Midwives

Opinion - Case 98HDC12370

Complaint

The Commissioner received a complaint from Mrs A concerning midwives, Ms B and Ms C. The complaint is that on 29 August 1996 Ms B:

- *Did not take timely and appropriate action during the labour and delivery of Mrs A.*
- *Did not fully inform Mrs A about the condition and health of her baby during the second and third stages of labour.*

Further to this, the complaint is that Ms C:

- *Advised Mrs A when 30 weeks pregnant that she would not carry out her blood tests because Mrs A was the patient of her midwifery partner Ms B. This meant Mrs A's blood tests were not carried out until she was 36 weeks pregnant.*

Investigation Process

The complaint was received on 6 March 1998. An investigation was commenced on 12 March 1998 and information was received from:

Mrs A	Consumer
Ms B	Midwife / Provider
Ms C	Midwife / Provider
Ms D	Midwife assistant
Mr E	Coroner

Advice was received from two independent midwives. The Coroner's Report was reviewed, including statements from witnesses and relevant clinical records and correspondence.

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Information Gathered During Investigation

Mrs A and her husband, Mr F first met midwife Ms B on 20 April 1996 in anticipation of the birth of their first child. Ms B stated at this meeting she gave full information of the options including full midwifery care, shared care, full obstetric care, and the options for place of birth. "*We discussed the partnership that midwives have with their clients, and the philosophy and issues of informed consent. I advised them of the midwifery review procedures*."

Ms B commented that the referral letter from the general practitioner had stated Mrs A would like to deliver at the public hospital. The range of options available for birthing was discussed and Ms B suggested to Mrs A that she look at all the hospitals and birthing units to facilitate her choice. Ms B said she would accompany her if she would like. Ms B also outlined the back-up cover that was available through her practice partner, Ms C, and other home birth midwives. Ms B stated that Mrs A looked at the facilities and then booked herself into the public hospital, which meant that she could use this facility if she wanted to. Ms B stated that Mrs A was interested in the option of home birth and therefore Ms B suggested some literature for her to read and home birth antenatal classes were discussed.

On 2 July 1996 Ms B recorded in the antenatal notes that a home birth equipment list was left, the booking for home birth antenatal classes confirmed and that Ms B was to confirm the booking for the public hospital.

Mrs A confirmed that discussions on options continued throughout the pregnancy but that Ms B omitted to inform her she had no access agreement for the public hospital. Ms B stated she would still have opted for a home birth even if she knew of this fact.

On 29 March 1996 Mrs A had an ultrasound scan which showed the placenta was low lying. This was the only unusual feature detected and a follow up scan at around 30 weeks was recommended.

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Accordingly Mrs A had another scan on 17 June 1996 which showed the placenta was "*without low extension*", which meant there was no longer cause for concern. This scan also showed that the foetus was "*... about 100 grams above the mean for the expected gestation of 30 to 31 weeks calculated from the earlier scan*".

Mrs A had recurrent urinary tract infections through out her pregnancy and was treated with several courses of antibiotics. Mrs A also tried herbal remedies to resolve the infections. Because Mrs A's urine analysis showed persistent infection, Ms B referred her to a specialist on 7 July 1996 with a view to Mrs A receiving prophylactic antibiotics. An appointment was made for the following day with Dr G, Obstetric Registrar, at Crown Health Enterprises' Women's Health Division.

Dr G organised full blood screens to check kidney function and a repeat ultrasound scan to check the size of the baby as Dr G felt the fundal height was less than what it should be for someone of Mrs A's dates. A short course of antibiotics was prescribed as well as a daily dose of prophylactic antibiotics that Mrs A was to take until delivery.

Ms B stated that when Mrs A received the request form for an ultrasound scan, Mrs A was unsure who made the request. Ms B stated:

> "[Mrs A] *was unhappy about a repeat scan as she had had one only three weeks previously which had shown the baby to be above the mean size for gestational age. We discussed the baby's size, the fact that the baby was growing well and on palpation felt an adequate size. The baby was active and there was plenty of movement – well in excess of the ten movements per twelve hours.* [Mrs A] *chose not to have another scan and as there was no clinical reason to insist on one I supported her decision.*"

Ms B did not contact Dr G to discuss Mrs A's reluctance to have another scan, or check to see why Dr G considered it may be necessary.

