Midwife, Ms C

A Report by the

Health and Disability Commissioner

(Case 04HDC20394)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Ms A	Consumer
Mr B	Consumer's partner
Ms C	Provider/Independent midwife
Ms D	Hospital midwife, the public hospital
Dr E	Obstetrician
Ms F	Charge midwife, the public hospital
Ms G	Independent midwife
Ms H	Midwife
Ms I	Midwife

Complaint

On 10 December 2004 the Commissioner received a complaint from Ms A about the services provided by independent midwife Ms C. The following issues were identified for investigation:

- *Whether independent midwife Ms C appropriately managed Ms A's labour and delivery on 15 August 2004.*

- *Whether Ms C provided Ms A with adequate information about her labour and delivery during the antenatal period.*

An investigation was commenced on 6 May 2005.

Information reviewed

- Information was received from:
  - Ms A
  - Ms C
  - Ms D
  - General Manager of Women's Health, a District Health Board

- Ms A's clinical records were obtained from Ms G, Ms C and a public hospital

- ACC Medical Misadventure Unit claim file, including the independent advice from midwives Sue Lennox and Terryl Muir.

Independent expert advice was obtained from midwife Sue Lennox.

Information gathered during investigation

Antenatal period
Independent midwife Ms G was Ms A's principal LMC throughout her first pregnancy in 2004. Ms G was a partner in a midwifery group with Ms C and a third midwife.

Ms G provided a computerised Care Plan for Ms A which records the information provided antenatally to Ms A. The Care Plan is brief and shows that pain relief was discussed with Ms A on 8 July 2004 and recorded as "wait and see". In relation to possible induction/augmentation of labour, on 12 August the comment was, "Wait and see. Discussed, to see specialist". Epidural anaesthetic and management of labour were noted on 12 August. There is no record of Ms A's preferences and what was discussed with her. Ms A's estimated delivery date was recorded as being 6 August 2004.

In response to the provisional opinion, Ms A stated that Ms G did not write in the Care Plan page in her Maternity Care book. She noted that 12 August 2004 was the day she believed her contractions started. Ms A stated, "A care plan should have been in place well before I was in labour."

14 August 2004
At 2.30pm on 14 August 2004 Ms G admitted Ms A to the maternity unit of a public hospital with irregular uterine "tightenings", which she had been experiencing for the previous four days. Ms A was 41 weeks' gestation. Ms G conducted an initial assessment of the progress of Ms A's labour. She performed a CTG (cardiotocograph — records uterine contractions and the fetal heart rate) which showed the fetal heart rate was within normal limits at 140 bpm (beats per minute), and an internal vaginal examination. Ms G determined that Ms A was not in established labour and noted her findings in the clinical record.

At 3.30pm Ms G found that Ms A was still experiencing irregular contractions strong enough to prevent her from resting, and suggested that she have some pain relief. At 5pm Ms G gave Ms A an intramususcular injection of pethidine for pain and an antiemetic, Maxolon. She recorded the fetal heart rate as 140 bpm.

As Ms C was the on-call midwife for the group at this time, Ms G arranged for her to take over the care of Ms A. Ms G asked the hospital midwives to monitor Ms A until Ms C arrived, and arranged for obstetrician Dr E to review her.

At 7pm charge midwife Ms F checked Ms A and noted that she continued to have irregular contractions but was resting comfortably after the pain relief. Ms C recorded that she assumed the care of Ms A at 7.15pm.

Ms C stated that at this time she discussed pain relief with Ms A and what she wanted to be done with the placenta. They also discussed the ecbolic (to assist the

contraction of the uterus and delivery of the placenta) and a vitamin K injection for the baby. Ms C stated that she "customarily uses the word 'ecbolic injection' rather than 'syntometrine' but also describes what the ecbolic is administered for". Ms C understood from their conversation that Ms A had already considered these matters and was giving her consent.

At 8pm Dr E reviewed Ms A and noted "G1 P0 [gravida one, para 0 — second pregnancy, no live birth]. Long latent phase. Sedate and wait." Ms C recorded that Dr E had advised that Ms A be admitted overnight to the antenatal ward.

Ms A stated that when she transferred to the ward from the delivery suite and entered the lift with her partner Mr B and Ms C, the lift malfunctioned, opening on the incorrect floor for the theatre suite. Ms A recalled that they had to "backtrack" to arrive at the correct floor.

Ms C handed Ms A over to the ward midwives to await establishment of labour and left the hospital.

The records show that Ms A was admitted to the ward by one of the hospital midwives at 8.30pm.

15 August 2004
Ms A spent a comfortable night on the ward and was reviewed at about 7am on 15 August 2004 by Dr E. Dr E ordered an epidural anaesthetic for Ms A, a Syntocinon infusion and rupture of uterine membranes, in order to progress her labour.

At 8.30am the ward staff recorded that Ms A's uterine membranes ruptured spontaneously. A CTG was commenced and Ms C was informed of Ms A's progress at 9am.

Ms A responded to the provisional opinion, stating:

> "It is noted that [Ms C] assumed care of me at 7.15pm on the 14 [August]. She may have verbally taken over from [Ms G], but I did not see or speak to [Ms C] that night. … The first time I saw or spoke to [Ms C] was after my waters broke on Sunday morning."

Ms A stated that the conversation with Ms C on Sunday morning was about pain relief, the vitamin K injection and whether she wanted to keep the placenta. She has no recollection of either "ecbolic" or "syntometrine" being mentioned.

Ms C admitted Ms A to the delivery suite at 10.15am, noting:

> "[Ms A] admitted to D/S [Delivery Suite]
> from […] floor in labour
> SROM [spontaneous rupture of membranes] @ 0900
> FH [fetal heart] 135

Mobilising well
Clear liquor"

Labour
During the following two hours, Ms C made brief notes of the progress of Ms A's labour, recording the frequency and duration of the contractions and fetal heart rate.

At 12.10pm Ms C noted that Ms A was "[d]istress in pain". Ms C performed an internal vaginal examination and found that Ms A was 9cm dilated and "fully effaced" with the baby at station 0.[1] The draining uterine liquor was still clear.

