. My expert stated:

> "If [Ms C] phoned for the ambulance at 0815 hours, then if it hadn't arrived by 0900 hours she should have phoned to check on the estimated arrival time. To not have called the ambulance until [1000] hours without this being agreed to by [Mrs A] is inappropriate care."

I accept my expert's advice that Ms C failed to provide Mrs A with appropriate care in relation to the ordering of the ambulance. I am, however, inclined toward the view that Ms C made a genuine error in her recollections of the ordering of the ambulance rather than deliberately falsifying the information she provided, in an attempt to deceive. Mrs A had clearly stated her wish to transfer to the pubic hospital for further assessment of her labour, and Ms C should have managed this in a timely manner. She should have followed up the

non-arrival of the ambulance earlier than she did, and given Mrs A an honest and accurate explanation for the delay. In my opinion, in relation to this matter, Ms C did not provide Mrs A with a service with reasonable care, and breached Rights 4(1) and 6(3) of the Code.

Opinion: No Breach

Mrs A was concerned about Ms C's management of her labour and the various procedures she instigated to expedite progress. Mrs A's concerns are addressed as follows:

Pain relief
Once at the maternity clinic, Mrs A chose to use the pool for pain relief. At 3am when the contractions became more painful Mrs A began to use Entonox for additional pain relief. At 4.50am Mrs A was experiencing an increased level of pain, and asked Ms C for pethidine. Ms C examined Mrs A and found that her cervix was almost fully dilated and the baby's head well down in the pelvis. Ms C does not recall Mrs A's request for pethidine, but would not have provided the drug to a mother at this stage of labour because of the risk to the baby.

My midwifery expert stated that Ms C's management of Mrs A's pain during this phase of her labour was appropriate. Ms C encouraged Mrs A to use a variety of strategies to manage her discomfort and assist the progress of her labour. At 4.50am Mrs A was in 'transition', and it is normal at this stage in the labour for the woman to feel that she is not coping. My expert stated that at this stage it is acceptable for the midwife to expect the mother to manage without medication, provided she has good support.

I accept my expert's advice that Ms C provided Mrs A with adequate measures to control her pain during her labour.

Foetal assessment
Ms C intermittently monitored the well-being of the baby by listening to the foetal heart rate during the early stages of Mrs A's labour.

My midwifery expert advised:

> "How often assessments are done is left to the midwife to decide and depends on how the labour is progressing and the condition of the mother and baby. It is generally accepted to listen to the foetal heart rate ½ hourly during established labour for at least 15 seconds, and to consider continuous monitoring if any abnormality is noted."

My expert noted that Ms C listened to the foetal heart rate at regular intervals (45-60 minute intervals) between 12.30 and 6.15am. I am advised that if the labour is progressing well and both mother and baby appear well, the frequency of the foetal heart monitoring can be left to the midwife to decide. Ms C's monitoring of the baby's heart rate during the first part of the labour was within acceptable limits.

I accept my expert's advice that Ms C's assessment of foetal well-being at this time complied with accepted practice.

Rupture of uterine membranes
At 4.50am Mrs A got out of the pool because her contractions were very painful. Ms C performed a vaginal examination and found that Mrs A had progressed to the point where her cervix was fully dilated but the uterine membrane in front of the baby's head was preventing any further progress. Ms C suggested to Mrs A that she rupture the membrane but Mrs A indicated that she would prefer matters to take a natural course.

At 6.30am Ms C advised Mrs A that there was a small lip of cervix remaining and the uterine membrane was intact and bulging through the cervical opening, preventing the baby's head from descending. She suggested to Mrs A that she rupture the membrane to assist progress. This time Mrs A agreed to the procedure.