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Mrs A confirmed it was correct that she did not wish to have a further scan. My midwife advisor stated:

> "[Ms B's] *notes indicate that fetal growth has been consistent with dates. This view is supported by the recent 30 week scan that demonstrated good growth and liquor volume.* [Mrs A] *was normotensive and without any significant medical history, she was also a non-smoker. In my view it would have been reasonable to question the registrar's request in light of the above and* [Mrs A's] *reluctance to have another scan.*"

Mrs A stated she saw the second midwife, Ms C, when 30 weeks pregnant. However Ms C stated she first visited Mrs A on 30 July 1996 when Mrs A was 36 weeks pregnant by dates and 34 to 35 by clinical estimation and this is confirmed in the antenatal notes.

Mrs A later agreed she was mistaken about the dates of her gestation at the time she made the complaint to the Commissioner about not having blood tests done at 30 weeks gestation by Ms C. Mrs A thought this meant that her blood tests could not be undertaken until she was 36 weeks pregnant. Mrs A stated Ms C advised her she would not carry out her blood tests because Ms B was the lead maternity carer.

Ms C advised the Commissioner the reason for her visit was primarily to get to know Mrs A prior to the birth and stated:

> "*Women generally have bloods taken between 34 - 36 weeks and I noted that these were due but in fact the antenatal clinic had already taken a full blood screen when* [Mrs A] *was 34 weeks pregnant. These therefore did not need to be repeated.*

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... Women usually have three blood tests in pregnancy. I believe [Mrs A] *had results for 3-1-96 and 1-6-96 as well as this later hospital test. It is always the role of the LMC to arrange for blood tests to be done unless there is an urgent reason for a second midwife to do this. Even if something urgent arose which necessitated testing (and it did not during my visits) I would confer with the LMC,* [Ms B]*, or any other provider who had contracted with the woman and her family to fulfil that role.*"

Mrs A later recalled having blood tests done by Dr G a few weeks earlier which would have been when Mrs A was about 33 to 34 weeks gestation.

Mrs A commenced labour on the afternoon of 29 August 1999. Ms B stated that the labour advanced as a normal labour: the foetal heart was taken at 20 to 30 minute intervals, audible to all in the room and at no stage did this give Mrs A cause for concern. Mrs A stated that she recalled being advised that they could hear the baby's heart beat.

At 7.30pm Ms B reported that Mrs A came out of the toilet and was pacing during a contraction. She appeared to be coping well with the contractions and showed no signs of distress. Ms B began to prepare for the birth, as the baby's head was visible at the vaginal opening.

Ms B reported that there were no membranes visible and no liquor draining. Mrs A indicated that she had experienced what might have been her membranes rupturing when she went to the toilet a few minutes earlier. Ms B reported that as the head advanced there were signs of old meconium on the baby's head, but no decelerations of the foetal heart beat. Mrs A reported that the last time she documented the foetal heartbeat was at 7.40pm of 128 beats per minute (bpm) and that she continued to listen regularly after this time. The subsequent rates were documented retrospectively by Ms B following the birth and before leaving the house later that night.

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Information Gathered During Investigation *continued*

Mrs A stated that during the second stage of labour Ms B did not give her information about the progress of her labour, and that Ms B was whispering to Ms C in front of her. Mr F told the Coroner that:

> "*From observing the midwives during the birth I noticed that during part of the birth that* [Ms B] *was asking a lot of questions of* [Ms C]. *This question time came at about three quarters of the way through labour at a rough guess. She just seemed to ask a lot of questions of* [Ms C] *which in hindsight did seem a little strange.* [Ms B] *had always told us that she would inform us if anything was going wrong. So if the questions asked by* [Ms B] *indicated something was not going right she certainly never let either me or* [Mrs A] *know.*"

In response Ms B stated to the Commissioner:

> "*As the first and second stages were normal, until the birth of the baby there was nothing abnormal present that I could inform* [Mrs A] *about. Her baby appeared entirely well until the birth. … If there had been anything at all which concerned me I would have informed* [Mrs A] *of this.*"

Ms B stated that Mrs A began actively pushing at 8.25pm and the baby's head was born. Ms C stated that she suctioned the baby's mouth and nose, and the baby was completely born at 8.38pm. Ms B stated that only a small amount of old meconium aspirate was obtained on aspiration. Ms B continued:

> "*I noticed there was no grimace reflex by the baby in response to suctioning. … The baby was hypotonic* [floppy]. *Normally a baby has body tone, it moves its arms and legs and frequently cries. This baby was pale (not the usual ruddy pink colour) and made no respiratory effect.*"

Ms B stated that immediately on the birth of the baby she passed the baby to Ms C who palpated a faint heartbeat, which quickly faded. Ms B did not palpate the heartbeat at all.

