Midwives Ms C and Ms D/ District Nurses Ms F and Ms G

A Report by the

Health and Disability Commissioner

(Case 99/10489)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Ms A	Consumer
Mr B	Consumer's husband
Ms C	Lead Maternity Carer/Midwife
Ms D	Midwife
Ms E	Midwife
Ms F	District nurse
Ms G	District nurse
Dr H	Obstetrician and Gynaecologist
Dr I	General Surgeon
Dr J	General Practitioner
Public Hospital	Public Hospital
MATPRO	Maternity Services Independent Practitioners Association

Complaint

On 23 September 1999 the Commissioner received a complaint from Ms A forwarded from MATPRO, concerning the care that she received from Ms C, midwife. The complaint is summarised as follows:

- *A week following the birth of Ms A's son on 7 February 1999, midwife Ms C inserted a further suture into Ms A's perineum without effective anaesthetic, advising her that the suture was in order for the perineum to heal correctly.*

- *Following insertion of the suture, Ms C advised Ms A that she would experience no further problems. Subsequently Ms A advised Ms C on several occasions that she was experiencing problems such as pain around the vagina and anus. Ms C informed Ms A that these problems were nothing to do with the birth.*

- *Ms C advised Ms A that her problems were outside the scope of Ms C's expertise and failed to refer her on for a second opinion.*

An investigation commenced on 27 March 2000.

Ms A also complained about the care she received from Ms D, midwife, Ms F, district nurse, Ms G, district nurse, and the Crown Health Enterprise. The complaint is summarised as follows:

- *During Ms A's labour on 7 February 1999, Ms D failed to undertake an episiotomy, which resulted in Ms A receiving a fourth degree tear to her anus, which Ms D did not diagnose.*

- *Following an operation to repair Ms A's perineum and anus following the birth of her baby on 7 February 1999, Ms F, district nurse, who was caring for Ms A's wound,*

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failed to recognise the signs of infection, resulting in a fistula forming and requiring emergency surgery on 26 May 1999.

- *Following an operation to repair Ms A's perineum and anus following the birth of her baby on 7 February 1999, Ms G, district nurse, who was caring for Ms A's wound, failed to recognise the signs of infection, resulting in a fistula forming and requiring emergency surgery on 26 May 1999.*

The investigation was extended to cover these allegations on 14 June 2000.

Information reviewed

- Complaint letter and further correspondence from Ms A
- Correspondence from Mr B and Ms A's sister.
- Responses from Ms C, Ms D, Ms F and Ms G
- Information from Ms E, Dr H, Dr I and Dr J
- Notes of interviews with Ms C, Ms D, Ms G, Ms F, Dr J, Dr H, Dr I and Mr B
- Ms A's clinical records from Ms C, Ms D, Dr J and the Crown Health Enterprise
- ACC file relating to Ms A

Independent expert advice was obtained from Ms Rhonda Jackson, midwife, Ms Ann Yates, midwife, and Ms Trish McHugh, district nurse.

Information gathered during investigation

Background

Ms A has had an extreme phobia about needles and medical procedures all her life. In 1996 Ms A gave birth to her first baby in Germany. She required an episiotomy (an incision of the perineal tissue surrounding the vagina at the time of birth to allow delivery of the baby), which was performed after she had received sufficient sedation by mouth to allow a general anaesthetic to be performed.

Antenatal care

Ms A became pregnant with her second child in New Zealand in 1998. A friend recommended Ms C, independent midwife, who became Ms A's lead maternity carer on 17 July 1998. (A lead maternity carer is a midwife, general practitioner or obstetric specialist selected by a woman to co-ordinate and provide comprehensive maternity care including the management of labour and birth.) Ms A chose midwife-only care for her pregnancy,

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because she believed that there was a scarcity of women doctors and gynaecologists and she did not wish any other male, apart from her husband, to be present at the birth.

Ms C recalled that early in the antenatal period, Ms A informed her that she had a severe needle phobia. Ms A had in the past seen a psychologist to help her manage her needle phobia, but it did not help her significantly and she stopped the sessions when she was posted overseas. The needle phobia was documented in the care plan. Ms C documented in Ms A's notes that she "becomes extremely distressed to even discuss needles". Ms C recorded that Ms A hoped for a needle-free delivery and wanted to deliver at home. Ms C advised me that, during the antenatal period, she informally approached a medical hypnotist to see whether he could help, and provided Ms A with his details. Ms A said that she would think about it but did not seek a referral. Ms C also thinks she would have mentioned the maternal mental health service.

Ms C took no blood tests and relied on the data available from the blood tests taken during Ms A's first pregnancy. As a result she saw no signs of the phobia until a scheduled hospital visit. Ms C was late and the hospital midwife co-ordinator called to tell her that her client was upset and had left. Ms C found Ms A sitting in her car sobbing and crying. After she calmed down, the hospital tour went ahead despite her obvious aversion to the hospital.

On 29 January 1999 Ms C recorded that, despite the needle phobia and the hospital tour, Ms A had decided on a hospital birth. Ms C recorded that she discussed the possibility of how they would manage the need for suturing and other interventions during childbirth, particularly if she had to have another episiotomy. Ms C also documented that she discussed with Ms A the likelihood of intervention requiring needles at her childbirth:

> "Ms A although very distressed at thought recognises that events often overtake the situation. Will probably avoid any pain relief other than gas. ... Will transfer home at earliest opportunity. Dislikes the hospital environment."

Ms C also recorded: "Ms A extremely fearful of this [needles] but feels that if the situation arises, she will cope somehow." Ms C stated that they spent a good deal of time talking about this issue.

Ms C stated:

> "Ms A's phobia regarding needles and hospitals is by far the most severe and unusual I have ever encountered. I was unprepared for the severity of it. Her phobias impacted greatly on my ability to deliver care to her in the usual manner."

Ms C noted that the full extent of the phobia was not clear in the antenatal period and that she was naïve enough to think Ms A could control it.

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Labour

On 7 February 1999 Ms A went to a Women's Hospital in labour. Ms C was unable to be present at the birth as she was already with a client in labour. Ms D, her midwifery colleague, stood in for her as a locum.

Ms D advised me that Ms C rang her at 4.00am on 7 February and asked her if she could come and assist with the midwifery care of Ms A, who was in established labour at the Women's Hospital. Ms D agreed to assist and arrived at the hospital at 4.20am.

When Ms D arrived Ms C told her that Ms A had a needle phobia and that "in accordance with Ms A's birth plan, needles were not to be used during the course of her birth process without Ms A's explicit informed consent". Ms D stated that she first met Ms A and her husband, Mr B, on 7 February. She was not aware how severe Ms A's phobia was. There was no documentation to suggest that the phobia was severe.

Ms D advised me that during the labour Ms A coped well and used a mixture of nitrous oxide (gas used as an anaesthetic) and oxygen for pain relief. Ms A progressed well in her labour, and her cervix was fully dilated within 30 minutes of Ms D's arrival. Her membranes ruptured and at 5.00am she commenced pushing. One of the Delivery Suite midwives agreed to provide assistance at the birth in the event of any unforeseen problems. Ms E, midwife, was present during the birth. She remained in the room for five to ten minutes, leaving before the placenta was delivered. Ms E does not remember the delivery.

Ms D advised me that Ms A's perineum (the region of the body between the anus and the urethral opening, including both skin and underlying muscle) "stretched well and during crowning of the baby's head there was no indication to perform an episiotomy". Ms D stated that the baby's hand emerged alongside the baby's head. However:

> "it would have been too late to perform an episiotomy at this stage and in fact the baby's head was born without any difficulty. It is standard practice to use a local anaesthetic to infiltrate the perineum prior to an episiotomy and this involves a needle, which was against Ms A's stated wishes. The baby's anterior shoulder was delivered with some difficulty and I required the assistance of the Delivery Suite midwife who was present at the birth to aid me in the process."

Birth and suturing

At 5.06am a baby weighing 3880g (one kilogram heavier than Ms A's previous baby) was delivered. The baby did not experience any problems as a result of the birth and had excellent Apgar scores (the evaluation of an infant's physical condition usually performed one minute and again at five minutes after birth).

Ms D said that she realised as soon as the baby was born that Ms A had sustained a perineal laceration (tear) from the delivery of the baby's anterior shoulder but she was unable to assess the severity of the tear. The placenta was expelled 14 minutes later at 5.20am.

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Ms D advised me that she told Ms A there was a tear in her perineum and that she would have to examine it and would possibly need to suture (close the wound with material such as silk or catgut, to facilitate the healing process). At this point Ms A's emotional state changed from being delighted about the birth of her baby to what Ms D described as "an obvious state of terror at the prospect of having to undergo a procedure involving needles".

Ms D stated that she discussed the option of local anaesthetic or an epidural (a type of regional block in which a local anaesthetic is injected into the epidural space surrounding the dural membranes of the spine) for pain relief during the examination of the perineum and subsequent suturing procedure. (Mr B said that the only pain relief option offered by Ms D was a local anaesthetic.) Ms A replied that she did not want to have anything to do with needles, but would make an exception for the needle attached to the suturing material. Ms A requested nitrous oxide and oxygen as pain relief during the examination and suturing procedure.

Ms D placed Ms A in a semi-recumbent position and put a roll of towel under her buttocks. Her practice is to wipe the perineum to remove the blood so as to see the extent of the tear. Ms D conducted a perineal examination (parting the labia and looking with a light to see whether the tissue had torn) but not a rectal examination. She had a reasonable view of the tear but Ms A was tense and pulling back, which made the examination difficult. Even before the examination, Ms D had seen enough to know that suturing was required, as it was plainly at least a second degree tear.

Ms D has seen a number of third degree tears. The first thing she checks is whether the anal sphincter is involved in the tearing. This requires a thorough examination of the internal area. Ms D stated, "In my professional judgement at that time, the laceration did not appear to involve the anal sphincter." Ms D thought she had examined Ms A sufficiently to conclude that it was a second degree tear. Ms D stated:

> "It was a difficult examination but I believed I had accurately identified the extent of the perineal injury and would like it to be noted that if I had thought that the laceration in any way encroached on the anal sphincter I would not have hesitated for a moment in calling an obstetrician to assess and repair the laceration. I have always considered the repair of a third or fourth degree laceration outside my scope of practice as a midwife."

Ms D said that Ms A started shaking and crying and saying she did not want needles on any account. Ms D drew up a local anaesthetic in the hope that Ms A would change her mind, but she remained adamant that she did not want anything involving needles. Ms D explained that the tear was quite large and involved the muscle. Ms D showed Ms A the equipment she would use.

Ms A agreed to use nitrous oxide gas while Ms D sutured the perineum. Ms D advised me that the use of nitrous oxide and oxygen for pain relief during suturing of the perineum is not standard practice. She told Ms A that she did not believe it would be sufficient to block the pain of the procedure.

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Ms D complied with Ms A's wishes and used gas. She inserted a suture into the apex of the laceration and began to insert an adjoining suture. At this point, Ms A told Ms D to stop suturing because of the pain. Ms D felt she had no option but to discontinue the procedure, as Ms A was screaming at her to stop. Ms D described the situation:

> "The lacerated edges were lined well together and there was no undue oozing of blood from the perineal area. Even though this was an extreme circumstance, the situation did not constitute an emergency and I felt at this stage that I had no option but to discontinue the procedure. It is not my philosophy or professional practice to leave perineal lacerations unsutured unless a small first degree tear. In these extenuating circumstances and in light of my professional judgement that this was a second degree tear of the perineum, the fact that I had sutured the apex of the laceration and that it aligned together well, I believed the wound would heal successfully by granulation."

Ms D would normally put two or three interrupted sutures at the apex and then do one or two layers of continuous suturing. There would be 8 or 9 sutures in the lower layer and in the outer layer.