My midwifery expert advised that Mrs A's progress had been satisfactory up until 5am when it slowed. It can sometimes take a while for the last part of the cervix to subside (although this can be a sign of problems in the labour). When Mrs A felt that she was not progressing Ms C appropriately recommended the amniotomy or ARM (artificial rupture of foetal membranes resulting in the drainage of liquor). Early amniotomy leads to a reduction of labour, on average, between 60 to 120 minutes, and although an ARM can produce instant results, it can be common to wait for one to two hours for a result. It was, in my expert's opinion, appropriate for Ms C to perform an ARM on Mrs A at 6.30am. I accept that view.

Intravenous line
At 7.45am Ms C was distressed and having difficulty coping with her labour. Ms C consulted with the obstetrician on call at the public hospital, who advised her to start Mrs A on intravenous fluids, to encourage dilatation of the cervix and aid delivery.

Mrs A was concerned that Ms C did not insert the intravenous line correctly at 8.15am, because shortly afterwards her hand and arm began to swell, and the luer needed to be re-sited by the public hospital staff.

The records show that Ms C started Mrs A on the intravenous fluid Plasmalyte, 2000mls, at 8.15am. Although the intravenous line was re-sited when Mrs A was admitted to the public hospital, the records do not indicate that the site of the intravenous line introduced by Ms C had 'tissued'.

I accept my midwifery expert's advice that the insertion of an intravenous line can be very painful, but there is no evidence that Ms C sited Mrs A's intravenous line incorrectly or inappropriately.

Communication
Mrs A stated that during the later stages of her labour she felt that she was not being listened to. Ms C kept telling her to push, and made her feel that she was not pushing hard enough and that it was her fault that the baby was not being delivered. Mrs B, Mrs A's

mother, did not comment on Ms C's attitude except to say that she gained the impression that the midwives expected the baby to be delivered at the maternity clinic.

The records Ms C kept of Mrs A's labour show that she discussed with Mrs A her options for progressing the labour, for example, at 4.50am Ms C suggested rupturing the uterine membrane to assist progress.

Ms C stated that it is her usual practice to make "every effort to support and encourage the woman to achieve the birth she has planned". My view, based on the information gathered, is that Ms C communicated appropriately and provided Mrs A with appropriate information about her labour (with the exception of the information about the ambulance).

In my opinion, in relation to her management of Mrs A's pain relief, rupture of membranes, intravenous line, monitoring of the foetal heart rate, and provision of information about the labour, Ms C provided Mrs A with services with reasonable care and skill, and complied with professional standards. Accordingly she did not breach Rights 4(1) and 4(2) of the Code in respect of these issues.

Postnatal care

Mrs A complained that Ms C did not visit her after she had delivered, that she attended a study day instead of visiting her at the maternity clinic on 22 May 2003, then took days off and did not plan to visit her again until 26 May.

Mrs A was detained at the public hospital overnight, instead of transferring back to the maternity clinic as she preferred. Ms C telephoned Mrs A at the maternity clinic on 22 May to inform her that she had a compulsory study day that day, and that she had asked the maternity clinic's midwives to monitor Mrs A and report any concerns to her. Ms C arranged to see Mrs A the following day.

Ms C saw Mrs A at the maternity clinic on 23 May. Mrs A stated that they discussed the possibility of her being delivered by Caesarean section if there had been a further delay in her transfer to the public hospital. Ms C confirmed that she "debriefed" Mrs A about her labour and delivery but could not recall discussing a Caesarean section. Ms C made arrangements to call on Mrs A at her home after the weekend. However, Mrs A decided to transfer to another midwife for her postnatal care and cancelled the appointment.

My midwifery expert advised that section 88 of the New Zealand Public Health and Disability Act 2000 requires the LMC to ensure that her client is provided with a daily visit while the woman is receiving inpatient postnatal care, unless otherwise agreed by the client and the maternity facility. The LMC must also ensure that the client receives one home visit within twenty-four hours of discharge. My expert stated that it was appropriate for Ms C to go to the study day and for her to arrange alternative cover of her patients for that day.

Mrs A was discharged home from the maternity clinic on 25 May 2003 and had been informed that Ms C's back-up midwife was available if needed until Ms C visited at 1pm on 26 May.