A further brief recording at 1pm notes a fetal heart rate of 140 bpm. The word "strong" was added (presumably referring to Ms A's contractions). Ms C stated that as she was "scrubbed" for the delivery she did not record any clinical details until after the delivery. Ms C recalled that Ms A began pushing with her contractions at 1pm. According to Ms C, at 2.30pm she told Ms A she needed to "make a cut" (ie, perform an episiotomy) to make way for the baby, and Ms A agreed to this.

In response to the provisional opinion Ms A stated:

> "[Ms C] did not at any time say she needed to make a cut. She said, 'You're nearly there', and 'One more push and you'll be there. Push. Push. Push.' Then she cut me without discussion or consent. … I felt a sharp sting and said, 'Did you just cut me?' to which she said 'Yes'. I would not have asked this if she had said, 'I need to make a cut'."

Ms C stated that the reason she had to perform the episiotomy was that the "baby needed to come". Ms A "was in a hurry and pushing hard" and it appeared that the perineum was going to tear. She did not document this as it was not practical when actively engaged in the delivery to take her gloves off to write notes.

Ms C rang the nurse-call for assistance when she could see the baby's head. She had planned active management to deliver Ms A's placenta — to assist the delivery of the placenta by administering an ecbolic to cause the uterus to contract. The ecbolic is usually given at the birth of the baby. (There is no evidence that this was discussed with Ms A.)

[1] 'Station' refers to the relationship of the presenting part of the fetus to the level of the ischial spines (outlet) of the mother's pelvis. When the presenting part is at the level of the ischial spines, it is an 0 station (synonymous with engagement). If the presenting part is above the spines, the distance is measured and described as minus stations, which range from –1cm to –4cm. If the presenting part is below the ischial spines, the distance is stated as plus stations (+1cm to +4cm). At a +3 or +4 station, the presenting part is at the perineum (synonymous with crowning).

When hospital midwife Ms D entered the room, the baby's head was crowning. Ms A's baby daughter was born normally at 2.35pm. The umbilical cord was cut and clamped by Ms C.

Ms D went to the incubator for a warm towel, then took the baby to the neonatal examination table for a check. Ms D asked Ms C if the ecbolic, Syntometrine, needed to be given. Ms C replied, "Yes, please". Ms D gave the Syntometrine injection into Ms A's thigh.

While Ms D was taking the baby and giving the ecbolic, Ms C was clamping, cutting and examining the cord. Ms C recalls that everything was happening at the same time and she does not know the precise time when Ms D gave the ecbolic. It could have been between one and a half to three minutes after the delivery but was certainly within five minutes. Ms C stated that it is her normal practice to leave the administration of the ecbolic to the assistant midwife when she is gloved and busy with the delivery.

Ms A is adamant that it was longer than three minutes after delivery before the ecbolic was administered, and that she endured "agony" in the interim.

To deliver the placenta, Ms C waited for the lengthening of the cord and a gush of blood, which indicates separation of the placenta. While she waited she took cord blood for analysis and checked Ms A's perineum for any tears. There was only a clean cut (episiotomy) to the perineum. When Ms C saw the cord lengthen and the gush of blood, she slid her fingers along the cord and, using the cord as a guide, felt for the position of the placenta. The placenta was sitting at the opening of the vagina. Ms C recalled that the placenta came out slowly and normally, but as the placenta was delivered into her hands, Ms C thought there was something unusual about its appearance.

There has been dispute regarding where Ms C placed her hand during the delivery of the placenta. Ms A stated:

> "After my daughter was born, [Ms C] asked me to push for the placenta to be delivered. I did attempt this, but it was very painful. I told her that it was more painful than trying to pass the baby's head. She asked me to push again. … I tried again and then asked for something to make it easier (meaning pain relief). [Ms C] was pulling, trying to get the placenta to separate from the uterus. I yelled, 'You're hurting me'. … It was a different pain to the birth, and I was making a lot more noise."

Ms C stated that sometimes women complain of pain at this time. At interview, Ms C stated she placed her right hand on top of Ms A's uterus in an open grip "to protect the uterus from coming down" and started gentle, controlled cord traction. She recalled that Ms A exclaimed in pain when she applied pressure to the fundus and tried to knock her hand away and she explained to Ms A that she had to do this, but eased the pressure off slightly.

Ms D recalled that Ms C applied controlled cord traction to deliver the placenta while guarding the uterus.

In response to the provisional opinion, Ms C changed her account of the delivery of the placenta:

> "I wish to submit as part of the record of the above case the circumstances surrounding my signing of a 'Transcript of Interview' conducted at my home on 13 September 2005. The transcript is not a true and accurate report in all respects of the interview. I mistakenly and innocently signed it as a 'true and correct record' on 16 September 2005.
>
> I wish to record and apologise for the fact that when signing the transcript, I had not in fact read it fully. In fact I read it in a cursory brief way and in so doing did not notice the error. I mistakenly assumed that the record would not need close scrutiny by me; assuming that it would be correct in all respects. I have not previously been in the position of being so formally interviewed and had not sought legal advice before signing the transcript. I very much regret not taking more care before signing the transcript.
>
> I confirm that English is not my first language and I accept the Commissioner's comment in his provisional report that my oral and written communication skills can be improved. This may in part explain the discrepancy in what I was trying to explain to the interviewer and what appeared in the transcript. I cannot give any other explanation for the error. I do not believe I would have used the word 'fundus' to describe that part of the body which I applied pressure to as part of a controlled cord traction. Perhaps that word was used but in another context.
>
> I am certain that at no time during third stage management did I apply pressure to the fundus of [Ms A] as part of my technique of controlled cord traction. My usual and long standing practice has always been to place my hand over the symphysis pubis. I accordingly wish a correction to be made to the transcript, specifically at page three — lines 36 to 39.
>
> There are many midwives with whom I work who can corroborate that I place my right land on the symphysis pubis and that this is my normal and usual practice. I have provided to my lawyer signed statements from two such midwives, namely [Ms H] and [Ms I] and have asked my lawyer to provide copies of these statements to the Health and Disability Commissioner."