Ms A confirmed that Ms D attempted to insert a second suture, but she could not bear the excruciating pain. Mr B said that Ms D offered no options after she was asked to stop suturing. He said there was no discussion about healing or when the suture was to come out. He wrote in his diary that Ms D described the damage as "bad grazing". Mr B recalled that Ms A "was at no stage on February 7 1999 hysterical with fear or unable to make rational judgements about the wisdom of specialist advice".

Ms D said that she explained that it would take longer to heal without suturing and would be more painful, and that Ms A accepted this and seemed to want the tear to heal naturally, without sutures. Ms D states that in retrospect this is probably why she did not seek a second opinion.

Ms D stated:

> "So I was having to be in a supportive role as regards her fear and fear of needles and just her total change of personality becoming quite hysterical about the whole thing and she was crying and screaming. The whole thing I guess had an effect on possibly me not consulting further. … [I]f everything was fairly normal, straightforward I would have judged things maybe differently and seen this was too much for me to handle but I was trying to be her support, to normalise the situation, to abide by her wishes to suture the perineum and do the right thing by her as regards treatment. Maybe I got this caught up in the whole thing and didn't see the larger picture and consult and say look I need help here … I thought this is something that will heal and looking at the circumstances I'm doing the best for her, not exposing her to needles and further trauma."

Ms D documented that at 6.00am Ms A was given Panadol for her sore perineum. At 7.55am Ms A was sent to the postnatal ward. At 8.15am it was noted that Ms A's fundus

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(the base of the uterus) was firm and her lochia (the material expelled from the uterus through the vagina after the completion of labour) was moderate. Ms D documented that Ms A would rest in the ward until lunchtime and then go home if all was well.

At 8.30am Ms D handed Ms A back into the care of Ms C and documented the events that had occurred. She recorded that there had been some difficulty in delivering the baby's shoulders and that he had a hand/head presentation, and that there was a secondary perineal laceration and one suture was inserted. She noted:

> "[Ms A] did not want me to continue as unable to cope with needles. Perineum looks as if it will heal without further suturing. Blood loss moderate. Fundus firm and central."

Ms D documented on the Labour and Delivery Worksheet: "One suture only as [Ms A] refused local and unable to tolerate any further suturing." Ms C stated that Ms D told her she would have liked to get more than one stitch in.

Dr H, obstetrician and gynaecological consultant, stated at interview that:

> "… I can well understand [Ms D's] absolute inability to do anything for her immediately after delivery, but I would have felt that it would have been appropriate for [Ms D] and [Ms C] to arrange for [Ms A] to have some consultation with the duty obstetrician – but that would have necessitated giving some form of intravenous medication …"

A midwife noted that Ms A was mobilising freely from the time she came to the postnatal ward. She documented that Ms A's lochia was heavy to moderate during the morning and, although she was a little faint, she was coping well with breastfeeding and mother care. Ms A was discharged at 1.50pm, with follow-up care from Ms C, who was aware that she was being discharged.

Dr H advised me that the birth of Ms A's baby took place in an open bed system operating at the Crown Health Enterprise. This system allows independent practitioners to care for their patients in labour. The Women's Hospital provides consultant obstetric cover and registrars are also available for consultation if the independent practitioner feels there are problems present before, during or after the labour. Ms A did not have any input from either consultants or registrars during her admission to the Women's Hospital.

Discharge

Following her discharge, Ms C saw Ms A on 8 February at her home and documented that she still had blood loss and her perineum was painful. She documented that Ms A was feeling good about the baby's birth.

Ms C examined Ms A's perineum for the first time on 9 February 1999, while she was lying on her side. In Ms C's opinion Ms A had a second degree perineal tear. Ms C could see no involvement of the anal margin and there was:

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> "… certainly no evidence of involvement of the sphincter [a circular band of muscle fibres that constricts a passage or closes a natural opening in the body] muscle. The tear clearly extended to just short of the anal margin and was gaping. I have discussed this with Dr H, the obstetrician I consulted with over [Ms A's] case, and he tells me it is quite unlikely I would have been able to see the extent of the tear at this stage."

Ms C documented in Ms A's notes that her perineum looked:

> "… a bit gaping. Stitch appears intact; [Ms A] feels that it is v. painful. Discussed that healing is likely to be slower than if it had been stitched more completely. Has moved bowels."

On 10 February, Ms C saw Ms A and documented that she was moving her bowels and was passing urine normally; however, her vaginal blood loss was noted to be slightly heavier that day.

On 11 February, five days after the birth, Ms C documented that the stitch in Ms A's perineum seemed to have fallen out and the perineum appeared to be gaping. She documented that the perineum was clean but painful. Ms C recorded:

> "[Ms A] naturally v. distressed about this. Discussed options of re-suturing or natural healing, which can take some time. [Ms A] adamant she couldn't bear to return to hospital to do this. Discussed fact that if unsutured perineum would be diminished."

Ms C advised that the following day, 12 February, she again discussed the need for Ms A to have a suture inserted at the hospital to promote good healing. She suggested to Ms A that it would be appropriate to have the on-call registrar or consultant see her perineum, as it was quite gaping. She documented that her wound "extends to anal margin but not into it". Ms C documented that Ms A was alarmed at her suggestion to see the on-call registrar or consultant.

Ms C stated:

> "I have never left a second degree tear unsutured, and although there is reference in midwifery literature of spontaneous healing, I have never actually witnessed this. I did discuss this fully with [Ms A]."

Ms C said that she never raised the possibility of suturing Ms A at home, but that on 13 February 1999 Ms A telephoned and asked her to do this. Ms C documented that Ms A told her that she thought that she might be able to cope with this, but she was very reluctant to return to the delivery suite.

Ms A alleged that in the week following the birth, Ms C told her that the problems she was experiencing with faecal incontinence were nothing to do with the birth. Ms C said that a second suture would be required in order for the perineum to heal correctly. Mr B recorded in his diary that Ms C commented that the first stitch appeared to be giving, so a second

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stitch was needed to reinforce the repair. Mr B said that Ms C suggested she could suture the wound at home but added that it could be done in hospital.

Ms C denies that she suggested Ms A be sutured at home. It had not occurred to her to do this, as it was unusual to repair a tear so many days post partum (after birth):

> "Because of [Ms A's] aversion to going back to Delivery Suite, and the lack of any other alternative, I agreed to do this [to suture Ms A at her home]. I hoped that if I could properly infiltrate the perineum with local anaesthetic, I could suture the muscle layer together, and that it would then heal properly."

Ms C documented that on her arrival at Ms A's home on 13 February, Ms A was distressed and had locked herself in the bathroom and was shouting, screaming and throwing things at the wall. Ms C documented that she and Mr B calmed Ms A down and talked her through the suturing procedure. She documented that she asked Ms A if she still wanted her to put the sutures in and Ms A agreed. Ms C documented that Ms A "feels in dilemma as wants normal healing with normal perineum but is completely and uncontrollably frightened by prospect of suture".

Ms C noted that she managed to get some local anaesthetic into Ms A's perineum. However, one side was numbed and the other only partially numbed. Ms C thought she could get three stitches in during the time she had available. However, only one stitch was inserted before Ms A said that she could not cope with the pain. Ms C examined the perineum and assessed the tear to be a second degree tear, involving only the perineum, without involvement of the anal margin or the anal sphincter. Ms C documented that one suture was not adequate to ensure that the perineum healed, but the lower part was much better aligned with the suture in place. Ms C and Ms A agreed to wait and see whether the one stitch would make a difference. Ms C documented that she discussed with Ms A the need to consult with a consultant or registrar if this suture did not work, but that Ms A was distressed at this suggestion.

Mr B's diary for 14 February records that Ms A felt something "give" and asked Ms C to visit. Ms C assessed Ms A's perineal area again and noted that the suture was very painful, so prescribed her Voltaren for pain relief. Ms C documented that the sutured area appeared to be holding, and there was no swelling, but the top part of the tear was not aligned.

On 15 February Ms C documented that despite the analgesia, Ms A was finding it very uncomfortable to walk around because of her painful perineum.

On 17 February, 11 days after the birth of her baby, Ms C again assessed Ms A's perineum. She noted that the stitch she had put in appeared to have come out and the area was gaping. She documented that there were "signs of epithelial growth happening but pronounced opening of wound". Ms C documented that she discussed the appearance of Ms A's perineum with her and the likelihood of the area returning to its former state. Ms C noted that Ms A was having no problems with her bowel motions but there was pain in the

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perineal area. She documented that Ms A was distressed about this and that "in view of her feelings about hospitals and needles it seems difficult to resolve".

At the home visits with Ms A on 19 and 23 February, Ms A advised Ms C that her perineum was less painful. On 26 February Ms C reported that Ms A's perineum was healing slowly, but it remained gaping and still extended to just "short of anal margin. Small raw patch evident but good epithelial growth". Ms C noted that Ms A was very disappointed that the sutures had not worked and was angry that she had gone through pain and trauma "for nothing".

On 16 March 1999 Ms A had her six-week postnatal check with Ms C. Ms A reported to her that she had had sexual intercourse with "minimal discomfort". Ms C assessed Ms A's perineum and documented that it appeared to have completely healed and that there were "no raw areas" apparent. However, there was a deep 'V', which presented to the anal margin and appeared to be "very gaping". She documented that she showed Ms A her perineum in the mirror. Ms C made a note "[Ms A] healing well" in the baby's Well Child Book at the time of this check. Ms C advised that this book is for comments about the child and was therefore not an appropriate place to record the status of Ms A's perineum.

Ms C noted that she discussed the overall events with Ms A and suggested that she consult with a gynaecologist regarding her perineum. She documented that Ms A felt that this would be traumatic. Ms C noted that Ms A complained to her at the six-week check that she was experiencing a sense of wetness around her perineum. Ms C stated that when she examined Ms A "she appeared to have a rash on her inner thighs, and I thought the wetness to be caused by vaginal secretions". Ms C felt that Ms A was in a real dilemma. She was terrified of going to hospital but wanted her perineum healed.

Ms A alleged that Ms C assured her during the six weeks after the birth that all was healing well and she would experience no further problems. Ms A stated that she told Ms C that she thought her perineum was completely gone and "resembled an open wound". Ms A said that Ms C assured her that her perineum was all right, although it looked different from how it had been. Ms C denied that she continually reassured Ms A that all was well, her perineum was healing and she should not experience any problems:

> "It was never my wish to leave it unsutured, and given her lack of consent in having it sutured, or in being referred to a specialist, my ability to help her was very limited."

Ms A said that on several occasions she told Ms C about the problems she was experiencing, including incontinence, wind, constant presence of faecal traces and pain around the vagina and anus. She claimed that Ms C told her that her problems were nothing to do with the birth and went outside the scope of her expertise.

Ms C denied that Ms A told her about faecal incontinence. Instead, Ms A reported that her bowels had moved. Ms C stated: "I was under the impression that this function was normal." She said that it was not until eight weeks after the birth that Ms A complained of faecal incontinence.

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Mr B said that he heard Ms A ask for a second opinion on at least two occasions in the five weeks after the birth. As far as he was aware there was no suggestion that Ms A return to hospital for a further repair.

On 25 March Ms A consulted her general practitioner, Dr J, and told her that she was suffering perineal pain and leakage. Dr J recalled:

> "I hardly needed to examine her to see this very gaping what we call perineal tear. Sort of the whole vaginal/rectal area – there was obviously a connection between the two. I mean I didn't even spend a huge amount of time prodding her because I could see this big gaping tear. … It was very obvious to me and I'm not a midwife even."

Dr J's notes record that she told Ms A to speak to her midwife and discussed referral to a psychiatrist.