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Ms C stated to the Coroner that:

> "[T]*here was a weak heart rate of approximately 80 beats per minute, which faded as I felt it. I also palpated the cord which was pulsating weakly and was really flaccid. We began resuscitation straight after that and* [Ms B] *contacted the retrieval team. The baby never made any respiratory effort at all. We continued resuscitation efforts until the team arrived and then they took over.*"

Mrs A stated to the Coroner:

> "*Once* [the baby] *was born they did check for a heartbeat. I heard* [Ms B] *say when she checked for the heartbeat that the heartbeat was very slight, she asked* [Ms C] *to check for a heartbeat and* [Ms C] *could not hear one.*"

Of the baby's cord, Ms B noted it was very short, quite pale, flattened and flaccid which is not normal. Furthermore, instead of being coiled, stretchy and pulsating, the cord was straight and looked as if it had been under considerable tension.

Resuscitation equipment was prepared and Ms B reported she could hear no heart sounds and the baby was making no respiratory effort. The two midwives immediately commenced cardiopulmonary resuscitation to which the baby did not respond. Ms B telephoned the Neonatal Unit at 8.44pm on their direct line to request the Neonatal Retrieval Team. When asked by the nurse on duty whether the baby had a heart rate, Ms B informed the nurse that the baby did not. Ms B returned to the lounge and continued with cardio-pulmonary resuscitation.

Ms B stated that the unit team arrived at 9.15pm and the registrar, Dr H and the neonatal nurse immediately re-commenced cardio-pulmonary resuscitation. Another nurse established telephone contact with consultant Dr I and advised him of the time of birth and the baby's condition from birth onwards.

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Information Gathered During Investigation *continued*

Dr H was told by the nurse speaking to Dr I that resuscitation should be discontinued in view of the time that had elapsed since birth without a heartbeat. Mrs A stated Dr H continued to put down an endotracheal tube and administer adrenalin. The nurse once more advised Dr H to stop.

Dr H stated resuscitation was discontinued at 9.20pm, 40 minutes post delivery. Mr and Mrs A were advised that their baby was dead and that in view of the time lapse since the baby was born it was no longer appropriate to continue resuscitation.

The unit team or the ambulance officer then telephoned the police. Ms B reported that the police arrived promptly before the placenta was delivered and that they spoke with Ms C in another room. Ms C stated to the Coroner that in her view the baby was not stillborn because the baby had an initial heart rate, which faded quickly. Ms C added that it was also correct that the baby made no respiratory and that this could be interpreted as no sign of life.

The placenta was delivered in due course after an injection of syntometrine to make the uterus contract. At one point the cord broke, as it was "*extremely friable*". During this process an intravenous line was inserted. Ms B reported that the cord was very short.

Ms B stated Mrs A had a minor first-degree tear to the perineum and post vaginal wall. Ms C then called in another midwife, Ms D, to assess and suture the tear. Ms D said that Ms B stayed with her while she did the suturing and that although both midwives were upset, both were functioning appropriately. Ms D said that there was still a lot to do with organising the Coroner, bathing the baby and supporting Mr F and Mrs A.

Ms B reported that the Police had contacted the Coroner that evening and left a message on his answerphone requesting him to return the call. The call was not returned until the following morning when the Deputy Coroner phoned the consumer's residence and spoke to Mr F. Ms B stated there appeared to be some confusion on the reporting of the birth, which was recorded as a stillbirth rather than a neonatal death.

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Information Gathered During Investigation *continued*

Therefore Ms B contacted the Coroner's office on 1 September 1996 when she was asked to call back the next day to speak to the person involved in the case. Accordingly on 2 September 1996 Ms B called the Coroner to clarify that in her opinion the death should be classified as a neonatal death rather than as a stillbirth.

The placenta and cord were later examined by a pathologist who reported that:

> "*The main change is of thrombus and acute inflammation in the cord along with some fibrin thrombus on the external surface. These indicate there has been some type of cord compromise. It is noted that the total length of the cord with the placenta is 280mm. It is assumed there is only a short length of cord on the infant. …* [A cord] *less than 320mm is considered to be abnormally short for a full term infant. It is noted that the cord was received in two parts, that the ends were rather ragged and the cord was described as 'friable' by the midwife. The features of cord comprise* [sic] *are most frequently due to cord entanglement, however these changes may reflect an abnormally short cord that has been under tension during delivery.*"

In the postmortem report the only abnormal feature observed was the presence of mucoid fluid containing meconium flecks in the alveolae and airways.