Ms D stated:

> "Approximately ten minutes later the placenta appeared to be delivering, however, it seemed to keep coming. My initial thoughts were that perhaps another dead foetus was attached as the appearance was not one of a normal placenta. I pressed the midwifery assist bell and [a midwife] entered the room. [The midwife] was also unsure of what was presenting and the midwifery assist bell was rung again. [A second midwife] entered the room, she was also uncertain what was presenting and rang the emergency bell."

Ms C stated that the placenta was protruding from Ms A's vagina about two to three inches. Ms C thought something was different but did not know what it was. She asked Ms A to cough as this sometimes assists the placenta to be delivered, but found that the placenta was too firm to pull.

Ms D stated:

> "Charge midwife [Ms F] and staff midwife [Ms H] entered the room. [Ms F] established that what had occurred was that the uterus had become inverted and requested that an emergency call be put out to the Obstetric and Gynaecology Registrar on call.

Ms F recorded a retrospective account of the events. She noted:

> "Approximately 1445 [2.45pm] answered emergency bell in […]. Told ? IUD [intrauterine death] of second twin. Patient not shocked — no bleeding.
>
> Large mass on green guard giving the appearance of a macerated infant in membranes delivered by breech with head undelivered.
>
> Emergency call for reg [registrar] and consultant.
>
> 2nd IV line inserted. Blood for urgent X-match sent. No body parts felt when mass loosely grasped and no descent. Thought ? hydatidiform mole — no grape-like appearance. On gentle exam for head realised it was a prolapsed uterus with placenta attached. Placenta gently removed from uterus. Attempt to replace uterus unsuccessful. Reg arrived.
>
> 888 call to alert anaesthetist and theatre. Given Ranitidine 150mg oral on way to OT [theatre] at 1512 [3.12pm]."

Ms A stated that when they got out the lift they found they were on the wrong floor for the theatre and had to "backtrack and go back into the lift". It was the same problem that she had encountered on the morning of 15 August when she transferred to the ward from the delivery suite, but this time she was in danger of haemorrhaging and the malfunctioning lift cost valuable time.

Once in theatre Ms A was asked to sign a consent form. She was in shock and hardly able to hold a pen. She woke up in recovery and was terrified as she did not know what had gone wrong or what the outcome was. Ms A said that the man looking after her there was "wonderful" in reassuring her.

Ms A was transferred to the ward from theatre where she recovered well and was able to breastfeed her baby with minimal assistance. She was seen by Dr E on the morning of 17 August. Dr E examined Ms A and noted that she was "emotional and very upset over birth experience. Explained in detail about uterine inversion, a very rare complication esp. in first birth." Dr E went on to outline Ms A's options for subsequent deliveries, that she would need to deliver in a base hospital with senior staff managing the third stage (delivery of the placenta).

At 9.45pm on 17 August Ms C saw Ms A and talked to her about her delivery. Ms A told Ms C that she was feeling better after talking with Dr E and wanted to be discharged the next day.

Ms C compiled a retrospective record of the events of Ms A's delivery as follows:

> "Written in retrospect
> 15/8/04 Started pushing at fully dilated
> 130[0]hrs cx
> 1435hrs Had a normal delivery of a female infant
> 1440hrs IMI Syntometrine given
> 1451hrs Placenta delivery by CCT [controlled cord traction] attached to uterus. Emergency bell rang. Charge midwife [Ms F] came in saw and detached placenta from uterus.
> 2X IV lure put in and bloods taken and sent for G+H+FBC.
> Normal saline IVL put up.
> 1510 […] called in for emergency, saw and took immediately to OT
> [Ms A] and partner reassured."

Ms A was discharged home on 18 August 2004 for follow-up postnatal care to be supervised by Ms G.

Additional information

Ms A
Ms A summarised her concerns as follows:

> "I am concerned about the lack of information I was given throughout my traumatic birth experience (I know it was an emergency, but I feel I could have been given some information. I was not told anything until I was back in the ward approximately four hours after the birth), and the lack of informed consent with both the episiotomy and the injection of Syntometrine, both of which were administered without any discussion or consent.

…

> I am grateful to the hospital for saving my uterus, but I have strong doubts about whether I had to go through this at all. I would like to know if the outcome would have been the same if a different midwife had treated me. …
>
> I believe my entire birth experience was a catastrophe. I believe a number of factors in my care were mishandled and I suffered greatly because of it."

The District Health Board

The District Health Board's General Manager of Women's Health responded to Ms A's concerns about the malfunctioning lift:

> "We are aware of the issues with the lifts and they are constantly monitored and corrected by our engineering staff when incidents such as yours occur."

ACC

On 23 February 2005 Ms A was informed by ACC that her medical misadventure claim had been accepted as medical mishap. In reaching the decision ACC took into account independent expert advice from midwives Sue Lennox and Terryl Muir. Ms Lennox summarised her advice to ACC as follows:

> "There is little evidence of any understanding in [Ms C's] notes of the correct procedure for active management. However, this does not prove she was not following a correct procedure. The notes are certainly very unclear about the process of applying counter-traction. …
>
> I find it surprising that the delivery of the placenta and uterus was described as 'easy'. It is hard to imagine that a uterus would invert easily, but perhaps it did. Although the literature suggests that in 75 percent of cases of uterine inversion the cause is iatrogenic [resulting from treatment] (Hussain, Jabeen, Liaquat, Noorani & Bhutta, 2004), there remains 25 percent of cases where it is a rare and unexpected outcome of active management of the third stage. …
>
> There is an inadequate description of events both in the clinical midwifery notes and in the retrospective notes supplied by the midwife's lawyer. There is a lack of explanation for deviations from normal practice procedures such as performing an episiotomy without adequate explanation and describing a vaginal examination to check whether the placenta has separated as 'normal' practice. There are also worrying details in the account of the third stage of management that is presented as a defence of [Ms C's] practice.
>
> In summary, there are significant differences between the stories of the midwife and the mother and I find it difficult to make a judgement about the different details of the two accounts. I find it is not clear which category this claim should be placed: whether it is error or mishap."