On 31 March 1999 Ms C documented that Ms A telephoned her and told her that she felt that she needed to consult a female gynaecologist because her perineum and anal area were still very painful. Ms A told Ms C that she had been to Dr J. Ms C noted that Ms A was concerned that her perineum was still gaping. Ms C documented that Ms A was mostly concerned that after she moved her bowels, further matter was passed involuntarily. Ms C organised a referral for two weeks' time. Ms A said that Ms C's response to the request was to say in a cross voice, "That's your right of course."

Ms C recalled that Ms A did complain of pain, but in her view it was related to her slow healing and to the birth of her baby. Ms C commented that Ms A did not report any episodes of faecal incontinence until eight weeks after the birth. Ms C denied that during the six-week post-natal period she did not acknowledge there was a problem and therefore failed to refer Ms A to someone with more expertise. As soon as Ms A was agreeable to being seen by a specialist, Ms C referred her to one for a second opinion.

On 4 April a distressed Ms A telephoned Ms C, as she had had a loose bowel movement through her vagina during a family celebration. Ms C immediately contacted the on-call obstetrician and gynaecologist and arranged for him to meet them at the Public Hospital.

Surgical input

Dr H saw Ms A as an emergency case on 4 April 1999. He documented that Ms A had a history of poor faecal control and was producing rectal gas without any control. When he examined her he noted that she appeared to have a third degree tear with division of the exterior sphincter. Dr H said that he could determine the problem by looking at the area. There was no substance or tissue separating the vagina and the rectum. He also said that he believed that Ms A had taken some medication to facilitate the examination. Dr H decided to refer Ms A to a colorectal surgeon, as he had not done a secondary repair of the perineum after a third degree tear for about 25 years.

Dr H wrote a letter to Dr I, colorectal and general surgeon, on 7 April and reported his findings:

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> "My examination suggests that this lady has had a third degree tear in that the external sphincter is divided and the configuration of the fourchette [top of the perineum] is such that one would say there is no fourchette present, and as a consequence faecal and gas control are extremely minimal."

Dr H further stated that Ms A's "needle phobia is the worst I have ever seen in a person and that may prove a very significant challenge both to you and the patient".

Ms A advised me that once she understood the extent of her injury, she tried to contact Ms C herself, as she was distraught over what had happened. She stated that Ms C had told her that she regretted her part in what had occurred and said that, had Ms A had a second stitch at the birth, she would not have had this problem. Ms A advised that Ms C did not try to contact her once the diagnosis was made.

Dr I saw Ms A in the Outpatients Surgical Clinic at the Public Hospital on 13 April. Dr I stated:

> "… [T]he tear was obvious on clinical examination and rectal examination, and did not require a confirmatory endorectal ultrasound …
>
> On examination of the perineum, it was clear that there was no perineal body and there was only at the most, flimsiest of tissue between the anal canal and the posterior vaginal wall. It was clear from the shape and the appearance of the perineum, there was a complete division of the external anal sphincter and all of the perineal body."

Dr I arranged to perform Ms A's surgery in the middle of May 1999 and he documented that Dr J had organised some counselling for Ms A about her needle and hospital phobias.

On 17 May Dr I operated on Ms A at the Public Hospital to repair her anal sphincter as a perineal reconstruction. Ms A was discharged from the ward on 21 May.

Dr I was asked if the tear could have been diagnosed by any health professional other than a consultant. He stated:

> "… [M]y feeling is that it should have been fairly obvious to an Obstetrician/Gynaecologist or indeed a midwife, on examining the perineum as this was grossly abnormal and likely to represent a major disruption of the perineal body and probably the sphincter complex."

District Nursing

Ms A was referred to the District Nursing Service, Public Hospital, for home visits to occur from 22 May 1999.

Ms G, District Nurse, was working on Saturday 22 May in the afternoon from 1.00pm until 9.30pm. She telephoned Ms A ahead of time to organise an appropriate time to visit. On arrival at Ms A's home, Ms G noted that there was no information on the referral form from the ward about the state of Ms A's wound. Nor was the date of the operation to repair

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her perineum documented. Ms G obtained this information from Ms A. The referral documented that Ms A had a hospital and needle phobia, was taking Buccastem for nausea and Panadol for pain relief, her skin was intact, she had a baby, and she was "encouraged to use a bath for hygiene". The referral stated:

> "[Patient] had 3rd degree perineal tear during delivery 3/12 ago. Very anxious prior to surgery. Please check on wound and assess. [Patient] has [follow-up] with Dr I in 2 – 3 weeks."

Prior to assessing Ms A's wound, Ms G washed her hands and put on disposable gloves, then cleaned the area from the vagina to the anus with sterile normal saline on sterile gauze. Ms G checked Ms A's perineal wound and noted that there was no surgical dressing on the wound. She inspected the perineum and suture line and noted that there were traces of clear straw-coloured ooze on Ms A's skin, which is a sign of a healing wound. Ms G stated:

> "The suture line was clean with the first signs of granulation apparent and no signs of inflammation or infection. Around the vagina and anus, there were no signs of inflammation or infection either."

There were no signs of a foul odour, redness, inflammation, or oedema. Ms A was not anxious about her pain and it appeared within normal limits. Ms A advised Ms G that she was managing her pain with Panadol. Faeces were not leaking. Ms A had had two bowel motions that day without any real problem.

Ms G stated:

> "My assessment of the surgical wound on day 5 was that it was clean, healing very well without any signs or symptoms of infection or inflammation."

Ms G wrote a care plan for Ms A stating that she should shower or bath after each bowel motion, pat her perineal area dry and use a blow dryer on the area for maximum dryness. Ms G wrote that each nurse seeing Ms A should check her perineal area each visit and check for the integrity of her suture line. She documented that the wound area should be cleansed with normal saline, then dried carefully and a pad applied. Ms G noted that the other nurses seeing Ms A should check she had regular bowel motions. Ms G asked the other nurses to give Ms A advice on her diet, fluids and her medications.

Ms G said that it was apparent that Ms A was distressed and angry about her midwifery care.

Ms G and Ms A discussed the next visit and decided that, because the wound was healing and there were no problems, the next visit would be in two days' time. Ms G told Ms A that if any problems developed between late Saturday afternoon and Monday morning, she should ring the District Nursing Service and a nurse would visit her. Ms G gave her the

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telephone number of the service. Ms A agreed with this arrangement and appeared happy with what had been decided. The visit took between 45 and 60 minutes.

Ms G stated that on Monday morning she telephoned the senior district nurse from her home to ensure that the same nurse would visit Ms A during the week. The senior district nurse said she had arranged for this to occur.

Mr B said that by Sunday 23 May Ms A was feeling fluey and sick.

Ms F, district nurse, was assigned to Ms A's care on Monday 24 May and received instructions from Ms G. Ms G advised Ms F to check the integrity of Ms A's wound, apply an aseptic dressing, and check her bowels, pain level and general well-being. Ms F was informed that Ms A was distressed about the care she had received from the midwives.

Ms F visited Ms A at her home and developed a good rapport. She examined and cleaned Ms A's suture line and found it was very clean and healing. There was a little ooze along the suture line. Ms F noted that Ms A was taking regular Panadol and Voltaren 75mg twice daily for pain. Ms F told Ms A to keep the perineal area dry if possible and to expose the area to the sunlight through a glass window if able to do so in a private area. Ms F stated that Ms A accepted her advice. (Ms A denied that she was told to air the wound.) Ms F told Ms A she would return the following day.

On Tuesday 25 May, Ms F visited Ms A again. She checked Ms A's suture line and documented that it was still clean and healing. Ms F saw no redness or exudate and there was no odour. Ms A did not complain of feeling unwell. Ms F documented that Ms A was still having pain with her bowel motions. Her bowels had moved four times over the past 24 hours and this had been extremely painful. Ms F told Ms A to speak to Dr J about reviewing pain relief, and she agreed to do so. Ms F thought that the level of pain described by Ms A was normal and documented:

> "… Will ask GP about pain relief (oral) and maybe local anaesthetic to insert rectally. Also discussed laxatives to keep motions soft. … Buttocks around anus excoriated – using zinc based cream."

Ms F telephoned Ms A later that day to check that she had contacted her general practitioner. Ms A said that she had not contacted her general practitioner, as the telephone line had been continually engaged, but that "her partner had gone into the doctor's surgery to get the GP's attention". Ms F went off duty that day feeling that Ms A would speak with her general practitioner.

Mr B said that by the end of the day Ms A was feeling very ill. At 9.00pm she let her husband inspect the area and he saw pus, infection and inflamed flesh. The area was festering. He called Dr J, who issued a prescription.

At 8.00am the following morning, Wednesday 26 May, the nurse who had been the on-call district nurse overnight, told Ms F that Mr B had paged her at around 10pm the previous evening. Mr B said he had spoken to someone in the ward about Ms A, but was told that

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they were unable to help her. The overnight on-call district nurse had told Mr B that Ms F was not available, and offered her own assistance, which had been declined. Ms F had telephoned Ms A that morning. Dr J had answered the telephone and told her that Ms A was going to be hospitalised.

Ileostomy

Mr B called Dr J early on the morning of Wednesday 26 May. She went to the house to examine Ms A and organised an ambulance and hospital admission. At 9.07am on 26 May Ms A was admitted to the Public Hospital. In the afternoon, under anaesthetic, a recto-vaginal fistula (an abnormal passage or opening between the rectum and the vagina) was examined and an ileostomy (surgical formation of an opening of the ileum onto the surface of the abdomen, through which faecal matter is emptied) was formed.

Dr I advised that the breakdown of the wound occurred in a dramatic fashion and that Ms A had shown no symptoms of major infection prior to 25 May.

During her admission Ms A was seen by an ileostomy district nurse, who continued to care for her after discharge on 31 May. Ms A continued to have district nursing input after her discharge from hospital. The district nursing notes documented on 1 June that Ms A found the loop ileostomy "repugnant".

Dr I wrote to Dr J on 17 June in relation to the examination and surgery. Dr I advised that Ms A had had a major wound breakdown with disruption of her sphincter, which had necessitated a laparoscopic loop ileostomy operation.

On 21 June 1999 ACC accepted Ms A's claim as medical mishap. The question of medical error was not pursued.

Ms A had a repeat perineal repair on 5 July, following which a small penrose drain was left in the perineum, and the wound was closed with sutures. Dr I followed up this operation with antibiotics. On 16 August Ms A underwent a closure of the loop ileostomy which was in place to cover an external sphincter and perineal repair. Examination under anaesthetic revealed that the sphincter injury was soundly healed.

While an inpatient in the ward, Ms A had input from the psychiatric service at the Public Hospital on 18 August, and was discharged that day. She had subsequent follow-up with Dr I on 21 September as an outpatient, after which he referred Ms A to physiotherapy for pelvic floor exercises.

Slow recovery

On 11 January 2000 Ms A consulted Dr I, who noted that she was still experiencing smears of leakage, particularly after she had had a bowel motion and while walking up hills. Ms A stated:

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> "Exercise of any sort, such as housework, light gardening, or pushing [the baby] in his pushchair, can cause the [anal] sphincter to open slightly. I feel very restricted in what I can undertake and have little confidence in my body."

On 11 April 2000 Dr I saw Ms A again, noting that her condition had improved. He noted that he would review her in six months from that date. Dr I advised her that future vaginal deliveries would be unwise and that she would need to have a Caesarean section for further children.

Ms A had been referred by ACC for hypnotherapy. In his final report to ACC, dated 24 August 2000, the medical hypnotherapist stated:

> "I am impressed with the way that [Ms A] has managed to change many of her attitudes and whilst her case of post-traumatic stress disorder was quite severe she has been able to come to terms with what happened to her."