Midwives are entitled to days off. My expert advised that if Ms C pre-warned Mrs A that she was taking her planned days off and arranged another midwife to visit (as she did when she visited her at the maternity clinic on 23 May) it was acceptable for Ms C to have the two days off at this time. In my opinion Ms C provided Mrs A with postnatal services that complied with professional standards, and did not breach Right 4(2) of the Code.

Comment

Mrs A complained about the manner in which she was treated by "the head midwife of the maternity clinic", who she recalled was "Ms E". Mrs A stated that this midwife was present during her labour and told her, "You think we're treating you rough, you wait until you get to the public hospital." Mrs A stated that the maternity clinic needs to be "held accountable" for the attitude of their staff.

Ms E was employed by the maternity clinic as the morning shift midwife on 21 May 2003.

There is a discrepancy in the information supplied as to whether one of the maternity clinic midwives (additional to Ms D) was present in the room with Mrs A to assist Ms C. Ms E commenced work at the maternity clinic at 6.45am on 21 May, when Mrs A was already labouring at the maternity clinic. Ms E stated that she did not enter the room where Ms A was labouring. Ms F, the night-shift maternity clinic midwife, and the maternity clinic midwife coordinator, are the only other midwives who were available to assist Ms C on 21 May, and both deny having any contact with Ms C or Mrs A at this time.

In light of the conflicting information presented I am unable to determine whether or not one of the maternity clinic midwives was present at Mrs A's labour and spoke to her in the manner alleged, and I do not believe further investigation by my Office will assist in resolving this issue.

Vicarious liability
In addition to any direct liability for a breach of the Code, employers are responsible under section 72(2) of the Health and Disability Commissioner Act 1994 (the Act) for ensuring that employees comply with the Code. Under section 72(5) it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the employee breaching the Code.

Ms C is an independent midwife who had an access agreement that enabled her to use the facilities of the maternity clinic. However, Ms C was not an employee of the maternity clinic. In the circumstances, no issue of vicarious liability arises on the part of the maternity clinic in relation to Ms C's breaches of the Code.

Recommendations

I recommend that Ms C:

- Apologise in writing to Mrs A for her breaches of the Code. The apology is to be sent to the Commissioner's Office and will be forwarded to Mrs A.

- Review her practice in light of this report.

Follow-up actions

- A copy of this report will be sent to the Nursing Council of New Zealand, the Midwifery Council, 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.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix A

Definitions

Lead Maternity Carer
The term "Lead Maternity Carer" refers to the general practitioner, midwife or obstetric specialist who has been selected by a woman to provide her with comprehensive maternity care, including the management of her labour and birth.

Presentation in relation to the ischial spines
The ischial spines are at the outlet of the mother's pelvis. When the presenting part of the foetus is at the level of the ischial spines, it is at an O station (synonymous with engagement). If the presenting part is above the spines, the distance is measured and described as "minus stations", which range from -1cm to -4cm. If the presenting part is below the ischial spines, the distance is stated as "plus stations" (+1cm to +4cm). At a +3 or +4 station, the presenting part is at the perineum (synonymous with crowning).

"Dips" or decelerations
Early decelerations are periodic decreases in the foetal heart rate resulting from pressure on the foetal head during contractions. The deceleration follows the pattern of the contraction, beginning when the contraction begins and ending when the contraction ends. The tracing of the deceleration wave shows the lowest point of the deceleration occurring at the peak of the contraction. The rate rarely falls below 100 bpm and returns quickly to between 120 and 160 bpm at the end of the contraction.

Late decelerations are those that are delayed until 30 to 40 seconds after the onset of the contraction and continue beyond the end of the contraction. This is an ominous pattern in labour because it suggests placental insufficiency or decreased blood flow through the uterus during contractions. The lowest point of the deceleration occurs near the end of the contraction, instead of at the peak.