Ms Muir advised ACC as follows:

> "An episiotomy is a surgical incision through the perineal tissue that is designed to enlarge the vulval outlet during delivery (Bennett & Brown, 1999). … Midwives in the past used to take pride in delivering the baby without perineal laceration, but in doing so, the perineal phase of the second stage of labour was sometimes unduly prolonged and the infant subject to intracranial injury and asphyxia (Bennett & Brown, 1999). A midwife should use her skill to decide when to perform an episiotomy. The decision to perform an episotomy or not has to be decided upon at the time, it can only be decided by the practitioners present in the room. However, it is a surgical procedure and must always be done with the woman's consent.
>
> The second stage of [Ms A's] labour was prolonged although not outside of normal limits for a primigravid woman. … The decision to perform the episiotomy had some grounds and the practitioners present are in the best situation to decide on its merits. [Ms C] does appear to have told [Ms A] that she felt an episiotomy would be of benefit and from her accounts felt that [Ms A] had consented to this.
>
> The second issue is whether the active management of the third stage of labour was correctly managed and whether or not the management caused the inverted uterus.
>
> Active management of the third stage of labour involves the administration of an ecbolic drug, early cord clamping and delivery of the placenta using controlled cord traction (CCT).
>
> The uterus can be described as inverted when the fundus has prolapsed into the body of the uterus or beyond. Beyond can be completely through the cervix or completely through the perineum. Uterine inversion is rare (approx 1:2,000). The cause of uterine inversion is unclear, although several predisposing factors are: adherent placenta, mismanagement of third stage — pressure on fundus, or traction on cord when uterus is relaxed, short cord, macrosomia [unusually large baby], twins, coughing, vomiting, primigravid, fibroids and bicornuate uterus (Boyle, 2002). Some studies have thought mismanagement of the third stage of labour to be responsible for 75% of uterine inversions (Hussain, Jabeen, Liaquat, Noorani & Karachi, 2004).
>
> It is difficult to ascertain in this case exactly what happened when … neither [Ms A's] recollection nor the notes were written contemporaneously. To do CCT before the ecbolic was given or had time to work would be considered mismanagement. To encourage maternal pushing without signs of separation would be mismanagement. Maternal pushing is not part of active or physiological third stage management, however, it does sometimes occur under supervision and with caution.

> To piece together what happened I have tried to marry [Ms A's] account of what happened and what is written. It is written that [Ms D] initially took care of the baby and then (I presume) gave the baby to [Ms A]. Once she had finished providing this initial care to the baby she asked about the ecbolic and proceeded to give it. The ecbolic is documented as being given at 1440 hours [2.40pm], 5 minutes after the birth. [Ms A] says that attempting to deliver the [placenta] was so painful that the baby was taken off her chest. As the baby was with [Ms D] initially I am happy to presume that the CCT was occurring after the ecbolic was given. …
>
> [Ms F] has commented that there was no bleeding. I presume she means from the uterus. There will have been a reasonable amount of bleeding from the episiotomy, which is what [Ms A] could possibly feel. …
>
> Once [Ms F] diagnosed the inverted uterus she removed the placenta. … [Ms F] then attempted to replace the uterus. [Ms A] has felt this as 'her insides being ripped out'. This would be expected. She also raises another issue here of not being informed of what was happening. Uterine inversion is an emergency, it is often necessary in an emergency to act first and then talk later. … I am happy that [Ms A] and her family were spoken to at an appropriate time."

Ms Muir advised ACC that, in her opinion, Ms C's treatment and care of Ms A was appropriate and there was no medical error.

Independent advice to Commissioner

The following expert advice was obtained from independent midwife Sue Lennox:

> "**Background**
>
> Independent midwife [Ms G] was [Ms A's] principal LMC throughout her pregnancy with her first baby from March to August 2004. [Ms G] and [Ms C] were in a midwifery collective with a third midwife. [Ms C] was the on-call midwife when Ms A went into early labour, with irregular tightenings at 2.30pm on 14 August 2004 and was admitted to [the public hospital delivery suite].
>
> [Ms A's] labour progressed normally and [Ms C] asked consultant obstetrician [Dr E] to assess her progress at 8pm. [Ms A] began pushing at 1pm on 15 August and at 2.30pm [Ms C] informed [Ms A] that she needed an episiotomy.
> [Ms C] activated the 'midwife assist' bell and hospital midwife, [Ms D] arrived to assist. At 2.35pm [Ms A] gave birth to a live female infant.

[Ms D] cared for the baby while [Ms C] took care of [Ms A]. At 2.40pm [Ms D] asked [Ms C] if [Ms A] had consented to have an IM ecbolic to contract the uterus. [Ms C] replied in the affirmative and [Ms D] gave the injection.

[Ms C] checked the position of the placenta and then commenced controlled cord traction. [Ms A] recalled that she experienced extreme pain at this time. When the placenta was delivered there was extraneous material attached. The emergency bell was rung and charge midwife [Ms F] arrived.

[Ms F] initially thought that the extraneous material was a macerated partial second infant or a hydatidform mole. On closer examination it was discovered that the mass was [Ms A's] uterus (inverted). [Ms F] gave [Ms A] a brief explanation of the circumstances and attempted to reduce the inverted uterus, but was unsuccessful.

The registrar was called and then a 888 call put out to alert theatre staff and the anaesthetist of the obstetric emergency. At 3pm the registrar attempted unsuccessfully to reduce the uterus before [Ms A] was transferred to theatre. [Dr E] performed a reduction under anaesthetic at 3.15pm. [Ms A] had two units of packed cells.

On 17 August [Dr E] reviewed [Ms A] and gave her a full explanation of her condition. [Ms A's] recovery/postnatal period was uneventful.

Complaint

Whether independent midwife [Ms C] appropriately managed [Ms A's] labour and delivery on 15 August 2005.

Whether [Ms C] provided [Ms A] with adequate information about her labour and delivery during the antenatal period.