Aftermath

Ms A continues to be traumatised by these events and has ongoing physical problems. Ms A feels that she has been "severely let down by all those who were supposed to be protecting" her interests. She lists the persons and agencies who she has been wronged by as follows:

"
- By the midwives at the birth who failed to notice such extreme tearing;
- By Ms C, whose lack of any sense of responsibility meant that she ignored my repeated and desperate questions about what was wrong, and who subsequent to the eventual diagnosis had nothing further to do with me, even to the limited extent of checking how I was;
- By the system under which I, as someone who is utterly terrified of hospitals, had to plea for a date for the humiliating and very painful surgery which the actions of medical professionals, including hospital employees, had made necessary;
- By the district nurses, who failed to notice that my body was rotting subsequent to surgery;
- By [the Public] Hospital staff, who having agreed to my bringing in my baby so that I could feed him, did nothing at all to enable me to care for him there, and who, having said I should not lift my baby or toddler subsequent to repeated surgery, had no interest in whether this was possible;
- By ACC, who suggested that my (invalid and [out of town]-resident) mother help me with the children. ACC eventually provided care for something like 30 hours a week, at a time when my husband was obliged to be working long hours, having committed himself to taking 11 weeks leave to care for me;

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- And now, by [the Office of the Health and Disability Commissioner] in failing to resolve this complaint for so long."

Independent Advice to the Commissioner

Initial midwifery advice – Ms Rhonda Jackson

The following expert advice was obtained from Ms Rhonda Jackson, an independent midwife:

"**The issues involving [Ms D] and [Ms C]**

- Was [Ms A] given enough information pre-natally about what to expect from the birth of her baby from [Ms C] and [Ms D]?

[Ms C] was solely responsible for the maternity care provided to [Ms A] in the antenatal period and therefore this issue does not involve [Ms D].

It appears from my reading of the documentation that [Ms C] was aware from early on in [Ms A's] pregnancy that [Ms A] had a needle phobia. This was discussed at [Ms A's] second antenatal visit on the 10th of August. [Ms C] states that she was aware of the severity of this phobia, and had offered [Ms A] the suggestion of seeing a medical hypnotist. There is good documentation in the care plan that this issue was discussed in depth. It appears that the decision made between [Ms A] and [Ms C] was to hope for a needle free delivery, but that if needles were required [Ms A] would 'cope somehow'. [Ms A] was at increased risk of tearing with this birth because of the scar tissue from her previous episiotomy. Therefore a more in depth care plan discussing the options should this occur was more appropriate.

[Ms A's] history is that her phobia was severe enough for her to need a general anaesthetic for the repair of her episiotomy at her first birth. The fact that her phobia had not improved in the interim despite having had psychiatrist input rings alarm bells and could alert the midwife for the need for specialist input even though this was not something [Ms A] wished to consider.

- Was there enough information given to [Ms A] in your opinion from [Ms D] at the birth of her baby? Was this information communicated appropriately?

- Were the actions of [Ms D] appropriate to address [Ms A's] perineal tear?

I have reviewed the information provided by both [Ms D] and [Ms A] about the birth. [Ms D] was working as a locum at [Ms A's] birth and had not developed a previous relationship with [Ms A]. She had been informed of [Ms A's] needle phobia and attempted to work within the constraints this provided. After the birth it was obvious that [Ms A's] perineum required suturing but [Ms A] was very upset by this fact and a

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thorough investigation of her perineum was very difficult for [Ms D] to do. The decision was made between [Ms D] and [Ms A] for [Ms D] to attempt to suture [Ms A's] perineum with the use of nitrous oxide for pain relief. This was too painful and frightening for [Ms A] to cope with and [Ms D] was only able to put in one suture. [Ms D] then decided that 'under these extreme circumstances the procedure be abandoned and the wound would heal by granulation'. This is not [Ms D's] usual practice. It is understandable that [Ms D] needed to abandon the procedure but no other alternatives appear to have been discussed with [Ms A] at this time. When a situation falls outside of a midwife's scope of practice it is necessary for her to *consult.* Given that [Ms D] was unable to do a thorough investigation of [Ms A's] perineum and that she had been unable to adequately repair it, it would have been appropriate for her at this stage to request specialist consultation and to have informed [Ms A] about the risks associated with leaving a large tear unsutured. I do not feel that sufficient communication had occurred at this stage both with [Ms D] discussing these issues with [Ms A], and also seeking medical advice. I do not feel [Ms D's] actions were appropriate although they were motivated out of a concern for [Ms A].

- In your opinion, should [Ms D] have undertaken an episiotomy?

From my reading of the documentation, it does not seem necessary that [Ms D] performed an episiotomy, although in hindsight it may have been a better option. It is sometimes after the event that the midwife can look back and say that it would have been better to do an episiotomy, but in this instance the need was not obvious before delivery. [Ms D] states that the perineum stretched well for the delivery of the baby's head, and that it was the baby's shoulders and hand that caused the perineum to tear. It is difficult to perform an episiotomy once the baby's head is born. Occasionally in a situation of true shoulder dystocia, where the baby's shoulders are completely stuck, an episiotomy is performed, but this baby's shoulders were able to be delivered without this being necessary.

- Was the appropriate follow-up care for this perineal tear given by [Ms C] and [Ms D]?
- Was it appropriate for [Ms C] to insert a further suture into [Ms A's] perineum without effective anaesthetic? What alternative measures could she have adopted to address [Ms A's] torn perineum?
- Was enough information and were enough options given to [Ms A] from [Ms C] post-natally concerning her torn perineum?

[Ms D] was not involved in providing post natal care.

[Ms C] provided all the follow-up care for [Ms A]. [Ms C] first saw [Ms A's] perineum on day 3. She was also aware that the tear was gaping but the stitch appeared intact. [Ms A] was also experiencing considerable perineal pain. [Ms C] again observed the perineum on day 5. The tear was gaping and extended to the anal margin but not into it,

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and the stitch had come out. [Ms C] suggested that [Ms A's] perineum should be seen by the on-call consultant or registrar. [Ms A] 'was alarmed' at this suggestion.

On day 7 [Ms C] was phoned by [Ms A] to ask [Ms C] to put some stitches in her perineum at home. When [Ms C] arrived at [Ms A's] place, [Ms A] was in a very distressed state, and took some time to calm down. [Ms C] attempted to infiltrate [Ms A's] perineum with local anaesthesia and suture it. However she was unable to anaesthetise the area properly and was *able to insert only* one stitch. [Ms C] was caught in trying to aid [Ms A] but her cares were inappropriate. [Ms A] was severely distressed and was showing the need for expert help. It seems clear that her phobia had become out of control and it would have been difficult for [Ms A] to make rational choices given the severity of her fear.

Re-suturing of a perineum at seven days post delivery is a surgical intervention which requires skills beyond the scope of practice of a midwife, and requires a sterile setting to prevent the risk of infection. [Ms C] was trying to help [Ms A] but this situation was now beyond her. It would have been appropriate for her to have at this point been very clear with [Ms A] about this and to have made hand-over mandatory but to have remained with [Ms A] for support. If [Ms A] had refused this, [Ms C] should still have consulted with an expert practitioner herself, and to have documented this. Midwives work in partnership with women but there are occasions when a midwife must set some professional limits, and it is important that a midwife recognise when she has reached the limit of her scope of practice.

Although [Ms C] continued to provide midwifery input, she was unable to assist any further with [Ms A's] perineal discomfort, which was indicating there were on-going problems with her perineum. [Ms A] was also continuing to show signs of distress with her situation. [Ms C] noted that at [Ms A's] six week check [Ms A's] perineum, 'appears to have completely healed in that no raw areas. Still very open with virtually no [?form, couldn't read from the notes]'. This suggests that even by [Ms A's] six week check, her perineum was incompletely or inadequately healed and that referral should have been made for on-going assessment/treatment.

- Were [Ms C's] and [Ms D's] choice of interventions and actions for [Ms A] appropriate and timely or should these have been done at an earlier occasion? If so, what would these have been and when should these have occurred?

I have answered this question throughout the above issues, when it was in context with the issues above.

- Were [Ms C's] and/or [Ms D's] actions in treating [Ms A] appropriate to meet the professional standards required of a midwife*?*

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STANDARD SIX
Midwifery actions are prioritised and implemented appropriately with no Midwifery action or omission placing the woman at risk. Ensures assessment is ongoing and modifies the midwifery plan accordingly.

[Ms C] failed to meet this standard in that, as the outcome shows, the ongoing lack of referral and skilled intervention that [Ms A] received resulted in a protracted and traumatic experience. [Ms C] was not involved in the actual delivery, and initial assessment of [Ms A's] perineum. However she did not make a realistic antenatal plan with [Ms A] in the antenatal period and left it to chance that all would work out well, when there were strong indicators that problems could occur. To have been able to have worked out *some other* options with [Ms A], and to have consulted appropriately antenatally would have meant she would have been in a better situation to access skilled help afterwards. When the situation with [Ms A's] perineum became acute postnatally, and her perineum completely broke down, to have omitted accessing skilled help and to have attempted an inappropriate intervention such as re-suturing a broken-down perineum did put [Ms A] at risk, and contributed to the unhappy outcome.

[Ms D] failed to meet this standard, in that when [Ms A] had delivered her baby, and it was obvious that she had sustained a significant tear, [Ms D] did not assess the perineum adequately, and therefore missed the seriousness of the tear that [Ms A] sustained. She then attempted to suture [in discussion with Ms A] without sufficient pain relief and had to abandon her attempt, leaving the perineum insufficiently sutured to prevent the subsequent problems from occurring.

It is outside a midwife's scope of practice to suture a third or fourth degree tear, and [Ms D] states that she is aware of this. To be able to diagnose what degree a tear is requires a thorough and complete examination. It is not appropriate for this not to have occurred, and once [Ms D] recognised that she was not able to do an adequate internal assessment, she should have discussed with [Ms A] the risks of not doing this and to have consulted.

It is a midwife's right to consult when a situation is outside her scope of practice, even if the patient does not wish to be personally examined. A discussion between [Ms D] and the on-call consultant/registrar would have been appropriate at this stage, and for this consultation to have been documented. It is possible that the on-call medical staff may have been able to find some way of developing trust with [Ms A] and to have then been able to follow up clinically. It is also possible that an anaesthetist may have been able to be involved and to have discussed with [Ms A] appropriate methods for providing anaesthesia, without the use of needles, as this had been carried out successfully with her first birth.

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In Summary

Firstly I would like to offer my sympathy to [Ms A]. This has obviously been an extremely traumatic experience, and it is obvious from her words that it has affected her deeply. I hope that with time the effects will lessen.

Both [Ms D] and [Ms C] have tried very hard to provide as positive an experience as possible for [Ms A].

[Ms D] was in the difficult situation of meeting someone for the first time and trying hard to accommodate her wishes. She obviously managed extremely well with a birth complicated by a difficult delivery of shoulders and hand. In all these aspects her care was excellent. The problems arose when she needed to attend to [Ms A's] perineum and this activated [Ms A's] phobia. For both [Ms A] and [Ms D] this must have been an upsetting experience, and it is possible to understand how the decisions were made to abandon the suturing and assessment. However this, as mentioned before does not comply with professional midwifery standards.

[Ms C] was also, from her records a very committed and caring midwife who also wanted the best for [Ms A], and in all other ways provided an excellent standard of care. However in trying to protect and support [Ms A] she did not comply with midwifery standards.

Further midwifery advice – Ms Rhonda Jackson

Ms Jackson did not have access to my interview notes when she provided her initial advice. After reviewing the notes taken after the interviews with Ms C, Ms D, Ms G, Ms F, Dr J, Dr H, Dr I and Mr B, Ms Jackson provided the following additional comments:

"My previous opinion on the above file covered most of the issues mentioned in your letter. This opinion is largely unaltered however I offer the following comments in response to the supporting information provided.