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Independent Advice to Commissioner

The Commissioner received advice from an independent midwife as follows:

Blood tests

"*The first lot of blood tests is usually done at the first visit, the second at around 28 weeks and the third lot at about 36 weeks. If everything is normal, this last blood testing is often omitted.*"

Meconium

"*In the asphyxiated baby the amount of meconium inhaled is significant. The meconium is usually thick and present in largish quantities. In a labour, where light meconium is noted a normal, healthy infant may well inhale small amounts of meconium liquor with no ill effect. I do not believe that the presence of meconium flecks in the airway and alveoli conclusively demonstrate fetal distress.*"

Midwives' actions during labour and records

"*There are no recordings of maternal blood pressure or pulse at any point in the Labour record, nor is there any evidence of a vaginal assessment having been discussed.*

[In addition] *in these notes there is no evidence of a birth plan.*

… The omissions in the labour assessments noted above probably have no direct bearing on the outcome in this case, given that the cord was so abnormally short. Cord comprise [sic] *can not be readily determined and it should be noted that the midwives did everything they could do to resuscitate the baby.*"

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Code of Health and Disability Services Consumers' Rights

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

RIGHT 4
Right to Services of an Appropriate Standard

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

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

...

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

RIGHT 6
Right to be Fully Informed

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

a) An explanation of his or her condition.

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Other Relevant Standards

New Zealand College of Midwives Standards for Midwifery Practice

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

CRITERIA

The Midwife:

- *documents her assessments and uses them as a basis for on-going Midwifery.*

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

CRITERIA

The Midwife:

- *ensures assessment is ongoing and modifies the Midwifery plan accordingly;*
- *demonstrates competency to act effectively in any emergency situation.*

The Second Decision Point in Labour

Information shared… from Examination

- *assess woman's wellbeing, including her emotional and behavioural responses;*
- *check blood pressure and pulse;*
- *discuss need for vaginal examination;*
- *assess contractions, lie presentation and descent of baby;*
- *assess baby's wellbeing, including heart rate;*
- *if membranes have ruptured, check liquor.*

Midwives

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Opinion: Breach

Midwife, Ms B

In my opinion Ms B breached Rights 4(2) and 4(4) of the Code as follows:

Right 4(2)

Ms B did not provide services that complied with the standards set by the New Zealand College of Midwives when assessing Mrs A while in labour. In particular, Ms B did not document blood pressure and pulse recordings, nor did Ms B document whether or not she considered undertaking a vaginal examination on Mrs A.

Right 4(5)

In my view Ms B did not provide continuity of care for Mrs A. On learning that Mrs A did not wish to undergo a third scan which was requested, Ms B should have contacted the obstetric registrar. If Ms B had advised the registrar, discussion on the reasons for requesting the scan would have occurred and this may have resulted in a different conclusion about the usefulness or otherwise of a scan at that time.

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Opinion: No Breach Midwife, Ms B

In my opinion Ms B did not breach of the Code of Rights with respect to the following Rights.

Right 4(3)

Ms B took timely and appropriate action both during and after the delivery of the baby when it became apparent there were complications. I accept my midwife advisor's view that Ms B did all that was possible to save their baby at the time of her birth, including a rigorous attempt at resuscitation and by promptly contacting the Neonatal Retrieval Team.

Right 6(1)

I accept Ms B's statement that she and the assisting midwife were not aware of any problems before the actual birth of the baby that should have been communicated to Mrs A. Mrs A's labour progressed normally and it was not until the baby was born that the gravity of the situation became apparent. I understand that during this time emergency assessments and procedures would take priority over either of the midwives discussing the situation with Mr F and Mrs A.

Opinion: No Breach Midwife, Ms C

In my opinion Ms C did not breach Right 4(5) of the Health and Disability Services Consumers' Rights.

I accept it was not necessary or required for Ms C to organise routine blood test screening for Mrs A when Ms C first visited Mrs A. Firstly because blood tests had been completed by the antenatal clinic two weeks earlier and secondly, because ordering blood tests is usually the role of the lead maternity carer who assumes overall responsibility for the client's maternity care. Unless an arrangement is made between the two midwives, it would seem inappropriate for the second midwife to conduct blood tests especially as the lead maternity carer may be aware of other tests that might need to be ordered at the same time.

Midwives

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Actions: Midwife, Ms B

I recommend Ms B take the following actions:

- Sends a written apology to Mr F and Mrs A for breaching the Code of Rights. This apology should be sent to the Commissioner who will forward it to Mr F and Mrs A.

- Ensures that all routine observations are undertaken during labour and that these are fully documented, as recommended in the Midwives Handbook of Practice, Page 36.

- Undertakes supervision for a six-month period from a midwife experienced in home births who can ensure Ms B correctly documents her observations during the labour process.

- Communicates more effectively with medical staff who are also involved in the care of her clients.

Other Actions

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