Supporting information

- Letter of complaint to the Commissioner from [Ms A], dated 7 December 2004, marked with an 'A'. (Pages 1 to 6)
- Letter, dated 6 May 2005 sent to [Ms C] by the Commissioner, notifying her of his investigation and asking her supply information, marked with a 'B'. (Pages 7 to 9)
- Response to the Commissioner from [the district health board], dated 24 January 2005, marked with a 'C'. (Pages 10 to 12)
- Letter to the Commissioner from [Ms A], received 31 March 2005, marked with a 'D'. (Pages 13 to 17)
- Notes taken during a telephone call with [Ms A] on 23 August 2005, marked with an 'E'. (Page 18)

- Notes taken during a telephone call with [Ms A] on 22 September 2005, marked with an 'F'. (Page 19)
- Response to the Commissioner from [NZCOM's] legal advisor, on behalf of [Ms C], dated 22 August 2005, marked with a 'G'. (Pages 20 to 23)
- Notes (and accompanying clinical records) taken during an interview with [Ms C] on 13 September 2005, marked with an 'H'. (Pages 24 to 52)

Expert information required

To advise the Commissioner whether in your opinion [Ms C] provided [Ms A] with services of an appropriate standard.

In particular:

1. *Was [Ms C's] reason for performing an episiotomy on [Ms A's] reasonable in the circumstances?*

Yes.

According to [Ms C] the perineum appeared to be about to tear and, in such circumstances, it is reasonable for [Ms C] to have carried out an episiotomy.

If [Ms A] was pushing hard it may have been difficult to slow her down to allow the perineum to stretch rather than tear. In these circumstances cutting an episiotomy is reasonable and usual practice. [Ms C] needed to explain briefly to [Ms A] the need for an episiotomy, be assured of acceptance and cut very quickly.

I agree with [Ms C] that it would be unusual to write this decision in the notes either at the time or later. In general the fact that an episiotomy has been performed is recorded and it is assumed that there was a sufficient reason such as [Ms C] has subsequently given.

2. *Did [Ms C] conduct the delivery of the placenta in accordance with the principles of active management?*

Although [Ms C] intended to actively manage the third stage some of the principles of such management were not followed.

The ecbolic is usually given directly after the delivery of the anterior shoulder or at the birth of the baby. Instead it seems to have been given just less than 5 minutes after the baby was delivered. This is unusual but is still within the limits of acceptable management and would generally make no difference to the outcome.

It appears from the conversation with [the HDC investigator] ([13] September 2005) that [Ms C] pulled on the cord after seeing the cord lengthen and a gush of

blood which indicated separation of the placenta. This is usual practice management.

[Ms C] says that 'when she saw the cord lengthen and the gush of blood **she slid her finger[s] along the cord**, using the cord as a guide to feel for the position of the placenta, which was sitting at the opening of the vagina'. Sliding one's finger up a cord to find the placenta is poor practice because it may introduce infection and in no way assists the placental delivery. This is poor practice not in line with the principles of active management and it would have mild to moderate disapproval from midwifery peers. However, it is not related to the uterine inversion.

She goes on to say: that she '**placed her right hand on the top of [Ms A's] uterus in an open grip "to protect the uterus coming down"** and started gentle [controlled] cord traction'. On the 16th September [Ms C] said the transcript of the interview with [the HDC investigator] was a true and correct record and in this record [Ms C] says '[Ms A] exclaimed in pain when she **applied pressure to the fundus and tried to knock her hand away'**. It appears that [Ms C] had her hand on [Ms A's] fundus. This description of placing the hand 'on top of the uterus' is incorrect third stage management.

Had she meant she placed her hand at the symphysis pubis to apply counter-traction and prevent the uterus coming down this would be correct management. By applying pressure 'on the top of the uterus' she has indicated she was not practising in line with principles of correct third stage management. She also says later in that interview that she asked [Ms A] to cough when what she thought was the placenta was protruding 2" or 3" out of the vagina. This request is not in line with the principles of active management though maternal effort may be used in physiological management of the third stage.

- Never place traction on the cord without counter-traction on the uterus above the symphysis; otherwise, one may mistake placental separation for cord lengthening due to prolapse or impending inversion.
- Cord traction is applied during active management only when counter-traction is applied. Counter-traction is performed by trapping the body of the uterus above the symphysis pubis and directing it cephalad and back. Traction is applied in a continuous, downward manner only when the uterus is well contracted.

3. *If not, what should she have done?*

With an actively managed third stage of the labour the cord is clamped and cut and the ecbolic is given either at the birth of the anterior shoulder or within the first 2–3 minutes after the birth of the baby. The signs that controlled cord traction can begin are that the clamped end of the cord lengthens and there is a small amount of blood loss perhaps 100mls discharged vaginally. The woman often feels a

contraction and the midwife holds back the uterus at the symphysis pubis and gently pulls on the cord with the other hand. As the placenta is coming down the uterus rises — the change from a contracting uterus to one which has dispelled its contents is felt as an upward movement and as a change in tone by the midwife's open hand facing upward and resting gently at the symphyis pubis.

4. *Did [Ms C's] management of [Ms A's] labour and delivery contribute to the inversion of her uterus?*

Yes.

[Ms C] will have delivered many babies presumably using the same technique and has never had a woman suffer an inverted uterus. Nevertheless the technique is wrong and, by placing her hand on top of [Ms A's] uterus (i.e. at the fundus), she was not in position to prevent a uterine inversion in the way that counter-traction at the symphysis pubis can and this may have contributed to the inversion.

With the hand on the fundus it would be impossible to know there was a problem with the uterus inverting. At the fundus an inverting uterus might feel similar to a contracting uterus whereas the feeling of the inversion at the symphysis is quite distinct.

It is possible that such misplacement might contribute to the inversion. I think the action of having a hand on the fundus instead of trapping the body of the uterus above the symphysis pubis would be viewed with severe disapproval by peers.