<u>Discussing the decisions made at delivery regarding the perineal tear.</u>

Perineal tears can often be left to heal without suturing however never if the rectal sphincter is damaged as complications such as occurred in [Ms A's] case can occur. Digital examination of the rectal sphincter is recommended as a routine after perineal repair or in this instance where the tear is not sutured. (A lubricated gloved finger is inserted into the anus to check the sphincter integrity.) Referral to a medical opinion must be sought if there is uncertainty as to the extent of the perineal / rectal damage. Occasionally women require an anaesthetic to repair perineal damage. Being able to fully see the extent of the damage is essential to the decision as to whether or not to suture. There were complicating factors in this situation and these contributed to the unfortunate outcome. [Ms D] was not the primary carer and did not provide the antenatal care for [Ms A], this meant she was not fully aware of the extent of [Ms A's] phobia and in the clinical setting she was presented with the situation would have been very difficult

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to manage. In this circumstance it was understandable that the midwife left the tear to heal believing that it was a second degree tear.

The main area of concern regarding the Midwifery decision making was around the 7th day when [Ms C] responded to a call by [Ms A] to suture the perineal tear at home. Repair of a tear after seven days should never be undertaken at home as some granulation of tissue will have occurred and therefore debridement of the wound to create a raw area able to heal when joined surgically is probably needed. [Ms C] recommended a referral to a consultant obstetrician which [Ms A] declined. [Ms C] became caught in trying to advocate for [Ms A] while recognizing that she had an abnormal response to medical input from her previous history. Also complicating the decision making was the fact that [Ms C] did not attend [Ms A] at the birth and therefore did not examine the initial tear. [Ms C] had an obligation to her midwifery practice in this situation to advise the woman of the need for referral and to ring for a medical opinion to discuss her concerns.

[Ms C] placed herself in a vulnerable position professionally by not seeking the opinion as she had recommended. Midwives need to seek guidance from other health professionals when they are concerned and feel that any situation is outside their scope of practice. This needed to be documented and the woman advised of this. It was understandable that the midwife was concerned to do as the woman wished as this is one of the roles of the midwife but not at the cost of her professional midwifery obligations regarding safety and scope of practice.

Standard Six: from the New Zealand College of Midwives standards of Practice. Midwifery actions are prioritized and implemented appropriately with no Midwifery action or omission placing the woman at risk. Ensures assessment is ongoing and modifies the midwifery plan accordingly."

Further midwifery advice – Ms Ann Yates

Additional expert advice was obtained from Ms Ann Yates, an independent registered midwife, once the interviews were completed:

> "My name is Ann Yates, I am a registered midwife. I am currently employed by Auckland District Health Board as Midwifery Leader, at National Women's Hospital. I have been elected by the New Zealand College of Midwives to act as an expert witness for the midwifery profession.
>
> I have been asked by the Health and Disability Commissioner to review this complaint by [Ms A] and the events surrounding the birth of her baby [name removed] on 7 February 1999 and subsequent postnatal care by midwives [Ms C] and [Ms D].
>
> I have reviewed the letters of complaint and responses from [Ms D, Ms C, Ms G and Ms F]. Also the clinical notes, interview notes and the expert opinion from Ms R Jackson.

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History

[Ms A] was expecting her second baby in February 1999, and had engaged Midwife [Ms C] to be her Lead Maternity Carer. Her GP [Dr J] did not provide obstetric care and was not involved in her care until 6 weeks after the birth [the] of baby.

During the antenatal period, [Ms A] revealed to [Ms C] that she had a needle phobia and an aversion to hospitals. This was discussed and documented early in her pregnancy at approximately 14 weeks. [Ms C] recommended consulting a medical hypnotherapist [name removed], however, [Ms A] was not keen and did not pursue this recommendation until after the birth.

The pregnancy progressed normally with regular antenatal visits by [Ms C]. There were two occasions antenatally where [Ms A's] phobia presented problems.

1. Blood tests are routine in pregnancy, at booking and again at 28 weeks gestation. These are essential diagnostic tests in pregnancy. [Ms A] declined to have these done during her pregnancy. Midwife [Ms C] relied on information from her first pregnancy to guide her.

2. A hospital tour was arranged at 36 weeks gestation, which caused [Ms A] some distress. Her midwife was late arriving at the hospital and was contacted by the co-ordinating hospital midwife to be told that [Ms A] was upset and had left. She was in her car crying and sobbing. Her husband was attempting to calm her down. She eventually settled down enough to tour the unit.

Both of these reactions were unusual and extreme and would have been an indication that any intervention requiring needles would have had a similar or possibly worse response.

It was discussed during the making of a care plan prior to delivery and documented in her clinical notes that there was a possibility of suturing/intervention. It states [Ms A] 'was very fearful of this but if the situation arose she ([Ms A]) would cope somehow'.

[Ms A] expressed a strong desire to avoid any intervention at her birth. This would entail no episiotomy, no intravenous medication, no analgesia or epidural or routine active management of the third stage of labour. All of these are often incorporated into the management of a normal labour / birth and are not in the realms of emergency situations. Emergency procedures such as anaesthetic and control of bleeding are common and all usually require needles.

The likelihood of [Ms A] requiring a needle even at a home birth had she decided to birth at home, was extremely high.

It was noted that her previous birth in Germany had been normal, but she had had an episiotomy performed and subsequently repaired under sedation. Sedation is

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uncommonly required to repair an episiotomy, though a third degree tear is usually sutured by an obstetrician under general anaesthetic or epidural anaesthesia. It is unclear whether [Ms A's] first birth resulted in a third degree tear or was a straightforward episiotomy. A known previous third degree tear may have been managed differently at a subsequent delivery.

It was documented that [Ms A] was very distressed at the thought of requiring needles. [Ms C] observed her to be tense and not happy discussing her phobia. This would have made it difficult to make a plan.

Both [Ms C] and [Ms A] adopted a 'wait and see approach' to the birth.

When [Ms A] went into labour, her midwife was already caring for another labouring client and called in independent midwife, [Ms D] to care for [Ms A]. Ms D recalls some discussion about a client of [Ms C's] who had a needle phobia, but was not aware of who it was or what the management of that client would be. [Ms D] did not meet [Ms A] prior to her labour, but was instructed at a brief hand over in delivery unit that [Ms A] had needle phobia and [Ms D] was to avoid administering anything via a needle.

[Ms D] states she had no idea how extreme this phobia was. [Ms A] coped well with a short normal labour. She used nitrous oxide gas and appeared to be in control and composed. Her husband [Mr B] was also present, providing support and encouragement to his wife.

Forty minutes after [Ms D] arrived in delivery unit, [Ms A] delivered [the] baby. There was a hospital midwife in attendance during the actual birth, who left immediately afterwards. The birth was complicated by [the] baby presenting with his hand up near his face. This and a delay in delivering his shoulders caused a tear to [Ms A's] perineum. [The baby's] head had emerged easily – normally a baby's head is the largest part to pass through the birth passage, however, occasionally with a large baby, the shoulders can become stuck and require some manipulation and traction to free from the pelvis. Inevitably this can create soft tissue trauma to the mother.

[Ms A] and [Mr B] held their baby while the placenta was delivered shortly after the birth. There were no complications at this stage of labour, and so far it had been needle free.

During the delivery of the placenta, [Ms D] noticed a tear on [Ms A's] perineum. She did not attempt to examine her more fully at this stage, but observed that externally the laceration extended to just above the anal margin.

She informed [Ms A] that she had a laceration requiring sutures. [Mr B] recalls [Ms D] saying that [Ms A] had 'bad grazing'. [Ms A] became distressed immediately. [Ms D] states [Ms A] did not want her perineum repaired with needles, and she declined to have an anaesthetic.

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Initially [Ms A] refused to allow the midwife to do anything, but then consented to her suturing if she used nitrous oxide gas to help calm her.

[Mr B] states that [Ms A] was unaware of what was happening due to a drop in blood pressure and exhaustion. There was no record or mention of a drop in blood pressure in the clinical notes. [Ms D] believes [Ms A] was fully aware of what was happening and was able to make decisions for herself.

[Ms D] attempted to examine and repair [Ms A's] perineum under extremely difficult and unusual circumstances. She believes that [Ms A] definitely consented to proceeding without anaesthetic and both she and [Mr B] had made a decision to proceed with this procedure as quickly as possible.

[Ms A] was placed in a semi recumbent position with her pelvis raised by a towel roll to enable a clear view of the perineal area. Examination of her perineum was difficult due to [Ms A's] tenseness and distress.

[Ms D] felt confident from this examination that [Ms A] had sustained a second degree tear involving the muscle layer. It appeared to extend to short of the anal margin. She did not perform a rectal examination to establish any damage to the anal sphincter. She states 'that if a laceration extends down to the rectal area, a rectal examination is important'. [Ms D] inserted one suture into [Ms A's] perineum, before [Ms A] became so distressed that she demanded this procedure stop.

[Ms D] was unhappy to have left [Ms A's] perineum unsutured as this was not her normal practice.

She considered that being a second degree tear and the extreme phobia about needles, the best option was to leave it to heal by granulation.

She did not consider this to be an emergency situation and felt that she had little choice given [Ms A's] reactions. She states she was also attempting to support [Ms A's] wishes.

Comment

There was insufficient planning made antenatally to inform [Ms D] about how to manage under these circumstances that arose. Both midwives had never experienced extreme needle phobia before and had no idea that it would impact on clinical decision making as it did.

[Ms A] and her husband would have both been very aware of the seriousness of the phobia and how this would likely manifest itself. It is unclear how in depth this was revealed antenatally, as it appears that [Ms A] became upset even discussing her phobia.

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It is not uncommon for women to state a fear and dislike of needles and almost always to be supported through situations where needles are required. Therefore it was not unreasonable to assume that [Ms A] was no different and could be talked through such a situation.

There were, however, indications that [Ms A] may have had an extreme phobia. This was her refusal to have routine antenatal blood tests, and her reaction to being in hospital for a voluntary tour of this unit at 36 weeks gestation. There was no documentation regarding how [Ms A] had coped with needles during her first delivery in Germany.

[Ms C] discussed [Ms A's] phobia with colleagues but did not consult a specialist, antenatally. A contingency plan was never made for the high likelihood needles were required, in fact it was all left to chance.

[Ms D] did not consult appropriately when she had reached the limit of her expertise.

Under the circumstances a discussion with an obstetrician or anaesthetist may have resulted in a very different outcome. [Ms A] was not given this option after attempts to suture her perineum failed. Ultimately the decision to have further intervention was [Ms A's]. However, she did not appear to have been given all the information available to make these decisions.

[Ms D] was not able to fully examine [Ms A's] tear due to her tenseness and distress. Therefore the full extent of the tear was not revealed. [Ms D] believed that the extent of the tear was not involving the rectum, but did not perform or suggest to [Ms A] that a digital rectal examination be performed to check the integrity of the sphincter. It is usual practice in this case of extensive tear to carry out this procedure.

[Ms D] had fully convinced herself that the tear was minor and required no further investigation and that whatever damage had occurred would heal itself naturally.

Postnatal history

[Ms A] went home from the postnatal ward on the day of delivery. This is quite common for many women who prefer to be in their own homes. Postnatal follow up care was provided by her L.M.C. [Ms C] at [Ms A's] home.

Day 3 [Ms A's] perineum was checked and noted to be painful and gaping.

Day 5 It was checked again. The single suture inserted by [Ms D] had fallen out and the perineum was gaping open at the wound site. [Ms C] documents that she discussed resuturing.

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Day 6 [Ms C] documents referral to a specialist and records that [Ms A] was not into it and that [Ms A] was alarmed at this suggestion.