5. *Was [Ms C's] recording of the events of [Ms A's] labour of an acceptable standard?*

The clinical notes are cryptic, uninformative and inaccurate. The labour details which cover more than four hours of care are outlined in 30 words. The timing of the spontaneous rupture of membranes is inaccurately recorded: [Ms C] says they ruptured at 0900 hours when in fact it was written on the preceding page as 0830 hours. This lack of attention to detail is an illustration of a poor standard of note taking.

There is little indication how [Ms A] felt or her response to the labour. I think the words on the 5th line might say 'Not coping well' but as 'notcoping' seems to be written as one word it may say something else entirely different.

These notes are all written before a problem existed and they are of a poor standard. The New Zealand College of Midwives' *Midwives Handbook for Practice*, Standard seven encourages midwives to 'clearly documents her decisions and professional actions'(Midwives, 2002). [Ms C] does not document with any sense of engagement with the woman or notions of professional practice.

The notes, even those written retrospectively about a rare and significant event are stripped of any sense of concern for [Ms A] as a person. Standard five of the NZCOM *Midwives Handbook for Practice* states: 'The midwife ensures the care plan is woman centred' but in these notes there is no sense of either a care plan or woman-centredness. The clinical note writing is mechanistic and reductionist.

Historically nursing and midwifery clinical notes were brief and mechanistic without a sense of the persons either giving or receiving care.

These notes appear to be of this older style of writing. They do not fulfil the New Zealand College of Midwives standards for practice particularly Standard seven.

However historically these notes would have been acceptable and I believe among some of her peers these notes would be met with a variety of responses from mild to moderate disapproval. This style of note taking is still evident in some places.

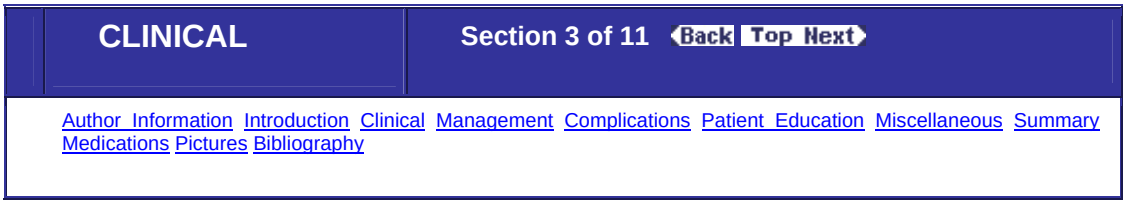
6. *Are there any aspects of the care provided by [Ms C] that you consider warrant additional comment?*

No

References:

1. *Midwives Handbook for Practice*. Christchurch: New Zealand College of Midwives (2002).

2. Retrieved on 23.10.05 from http://www.emedicine.com/med/topic3569.



All women who deliver are at risk of complications in the third stage of labour. These complications include PPH, retained placenta, and uterine inversion. Others include conditions that commonly manifest for the first time during the third stage (eg, placenta accreta and its variants). The numerous risk factors for each of these conditions may be found in articles detailing these individual complications. Remember that most complications of the third stage occur in low-risk women; therefore, caregivers and institutions must have management strategies in place to deal with these problems when they arise.

Signs of placental separation

Traditionally, 4 signs of placental separation are taught (Sleep, 1993; Cunningham 2001).

1. The most reliable sign is the lengthening of the umbilical cord as the placenta separates and is pushed into the lower uterine segment by progressive uterine retraction. Placing a clamp on the cord near the perineum makes it easier to appreciate this lengthening. Never place traction on the cord without counter-traction on the uterus above the symphysis; otherwise, one may mistake placental separation for cord lengthening due to prolapse or impending inversion.

2. The uterus takes on a more globular shape and becomes firmer. This occurs as the placenta descends into the lower segment and the body of the uterus continues to retract. This change may be clinically difficult to appreciate.

3. The uterus rises in the abdomen. The descent of the placenta into the lower segment, and finally into the vagina, displaces the uterus upward.

4. A gush of blood occurs. The retro-placental clot is able to escape as the placenta descends to the lower uterine segment. The retro-placental clot usually forms centrally and escapes following complete separation; however, if the blood can find a path to escape, it may do so before complete separation and thus is not a reliable indicator of complete separation. This occurrence is sometimes associated with increased bleeding and a prolonged third stage, with the delivery of the leading edge of the placenta and maternal surface first (Matthews Duncan method), rather than the cord insertion and fetal surface, which is more common (Schultze method).”

Responses to Provisional Opinion

Ms A
In response to the provisional opinion, Ms A stated:

> "I had an image in my mind of how I wanted my baby's birth to go. My partner and my mother with me, and only a midwife or a doctor in the room. Instead I had around ten people in the room while midwives held my ankles and pulled at me. My dignity will never be restored.
>
> It has now been sixteen months. I cannot have children normally — any future deliveries must be by Caesarean section to avoid my uterus inverting again. I still have nightmares. I still get upset at having to recount this whenever another letter has to be written. My relationship has suffered greatly … . And possibly the worst of all, the best day of my life is also the worst, as the memory of my beautiful daughter being born is tarnished by the terror I went through when I should have been holding my daughter in my arms. …
>
> With reference to [the district health board's] comments about the lift. My concerns have not been adequately addressed. [Ms G] told me a couple of days after I came home that 'Those lifts have always been like that'. I do not feel confident that my concerns were taken seriously nor that anything happened because of my complaint."

Ms C
New Zealand College of Midwives' legal advisor responded to the provisional opinion for Ms C, stating:

> "Whilst [Ms C] disputes that she placed her hand on the fundus as explained in her Affirmation, she does accept that she could have managed the third stage better and that in particular she did not appreciate the significance of [Ms A's] pain as a possible sign of an inverting uterus. It may be noted that the situation facing [Ms C] was a very rare one — one that many practitioners would never face in their practice. However, she fully accepts that she is accountable for her practices and takes responsibility for not recognising the significance of the pain. She says that she had certainly learnt from this experience. She wishes to advise that she has taken the following steps as a result of this case:
>
> 1. She has received advice from the educational arm of the New Zealand College of Midwives and has been forwarded various materials which she has read, and has reflected on her own practices in the terms of the information provided. …
>
> 2. [Ms C] has contacted […] who has agreed to review [Ms C's] documentation. [Ms C] will now seek to improve her documentation practices and this will be audited by […].