Day 7: [Ms A] phoned [Ms C] and requested she be resutured at home in order to avoid hospitalisation. On arrival at [Ms A] and [Mr B's] home Ms C finds [Ms A] distressed in a state of panic shut in the bathroom crying and throwing things at the wall. [Ms A] decides to go ahead after being calmed by her husband and [Ms C].

[Ms C] agrees and discussed a strategy which involved infiltrating the perineum with local anaesthetic. [Ms C] had decided that the wound stood a good chance of healing given it was still raw and the wound edges would heal. Unfortunately the local anaesthetic was only partially successful and only one suture was inserted.

[Ms C] states she again discussed the need to consult a specialist but this was unacceptable to [Ms A].

The wound continued to gape open and cause pain.

Day 11 [Ms C] documents that she made [Ms A] aware of the fact that without further treatment her perineum would not be the same as formerly. Consultation was declined.

Week 3 postpartum, [Ms C] documents slow healing, visible epithelial growth but a perineum gaping to the anal margin. [Ms A's] reaction was anger that previous attempts to repair the wound had failed.

Week 6 after delivery [Ms C] notes that [Ms A's] perineum had healed well in that the torn edges of the wound were no longer raw. Her perineum was very open. [Ms A] was shown with a mirror. There was a rash over her thigh area thought to be from dampness from vaginal secretions.

Events and past occurrences were discussed and [Ms C] again suggests referral to a specialist for repair of the perineum. [Ms A] declined, stating it would be too traumatic. There was no record of any incontinence by [Ms C], she did record that [Ms A] had told her she had sexual intercourse by six weeks. [Ms A] was discharged from maternity care at this point.

Week 8 [Ms A] visits her GP. She complained about faecal incontinence and was referred to a specialist, this was arranged by [Ms C] and an appointment was made with a female gynaecologist.

Five days later a crisis arose. [Ms A] was distressed at having loose bowel motions and no sphincter control. Her appointment was not for 10 days with the gynaecologist, [Ms C] was again contacted and immediately arranged a consultation with the on-call obstetrician and gynaecologist [Dr H]. Letters from [Drs H] (Obstetrician) and [Dr I] (Colorectal and General Surgeon) describe examination of [Ms A's] perineum

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postnatally as having no perineum, a divided sphincter and the lower part of the anal canal communicating with the posterior vaginal fourchette. The anterior sphincter complex was completely gone.

The subsequent management of her reconstructive surgery and post surgical nursing care is outside of my scope of practice as a midwife.

Comment

[Ms C] was aware of the difficulty [Ms D] had in repairing [Ms A's] damaged perineum, she knew [Ms D] was uncomfortable about leaving it; and that as a result of this, [Ms A's] perineum was open and gaping. Her attempts at rectifying this involved repeated requests to [Ms A] to see an obstetrician to have it repaired and a futile attempt to insert sutures under local anaesthetic at home.

Both of these options created fear and distress for [Ms A] whose phobia about needles appeared to limit rational decision making.

[Ms C] and [Ms D] both appeared to consider her needle phobia did not create a diminished responsibility and respected [Ms A's] right to refuse treatment.

Response to complaint

During [Ms A's] labour on the 7 February 1999, [Ms D] failed to undertake an episiotomy that resulted in [Ms A] receiving a fourth degree tear to her anus which [Ms D] did not diagnose.

The practice of routine episiotomy at subsequent births where the first delivery had an episiotomy has long ago been abandoned as unnecessary, uncomfortable and increasing the risk of infection and blood loss.

A systematic review by Cochrane database does not support routine use of episiotomy to prevent third degree tears, prevent trauma or reduce urinary incontinence. 'Restrictive episiotomy is shown to result in less posterior perineal trauma, less suturing and fewer complications' (*National Women's Annual Report 2001 – A Yates Director of Midwifery).*

Given the current recorded evidence and contemporary midwifery practice, an episiotomy would have been unlikely to have prevented the fourth degree tear [Ms A] sustained.

Gomme, Yiannouzis, and Ullman (September 2001) found in their study that perineal trauma during childbirth is extremely common. 60–70% of women required suturing. The incidence of second degree tears during birth is high. *Samuelsson, Ladfors, Lindblom, Hagbert (January 2002),* found that in their study of 2883 women, only 34.2% of women having subsequent birth had no tears at all. They concluded that the majority of women undergoing childbirth had a tear and 47.1% suffered from perineal

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lacerations. Nulliparous women were more likely to have severe perineal lacerations or episiotomies.

According to *Martin, Labrecque, Marcoux, Berube, Pinault (April 2001)* having perineal trauma at the first delivery (second degree tear or higher or episiotomy) more than tripled the risk of spontaneous perineal tear of the second delivery. The risk of spontaneous perineal tear at the second delivery increased with the severity of previous perineal trauma at birth.

The risk of a spontaneous perineal tear occurring was high due to the fact [Ms A] had already had significant perineal damage from an episiotomy at her first delivery. There is also research that suggests that following repair of an extended episiotomy (third or fourth degree tear) abdominal delivery is recommended. There appears to be a higher incidence of severe incontinence in women who have subsequent vaginal deliveries after repair of fourth degree tears.

Signorello, Harlow, Chekos and Rekle (January 2000) demonstrated in their retrospective cohort study on 'Midline Episiotomy and Anal Incontinence', that there is a higher risk of faecal incontinence at 3 to 6 months postpartum compared with women with an intact perineum.

The details surrounding the extent of [Ms A's] repair occurring at her first delivery in Germany are unclear and may have impacted on the outcome of her second delivery.

Midwife [Ms D] diagnosed a second degree tear, this is a tear extending through skin and muscle layer between vagina and anus. It does not involve the anal sphincter. A second degree tear would usually be examined fully to exclude damage to the anal sphincter and vaginal wall. This requires good lighting and a co-operative patient. It is not possible to establish the extent of a tear looking at the external damage. Most women find this uncomfortable and require local anaesthetic to be fully relaxed about this area being touched. Blood loss can sometimes prevent full examination until controlled.

[Ms D] maintains she did fully examine [Ms A's] perineum and concluded she had a second degree tear which would heal with or without sutures. It became evident from later events that [Ms A] had in fact a third/fourth degree tear. [Ms D] failed to diagnose this at delivery and to refer appropriately.

Midwives are able to diagnose and differentiate between the types of tears and trauma to the birth canal and vulval areas. It is within our scope of practice to repair uncomplicated tears and to refer when the limit of expertise is reached.

Primary repair of the anal sphincter should be undertaken by an experienced medical clinician under adequate analgesia. Explanation and follow up by medical staff is urged due to the increased incidence of anal incontinence following sphincter trauma.

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Midwives have tended to leave minor perineal lacerations to heal spontaneously, and clinical experience and studies show that women can suffer from sutured perineums. Several studies have shown the importance of different suture techniques and different suture materials in the healing process.

There is, however, little evidence to base leaving a comprehensive second degree tear unsutured. Most studies focus on leaving minor tears or superficial layers of an episiotomy unsutured at skin level demonstrating healing as the same and pain level considerably better.

In my opinion if [Ms D] was uncomfortable about leaving a second degree tear of that magnitude unsutured she should have consulted with a specialist at the very least. The opinion of an obstetrician after delivery may well have had enough impact on [Ms A] and [Mr B] to consider another form of care.

It appears from [Ms A] and [Mr B's] evidence that they were reassured at the magnitude of the perineal trauma believing it to be fairly minor at the time.

A week following the birth of [Ms A's] son on 7 February 1999, Midwife [Ms C] inserted a further suture into [Ms A's] perineum without effective anaesthetic and advising her it was in order for the perineum to heal correctly.

The documented account of this procedure by [Ms C] describes a request from [Ms A] to have her perineum repaired at home rather than admit herself into hospital and seek specialist care. [Ms C] agreed to this because:

(a) She was unhappy that [Ms A] had a gaping unsutured perineum.
(b) [Ms A's] aversion to hospitals and needles may mean this was the best opportunity to rectify the situation.

Her rationale was that she was equipped and skilled to repair a damaged perineum following a home delivery and therefore a postnatal repair under these circumstances could still result in better healing than doing nothing at all.

Unfortunately the local anaesthetic was not adequate to relax [Ms A] and permit this procedure to continue. It was correct for [Ms C] to discontinue suturing when her client requested that she stop. Unfortunately [Ms A's] perineum required more than one or two sutures to make a difference.

Following insertion of the suture, [Ms C] advised [Ms A] that she would experience no further problems. [Ms A] subsequently advised [Ms C] on several occasions that she was experiencing problems such as pain around the vagina and anus. [Ms C] informed [Ms A] that these problems were nothing to do with the birth.

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Evidence from [Ms C] does not support this statement. She states 'after putting one stitch in, [Ms A's] overwhelming fear made it impossible for me to go any further. I did not believe that one suture would be sufficient, but had no option but to discontinue. When it became obvious that my attempt was unsuccessful, I again advised that she consult a specialist. Again this advice was too upsetting for [Ms A] to consider.'

The postnatal records clearly document decisions about [Ms A's] painful gaping perineum, and repeated recommendations that [Ms A] should consult with a specialist at the hospital. [Ms A's] letter of complaint does not reflect this ever happening.

Given the explicit level of documentation, it is unlikely that [Ms C] ignored the problem or regarded it as unrelated to the birth. Perineal pain associated with birth trauma was highly likely under the circumstances, as slow healing of an unsutured wound would have taken considerably longer to resolve than usual.

[Ms C] advised [Ms A] the problems were outside her scope of her midwifery expertise and failed to refer her on for a second opinion.

There is a difference of opinion between [Ms A] and [Ms C].

[Ms A] does not recollect or reflect in her complaint the conversations recorded in [Ms C's] clinical notes. If Midwife [Ms C] had identified that [Ms A's] problems were outside her scope of practice, it would have been normal practice to have referred the problem to a medical specialist.

Standards for Midwifery Practice – Standard 6
Midwifery actions are prioritised and implemented appropriately with no midwifery action occurring placing the woman at risk.

Criteria
Identifies deviation from the normal and after discussion with the woman, consults and refers appropriately.

[Ms C] refutes this complaint and states that she discussed referral on many occasions. This was declined until the request for referral came through [Dr J], [Ms A's] GP at 8 weeks. At this point [Ms A] had become incontinent and the referral was urgent. [Ms C] complied with this request and acted appropriately by accompanying [Ms A] to see the On-call Specialist when the situation had become desperate. This was after discharge from Maternity Care and [Ms C] was no longer required to act as an LMC.

It can be difficult in this situation where there are ongoing problems postnatally and the maternity system requires hand-over of care to a GP and well child carer.

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However, this hand-over must be clear to the client and a full report to whoever she hands care to is required.

Response to issues
Was [Ms A] given enough information antenatally about what to expect from the birth of her baby from [Ms C] and [Ms D]?

[Ms D] was not involved with [Ms A] antenatally and so was not responsible for antenatal decision making.

Standards for Midwifery Practice – Standard two
The midwife upholds each woman's right to free and informed choice and consent throughout her childbirth experience.

Criteria
- The Midwife shares relevant information including birth options, and is satisfied that the woman understands the implications of her choices.
- Facilitates the decision-making process without coercion.
- Negotiates her role as care giver and clearly outlines mutual responsibilities.
- Develops a plan of midwifery care together with the woman.
- Respects the decisions made by the woman, even when these decisions are contrary to her own belief.
- Respects the woman's right to decline treatment or procedures.
- Clearly states when her professional judgement is in conflict with decisions or plans of the woman.
- Discusses with the woman, and colleagues as necessary in an effort to find mutually satisfying solutions.
- Attends when requested by the woman in situations where no other health professional is available.
- Documents decisions and her midwifery actions.

The birth plan was developed antenatally between [Ms A] and [Ms C] with [Mr B], [Ms A's] husband present.
The birth plan is not dated or signed. It states clearly that [Ms A] has a severe needle phobia. It outlines briefly the previous birth requiring a general anaesthetic for repair of [Ms A's] episiotomy and that she had become distressed at the time.

It states [Ms A] also has an aversion to seeking help because of her discomfort discussing needles.

The plan described hoping and praying for a needle free delivery and a possible home birth or an early discharge home as [Ms A] dislikes hospital environments. There was no plan should needles or intervention be required. [Ms C] understood that if the need arose, then [Ms A] would cope.

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[Ms C] states that 'there is no way any practitioner can guarantee that a tear would not occur and we did discuss what would happen in this instance.'

In my opinion there may have been discussion antenatally but there was inadequate planning and documentation for the high likelihood [Ms A] would require intervention. This put any back up midwife in a difficult position in the event [Ms C] was unable to attend [Ms A]. It is not clear, whether referral to a specialist was recommended antenatally.

It was all left to chance that everything would be alright on the day. A discussion between [Ms C] and a specialist may have resulted in a referral to an anaesthetist who could have made a clear plan for management of [Ms A's] fear of needles in the event of a perineal tear.

It was not discussed in any clinical notes, so in my opinion all options were not explained antenatally, therefore [Ms A] was never given the information she needed to make a fully informed decision before the birth of her baby.

Was there enough information given to [Ms A] from [Ms D] at the birth of her baby? Was this information communicated appropriately?

In my opinion [Ms D] failed to provide adequate information to [Ms A] to enable proper inspection of her perineal tear and subsequent repair.

She had reached the limit of her expertise under extremely difficult circumstances, but the option to do nothing further was incorrect in my opinion.

Consultation with the On-call Specialist may have resulted in a different outcome for [Ms A] and at the very least would have provided information for [Ms A] to have made a fully informed decision.

Should [Ms D] have performed an episiotomy?

The decision to perform an episiotomy is almost always made at the time of delivery. Given the research around this subject, presented in the Systematic Review by Cochrane a conservative approach to episiotomy was appropriate – routine episiotomy is rarely performed during a normal delivery without fetal distress or failure to progress. Neither of which occurred during [Ms A's] birth. An episiotomy was unlikely to have prevented a third or fourth degree tear. It would have been contrary to [Ms A's] request for a needle free birth as much as possible.

In my opinion [Ms D] was correct in not performing an episiotomy.

Were the actions of [Ms D] appropriate to address [Ms A's] perineal tear?

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[Ms D] attempted to minimise the distress for [Ms A] discovering she had a second degree tear by:

1. Acting promptly to repair her perineum.
2. Using nitrous oxide and entonox gas to help her to relax.
3. Gathering suturing equipment together away from [Ms A's] vision.
4. Negotiating the use of a local anaesthetic.

Initially [Ms A] refused to have her perineum repaired and later agreed to this.

[Ms D] clearly thought that she would be able to get sufficient sutures in place if she acted swiftly while [Ms A] was using entonox gas.

Unfortunately [Ms A] was too tense and distressed and so [Ms D] was asked not to continue after inserting the first suture. This was not adequate and under normal circumstances [Ms D] would have used local anaesthetic and repaired [Ms A's] perineum in layers.

It was unsatisfactory to leave [Ms A's] perineum in a sub-optional state without discussing fully all options of repair and possible consequences if nothing further happened. I could find no evidence to support leaving a significant second degree tear unsutured.

This is not usual midwifery practice, though many midwives would have seen healing by granulation where sutures have broken down, this would not usually be given as a choice unless the tear was relatively minor.

Was the appropriate follow-up care for this perineal tear given by [Ms C] and [Ms D]?

Other than reporting on events of delivery, [Ms D] had no further responsibility for follow up and postnatal care was provided by her Lead Maternity Carer [Ms C].

It was well documented in the clinical records that [Ms C], examined, discussed and recommended referral to a consultant throughout the 6 weeks postnatal period. [Ms A's] phobia was fully evident to [Ms C] who attempted to repair her gaping perineal wound at home on Day 7. This attempt failed and at this point [Ms C] should have consulted with a specialist about the likelihood of healing.

[Ms A] was made aware of the appearance of her perineum gaping and that without treatment it would not be the same as formally. She continued to decline referral to a specialist regardless.

Was [Ms A] examined appropriately?

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The initial examination after delivery was described by [Ms D] as difficult because [Ms A] was tense and became distressed. It was obvious to her that [Ms A] had sustained a significant second degree tear that she believed stopped short of the anal margin. There was no description of the posterior vaginal wall or anal sphincter.

It is possible that even with adequate analgesia a third or fourth degree tear may have been missed, but because a comprehensive examination never took place, I doubt that this is a valid speculation.

Both midwives believed this to be a second degree tear with no involvement of the anal sphincter. [Ms C] would have believed this from the handover of information after delivery by [Ms D].

It is possible that she too was unable to properly examine [Ms A] due to her distress and anxiety when attempting to resuture her on Day 7.

In any event, suturing of a second degree tear by either midwife would not have prevented the incontinence that occurred two months later. Repair of a third or fourth degree by a specialist after delivery is what was required.

In my opinion [Ms A] was not examined appropriately at the time of delivery.

Was it appropriate for [Ms C] to insert a further suture into [Ms A's] perineum without effective anaesthetic? What alternative measures could she have adopted to address [Ms A's] torn perineum?

[Ms C] believed [Ms A] to have a second degree tear that was raw and gaping. [Ms A] refused to have treatment in hospital, [Ms C] was concerned about the gaping wound. Under the circumstances, she felt justified in performing a repair at home.

A secondary repair of a second degree tear at home was outside the scope of practice of a midwife in my opinion. Given the difficulties encountered in attempting to repair her perineum, it was highly likely that [Ms C] would have problems in a subsequent attempt.

Repair of [Ms A's] perineum one week later at home, would be less likely to be successful because some granulation would already have occurred and without the benefit of adequate anaesthesia, aseptic surroundings, lighting and consultation with a specialist, it was unlikely to be successful.

The ineffective local anaesthesia and suturing only increased [Ms A's] phobia about needles.

I took from the clinical note that attempt to suture [Ms A's] perineum ceased on her request when it became clear that the anaesthetic was insufficient.

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Usually in these circumstances, the midwife would insert more local anaesthetic until anaesthesia of the wound area was complete. However, this was possibly not offered due to [Ms A's] distress at the time and fear of needles.

The only other alternative was hospital admission for repair under anaesthetic by an obstetrician.

[Ms C] maintains that this option was repeatedly declined by [Ms A].

Was enough information and were enough options given to [Ms A] from [Ms C] postnatally concerning her torn perineum?

From documentation by [Ms C] in the clinical notes, there was considerable discussion postnatally with [Ms A]. This is not recollected in [Ms A's] complaint at all.

There was no documentation or mention of faecal incontinence until 8 weeks postpartum, via [Ms A's] GP.

The significance of faecal incontinence earlier would have alerted the midwife to the possibility of sphincter damage and information and advice would have been on a different level. The impact of the second degree tear healing unsutured was documented as 'we talked about the appearance of perineum and that it was unlikely to return anything like it was formerly'. On the 16 March at her 6 week check, [Ms A] was shown her perineum in the mirror during a discussion about her perineal tear.

In my opinion there were only two options for [Ms A] to consider:

1. Leaving her perineum unsutured
2. Repair in hospital under anaesthetic.

The second option was not explored until a crisis arose, though referral to a specialist is documented as being discussed on several occasions by [Ms C].

In my opinion [Ms C] acted appropriately in suggesting referral to a specialist in the postnatal period.

Was [Ms C's] and [Ms D's] choice of intervention and actions for [Ms A] appropriate and timely or should these have been done at an earlier occasion? If so, what would these have been and when should these have occurred?

[Ms C] could have discussed the needle phobia with an anaesthetist antenatally. This would have given [Ms A] options for sedation and anaesthetic, which were less frightening and offered the opportunity for proper examination of any perineal damage, which may occur.

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After delivery [Ms D] was left in the difficult situation of trying to manage an extreme needle phobia and a significantly torn perineum. Timely referral at this point may have enabled appropriate repair of the perineum and anal sphincter. Postnatally when [Ms C's] attempted suturing on Day 7 failed, referral to a specialist would have also been appropriate.

Were [Ms C's] and/or [Ms D's] actions in treating [Ms A] appropriate to meet the professional standard required of a midwife?

In my opinion both [Ms C] and [Ms D] failed to meet professional standards in that they failed to consult or refer [Ms A] when they had reached the limit of their expertise.

SUMMARY

Neither midwife had experienced extreme needle phobia like [Ms A's], and it impacted hugely on their judgement and clinical decision making. There was no antenatal plan for dealing with the high likelihood of a perineal repair being required, and the possibility that someone other than [Ms C] may have to deal with the situation.

[Ms D] was not able to deal with the actual phobia occurring and failed to examine [Ms A] adequately. Her offer to suture a significant perineal tear without anaesthetic was thought to be a compassionate compromise which left her perineum gaping and further increased [Ms A's] fear of needles.

Both midwives acknowledge [Ms A's] phobia but did not believe this created diminished responsibility, nor was her condition life threatening. They believed they were supporting her right to non-consent for treatment.
Unfortunately, because neither midwife was able to examine her properly the extent of the damage remained unknown for 8 weeks. Therefore discussion about the implications of a torn anal sphincter never took place and [Ms A] was unaware about the potential impact of her decision not to be sutured by a specialist.

This unfortunate set of circumstances have undoubtedly had a profound effect on [Ms A's] health and increased her fear of hospitals and needles.

Both midwives, in attempting to be supportive and compassionate, failed to refer to a specialist when they reached the limit of their expertise.

References

Gomme, Yiannouzie and Ullman (September 2001) 'Developing a Tool to Assess Perineal Trauma', British Journal of Midwifery 9 (9) 538–44.

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Samuelsson, Laddfors, Lindblom, Hagbert (January 2002) 'A prospective observational study on tears during vaginal delivery: Occurrences and Risk Factors.' Acta Obstetrica at Synaevcologica Scandinavica: 81 (1) : 44–9.

Signorello, Harlow, Chekos and Repke (January 2000) 'Midline Episiotomy and Anal Incontinence: retrospective cohort study.' BMJ. 320 (7227) : 86–90

Martin, Labrecque, Marcoux, Berube, Pinault (April 2001) 'The association between perineal trauma and spontaneous perineal tears.' Journal of Family Practice. 50 (4): 333–78

New Zealand College of Midwives Handbook for Practice."

District nursing advice – Ms Trish McHugh
The following expert advice was obtained from Ms Trish McHugh, an independent district nurse:

"**Issues of concern identified in the complaint from [Ms A]**

The District Nurse failed to recognise signs and symptoms of infection or fistula formation.

Supporting Evidence
The referral sent to the District Nursing Service from [the ward at the Public Hospital] gave the District Nurse very little information

'Pt had 3rd degree perineal tear during delivery 3/12 ago. Very anxious prior to surgery. Please check on wound & assess. Pt has follow-up with Dr I in 2-3wks.'

There was no documentation of date of surgery, surgery detail or wound assessment prior to discharge.

This information was obtained from the patient who was already anxious.

[The] District Nurse completed the initial assessment within the guidelines of accepted practice and documented aspects of her assessment.

1. Wound assessment and care.
The care was appropriate with swabbing with saline from the front to the back of the wound. The exudate or discharge was minimal no mention was made to the odour of the discharge.

2. Pain
Was assessed and was seen to be consistent with post op pain. It was managed effectively with Paracetamol.

3. An ongoing education plan was developed to assist in the recovery period.

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4. Follow-up visits were arranged with information given on how to contact the District Nurse if [Ms A] was concerned.