3. Ms C has approached […] who is advising her on the taking of a paper regarding third stage management.

[Ms C] is most willing to provide a written apology to [Ms A]. However, in the circumstances it would be my submission that it would not be necessary to refer [Ms C] to the Midwifery Council for a competency review; particularly as [Ms C] has taken steps to address the areas in which her practice is deficient. She is more that happy for a report to be given to the Commissioner at a later date as to progress with the steps she has taken."

Ms C produced statements from midwife Ms H and Ms I (who had been a charge midwife at the public hospital). Ms H stated:

"I have seen [Ms C] carry out active management of third stage many times during which she has acted as recommended for active management, and she has always in my experience dealt efficiently with any third stage complications. Since [Ms C] is left handed she delivers from the left hand side of the woman. In carrying out active management after an ecbolic has been given, [Ms C] has waited for the signs of separation (gush of blood, lengthening of the cord), she then places her right hand over the symphysis pubis guarding the uterus and applies controlled cord traction while guarding the uterus and in this way delivers the placenta."

Ms I stated:

"I have also witnessed her deliver the placenta by controlled cord traction, one hand above the symphysis pubis and the other hand holding the umbilical cord and gently applying traction. [Ms C] had delivered placentae and completed third stage of labour with no problems at all."

Code of Health and Disability Services Consumers' Rights

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

RIGHT 4
Right to Services of an Appropriate Standard

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

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

RIGHT 6
Right to be Fully Informed

1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including —
   a) An explanation of his or her condition; and
   b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; …

Relevant Standards

New Zealand College of Midwives *Midwives' Handbook for Practice* (2002) states:

"**Competency Two**

Performance Criteria

The midwife:

…

2.15.1 shares decision making with the woman and documents those decisions;

2.15.2 provides accurate and timely written notes and relevant documented evidence of all decisions made and midwifery care offered and provided;"

Opinion: Breach — Ms C

Rights 4(1) and 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code) state that every consumer has the right to have services provided with reasonable care and skill, and in compliance with professional standards. The New Zealand College of Midwives' *Handbook for Practice* details midwifery competence performance criteria, which include that the midwife "shares decision making with the woman and documents those decisions".

Management of labour and delivery
Ms A is not concerned about the management of the first stage of her labour. She is concerned, however, about the need for the episiotomy and the management of the delivery of the placenta. Although Ms A is grateful to the hospital for saving her uterus, she "has strong doubts about whether she had to go through this at all".

Episiotomy
Ms C had concerns that the pressure of the descending baby's head would tear the perineum. She stated that she briefly advised Ms A that she needed an episiotomy, when Ms A was pushing hard in second stage. Ms A disputes Ms C's statement that she informed her of the need for the episotomy.

An episiotomy is an incision through the perineal tissue, made to enlarge the vulval outlet during delivery. The intention of episiotomy is to shorten the length of the perineal phase of the second stage of delivery and therefore lessen the likelihood of intracranial injury and asphyxia in the infant. The decision that an episiotomy is necessary can be made only by the practitioner managing the delivery, using their experience and skill to determine the best interests of the mother and baby. Independent midwife Terryl Muir advised ACC that Ms C's decision to perform an episiotomy on Ms A appeared to "have some grounds".

My expert Sue Lennox also considered it reasonable for Ms C to carry out an episiotomy in the circumstances.

On occasions, the decision to proceed to episiotomy needs to be made quickly in response to the presenting clinical picture, and in these circumstances the practitioner has only sufficient time to inform the mother that he/she is about to cut. Even when time is critical, the practitioner should "be assured of the acceptance" of the proposed procedure by the mother, in the words of my expert independent midwife Sue Lennox.

There is no evidence that there was a risk to the baby in this case, but Ms C states that she was concerned that the perineum was about to tear. In my view, this is a reasonable explanation for Ms C's wish to undertake an immediate episiotomy. I note that Ms C claims that she informed Ms A that she needed to "make a cut" and that Ms A agreed. Ms A denies that she was given any such information: "[Ms C] did not at any time say she needed to make a cut." I am unable to resolve this conflict but draw Ms C's attention to the need to give consumers enough information — even in an

urgent situation — to make an informed decision. This issue is further discussed under "Adequacy of information and documentation", below.

Accordingly, in my opinion this aspect of Ms C's management of the labour and delivery was appropriate.

Delivery of placenta

Third stage of labour/delivery of the placenta can be managed in two ways — by active management or physiological management. In active management, an ecbolic/prophylactic uterotonic agent that stimulates the uterus to contract is given with the birth of the baby. Controlled cord traction (CCT) is applied and the cord is clamped early. In physiological management, an ecbolic is not given, there is no CCT and usually the cord is clamped only when pulsation ceases. Only in physiological management is maternal effort — such as pushing and coughing — used. Proponents of physiological management argue that natural processes promote normal separation and lead to fewer complications, such as neonatal jaundice. Active management proponents state that the use of uterotonic agents promotes strong uterine contractions and leads to faster placental separation and delivery, and reduces the risk of heavy blood loss. The midwife must discuss with the mother the options for delivery of the placenta.

Ms A described how, after her baby was born, Ms C encouraged her to push the placenta out. Ms A attempted to do this but found it very painful. She recalls Ms C pulling, trying to get the placenta to separate from the uterus.

Ms A suffered a uterine inversion. This is a rare complication, occurring in approximately 1 in 2,000 cases. The cause is unclear, although there are a number of known predisposing factors, which include pressure on the fundus and traction on the cord when the uterus is relaxed.

Ms Lennox advised ACC that she was surprised by Ms C's description of the delivery of the placenta as "easy". There is evidence that in 75% of cases of uterine inversion the cause was found to be the result of treatment, but in 25% of cases it occurs as "a rare and unexpected outcome of active management of the third stage". Ms Lennox stated, "It is hard to imagine that a uterus would invert easily, but perhaps it did." Ms Lennox found it difficult to provide advice because of the lack of explanation from Ms C and her inadequate records (both contemporaneous and retrospective). Ms Lennox also noted the divergence of the accounts from Ms C and Ms A.