[Ms F] documented the same assessment of the wound as her colleague but asked [Ms A] to seek advice for her pain which had increased as had her number of bowel motions.

In the evidence cited there is no suggestion of infection or fistula formation apart from the increase in pain which the nurse requested the patient to contact the GP.

The evidence clearly demonstrated the District Nurses working within the accepted scope of practice to meet the professional guidelines.

The development of a fistula would only have been obvious to the nurse with the increase of discharge, which would have been offensive in odour and faecal in colour. There was no documentation of odour or colour of the discharge.

In my opinion [Ms F] and [Ms G] provided [Ms A] with care appropriate to the scope of practice of a District Nurse."

Response to Provisional Opinion

[Ms A], [Mr B] and [Ms A's] sister provided comprehensive submissions in response to my provisional opinion. The submissions raised concerns about my assessment of the relative credibility of the parties, that the expert midwifery advice was not reflected in my conclusions and that the implication of my opinion was that [Ms A] was entitled to a lesser standard of care because of her phobia. [Ms C] also provided further information in response to my provisional opinion. My opinion has been finalised taking into account these submissions.

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.

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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 –*

   …

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

Clause 3

1) *A provider is not in breach of this Code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in this Code.*

2) *The onus is on the provider to prove that it took reasonable actions.*

3) *For the purposes of this clause, "the circumstances" means all the relevant circumstances, including the consumer's clinical circumstances and the provider's resource constraints.*

Other Relevant Standards

New Zealand College of Midwives

THE SCOPE OF PRACTICE OF THE MIDWIFE (1993)

(Based upon the World Health Organisation Definition)

The midwife must be able to give the necessary supervision, care and advice to women prior to, and during pregnancy, labour and the post-partum period, to conduct deliveries in her own responsibility and to care for the newborn and the infant.

This care includes preventative measures, detecting complications in mother and child, accessing medical assistance when necessary and carrying out emergency measures. She has an important task in health counselling and education, not only for women, but also within the family and the community. The work should involve pre-conceptual and antenatal education and preparation for parenthood, and extends to certain areas of women's health, family planning and child care. She may practise in any setting, including the home, hospital and community.

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

CRITERIA

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

Opinion

Health care providers are required to comply with the duties contained in the Code of Health and Disability Services Consumers' Rights (clause 1(2)). Under the Code, consumers have the right to effective communication (Right 5), to be fully informed (Right 6), and to make an informed choice and give informed consent (Right 7). Right 7(7) of the Code gives consumers the right to refuse services and to withdraw consent to services. Providers have a corresponding duty to provide balanced information on the options, risks, side effects, benefits and costs of each option. Consumers also have the right to services of an appropriate standard (Right 4). Providers are required to comply with relevant professional standards and to provide services with reasonable care and skill.

Clause 3 of the Code excuses providers who establish that they have taken "reasonable actions in the circumstances" to give effect to a consumer's rights. "The circumstances" are defined to mean "all the relevant circumstances including the consumer's clinical circumstances …". Relevant circumstances include the fact that the consumer chose to ignore the provider's advice, and the subsequent care arrangement agreed to between the provider and the consumer.

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Where a provider elects to support a consumer who has chosen not to follow the advice of the provider, the provider must ensure that the consumer understands the basis upon which care is being provided. For example, if the provider believes that a referral to a specialist is necessary and the consumer chooses to ignore the advice, it is the responsibility of the provider to ensure that the consumer understands the expected risks, side effects and benefits (if any) of this decision. The provider must also ensure that the consumer is aware of other available options (if applicable). The provider must explain the nature of the care she is able to offer in the circumstances and obtain the consumer's consent to such care. Good documentation is important. While the consumer cannot expect to receive care beyond that agreed to, she can expect to have that care provided with reasonable care and skill.

Ms A suffered a traumatic experience following the birth of her child in February 1999. In bringing this complaint she has sought to have a number of health professionals held accountable for what happened to her.

Having reviewed all the available evidence, I do not believe that all the responsibility for Ms A's trauma and the horrific injury that she unfortunately suffered can be laid at the door of the midwives or the district nurses who cared for her. I am satisfied that Ms A's health care providers were compassionate and caring in the face of extremely difficult circumstances. Ms A was a challenging and controlling client. Her behaviour was affected by her extreme phobia. This does not mean that Ms A was not entitled to receive services of an appropriate standard. However, the limits that she imposed on her providers cannot be ignored in assessing the appropriateness of their care. A key issue in forming a view on the validity of Ms A's complaints is the reasonableness of the way in which her providers responded to the situation they faced.
My findings in relation to Ms A's specific complaints are set out below.

Complaint about Ms D's failure to undertake an episiotomy
I am satisfied that an episiotomy was unlikely to have prevented the tear Ms A suffered, and that Ms D acted appropriately in not performing an episiotomy. Even if an episiotomy had been clinically indicated, Ms A's extreme aversion to any intervention would almost certainly have led her to refuse an episiotomy. Her complaint after the event is unjustified. In my opinion Ms D provided appropriate midwifery services at the birth and did not breach Right 4(1) of the Code.

Complaint about Ms D's failure to diagnose extensive tear
Ms D told Ms A there was a tear in her perineum and that she would need to examine it and would possibly need to suture it (close the wound with material such as silk or catgut, to facilitate the healing process). Pain relief was discussed. At this point Ms A's emotional state changed to what Ms D described as "an obvious state of terror at the prospect of having to undergo a procedure involving needles". I note Mr B's submission that throughout Ms A was able to make rational decisions over the best course of medical action. Ms D said that it was a difficult examination, but that she was satisfied it was a second degree tear. It was her professional judgement that the perineal tear did not involve the anal sphincter. This was not the case – it was in fact a third or fourth degree tear.

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During the repair of the tear, Ms A instructed Ms D not to continue suturing the tear. Ms D said that she explained that it would take longer to heal without sufficient suturing and would be more painful. In light of her belief that it was a second degree tear, Ms D considered it was not necessary for her to obtain specialist advice in the face of Ms A's decision. I note that a specialist may have found the situation similarly challenging. My midwifery advisor, Ms Jackson, stated that "in this circumstance it was understandable that the midwife left the tear to heal believing that it was a second degree tear".

In my view, while Ms D failed to recognise the extent of the tear, she made reasonable efforts to assess it in the face of extremely difficult circumstances. If Ms D realised the tear encroached upon the anal sphincter she would have consulted with a specialist. I am also satisfied that Ms D adequately informed Ms A of the expected risks associated with not suturing what she considered was a second degree tear. This is particularly important when a patient is refusing optimal care. Although I accept that Ms A was not forewarned of the distressing events that in fact transpired, I do not consider that these events were reasonably foreseeable and it was therefore not incumbent on Ms D to warn Ms A about them.

In my opinion, although Ms D failed to accurately diagnose the extent of the tear, she acted reasonably in the circumstances and did not breach Right 4(1) of the Code.

Complaint about Ms C's use of anaesthesia when suturing
Ms C agreed, against her better judgement, to suture Ms A's perineum at home on 13 February. She arrived to find that Ms A had locked herself in the bathroom and was shouting, screaming and throwing things at the wall. Ms C and Mr B managed to calm her down. Ms A agreed to go ahead with the suturing, and Ms C applied some local anaesthetic. The anaesthetic was an inadequate pain block, and after one stitch Ms A insisted that Ms C cease suturing.

It would obviously have been preferable for Ms A's perineum to be fully numbed before Ms C attempted to suture. However, Ms C was constrained in her ability to provide adequate anaesthesia by her client's response to the situation. I am satisfied that Ms C took reasonable actions in the circumstances to provide Ms A with adequate anaesthesia, and did not breach Right 4(1) of the Code.

Complaint about information given by Ms C during postnatal care
Ms A claimed that following insertion of the suture on 13 February, Ms C told her that she would experience no further problems. I am faced with a conflict of evidence. I do not find it credible that Ms C would have made such a statement, particularly when she documented that her attempt at suturing had been unsuccessful, and that Ms A needed to see a specialist.

Ms A also claimed that Ms C told her that the contracting pain in her anus and vagina was nothing to do with the birth. Again, Ms A's allegations strain credulity and are inconsistent with Ms C's documentation about the painful gaping perineum and the need to see a specialist. I do not accept that Ms C made the statements attributed to her.

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Accordingly, this aspect of Ms A's complaint is not sustainable.

Complaint about Ms C's failure to refer Ms A for a second opinion
Ms A complained that she repeatedly asked Ms C whether she should consult a specialist and was assured by Ms C that it was not necessary. It is true that Ms C did not in fact refer Ms A for a second opinion until 31 March. However, I accept Ms C's account (corroborated by her notes and circumstantial evidence) that she repeatedly advised Ms A about the condition of her perineum and recommended that she consult a specialist. Ms A and Mr B challenge the veracity of Ms C's notes and suggest that they may have been created later. I have received no evidence to support this serious allegation. Looking at all the circumstances in the round, the overwhelming inference is that Ms A was only prepared to consult a specialist when her condition significantly deteriorated on about 31 March.

On 25 March Ms A consulted her GP, Dr J, and was advised to consult a psychiatrist and recheck with her midwife. It appears that on 31 March Ms A finally agreed to see a female gynaecologist. Ms C arranged this for two weeks' time, but the planned consultation was overtaken by the distressing events of 4 April. Ms A contacted Ms C on 4 April about her disturbing faecal incident. Ms C immediately contacted the on-call obstetrician and gynaecologist and arranged for him to meet them at the Public Hospital. Ms A was given some medication to enable a proper gynaecological examination.

While I accept that Ms C did not forewarn Ms A of the events that in fact transpired, in my view, she was sufficiently informed of the expected risks associated with not consulting a specialist in relation to her condition and made her decision accordingly.

Midwives work in partnership with women. It would be inconsistent with that partnership model and with the right of an informed and competent woman to make her own decisions, for a midwife to ignore her client's wishes and refer her to a specialist. There may be circumstances where a midwife believes that she can no longer safely provide care. In such a case she should explain the situation to the woman, offer to refer her to an appropriate provider, and withdraw her services.

As noted by my first midwifery advisor, Ms C was "caught in trying to aid Ms A but her cares were inappropriate". Nonetheless, Ms A's specific complaint about Ms C's failure to refer is not justified. In my opinion Ms C made reasonable (and repeated) efforts to refer Ms A to a specialist, and recognised her client's right to co-operation among providers to ensure quality and continuity of care. Accordingly, Ms C did not breach Right 4(5) of the Code.

Complaint about district nurses' failure to recognise signs of infection
Ms G and Ms F provided Ms A with "care appropriate to the scope of practice of a District Nurse". From the evidence gathered during my investigation, I am impressed by the thoroughness and attentiveness of the district nurses who visited Ms A from 22 to 26 May 1999. It follows that, in my opinion, Ms G and Ms F did not breach Right 4(1) of the Code.

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Conclusion
In summary, none of the specific complaints made by Ms A is upheld.

I wish to record my gratefulness to my expert advisors for their assistance. Ms Jackson has noted that, in some respects, Ms D and Ms C did not comply with professional midwifery standards. Ms Yates has commented: "Both midwives in attempting to be supportive and compassionate, failed to refer to a specialist when they reached the limits of their expertise."

I accept that in some respects Ms A's midwives did not care for her appropriately. I recommend that Ms D and Ms C review their practice in light of my advisors' comments.

The investigation of Ms A's complaints has taken almost three years. I regret the long delays during the investigation process, and apologise to Ms A and the providers under investigation for the stress they have suffered. I trust that this report will help achieve some closure for the parties.

Actions

- A copy of this opinion will be sent to the Nursing Council of New Zealand.
- A copy of this opinion, with all identifying features removed, will be sent to the Nursing Council of New Zealand, the New Zealand College of Midwives, and the Maternity Services Consumer Council.