At interview, Ms C explained that she had planned active management to deliver Ms A's placenta. There is no evidence that this was discussed with Ms A. Ms C stated that she applied controlled cord traction after the ecbolic had been given by the assisting midwife (who arrived in the room after the birth of the baby). Ms C believed she witnessed the normal signs that the placenta had separated — a lengthening of the cord and a small gush of blood. Ms C described how, once she had located the position of the placenta by sliding her finger along the umbilical cord, she placed her

right hand on top of Ms A's uterus, in an open grip, to protect the uterus coming down, and started cord traction. Ms A exclaimed in pain and tried to knock away Ms C's hand. Ms C slackened her grip slightly and explained to Ms A that she had to perform this manoeuvre to deliver the placenta, which came away easily.

When Ms Lennox provided me with advice she had the advantage of seeing the additional information provided by Ms C, namely her interview statement in which she outlines her management of third stage and describes applying fundal pressure, as discussed above. Ms Lennox is therefore in a better position than when she advised ACC to judge whether Ms C complied with the principles of correct third-stage management.

Ms Lennox stated that the timing of the administration of the ecbolic to Ms A (just less than five minutes after the delivery of the baby) was unusually long but still within the limits of acceptable management. The ecbolic is normally given within two to three minutes of the birth, but a delay in giving the ecbolic would generally make no difference to the outcome.

Ms Lennox advised that Ms C's description of placing her hand on top of the uterus is incorrect third-stage management. Although Ms C may have used this technique to deliver many placentas without consequence, her technique is wrong. Ms C should have rested her open hand gently on the symphysis pubis to hold back the uterus, and gently pulled on the cord with the other hand.

Ms Lennox stated:

> "With the hand on the fundus it would be impossible to know there was a problem with the uterus inverting. At the fundus, an inverting uterus might feel similar to a contracting uterus whereas the feeling of the inversion at the symphysis is quite different.
>
> It is possible that such misplacement might contribute to the inversion. I think the action of having a hand on the fundus instead of trapping the body of the uterus above the symphysis pubis would be viewed with severe disapproval by peers."

In response to the provisional opinion (having seen Ms Lennox's criticism), Ms C changed her story and denied that during the third stage she applied fundal pressure by placing her hand on top of Ms A's uterus. Ms C stated that her interview statement — which she had signed as a "true and correct record" — misrepresented what she actually said. She is certain she did not apply pressure to the fundus as part of her technique of controlled cord traction. Her "usual and long standing practice" is always to place her hand over the symphysis pubis. I note that Ms D, the assisting hospital midwife, observed Ms C guarding the uterus while applying controlled cord traction. Ms C provided statements from two colleagues, one of whom had been a public hospital delivery suite charge midwife, who endorsed her statement that she always guarded the uterus during third stage. This gives weight to Ms C's statement, although her late change of story must be viewed with some scepticism.

In any event, I am concerned that when Ms A yelled and tried to push Ms C's hand away during third stage, Ms C did not consider that this was an abnormal reaction, but reassured Ms A and continued to actively manage the delivery of the placenta. It is not normal for a mother to experience severe pain during third stage, and experience of such pain should be a signal to the practitioner to review the situation. In her response to the provisional opinion, Ms C accepts that she should have recognised the significance of Ms A's pain.

Ms C instructed Ms A to cough when she thought the placenta was at the entrance to the vagina. In doing so, she mixed the principles of active and passive third-stage management. Ms Lennox advised that although maternal effort may be used in physiological management of third stage, this request is "not in line with the principles of active management".

Ms Lennox was also critical of Ms C sliding her finger up the length of the cord to locate the position of the placenta, because this may introduce infection and does not assist the placental delivery. Ms Lennox stated that this practice would be viewed with mild to moderate disapproval by midwifery peers.

While I accept that Ms C's management did not contribute to the inversion of Ms A's uterus, in my view her overall care of Ms A during third stage did not meet professional standards. Accordingly, in my opinion, Ms C breached Right 4(2) of the Code.

Adequacy of information and documentation
Independent midwife Ms G, who was Ms A's primary midwife, completed a computerised Care Plan for Ms A which recorded that aspects of the management of her pregnancy labour and delivery had been discussed. As noted above, Ms C took over responsibility for Ms A's care as the on-call midwife for the midwifery group of which she was a partner, at 10.15am on 15 August 2004.

Under Right 6(1) of the Code, Ms A was entitled to an explanation of her condition throughout her labour and delivery, and to information about intervention options sufficient for her to make an informed choice and give (or withhold) her consent.

Ms A is concerned about the lack of information that was given to her throughout the labour and delivery, and that she did not have an opportunity to give informed consent for the episiotomy and the ecbolic.

There is a discrepancy about the information provided to Ms A. Ms C stated that during the time Ms A was in labour, from 10.15am to 2.30pm on 15 August, she discussed the options for pain relief, disposal of the placenta and post-delivery injections for mother and baby. Ms C understood from their conversation that Ms A had already considered and consented to these matters.

Overall, Ms C's recording of Ms A's labour is very brief. Ms C had taken over the care of Ms A from Ms G, and was responsible from that time for ensuring that Ms A was provided with appropriate and relevant information. Ms Lennox described Ms C's notes of the labour as "cryptic, uninformative and inaccurate". Ms Lennox noted that Ms C's recording of the timing of the rupture of Ms A's membranes was 9am, when it was written on the preceding page that this occurred at 8.30am. Ms Lennox stated, "This lack of attention to detail is an illustration of a poor standard of note taking."

The labour lasted more than four hours, but the details of the care are outlined in 30 words. Ms Lennox stated that Ms C did not document "with any sense of engagement" and there is little indication in the notes of how Ms A felt or her response to the labour. Historically, nursing and midwifery clinical notes were brief, without a sense of the people giving and receiving the care. Ms Lennox described Ms C's notes as being "mechanistic and reductionist", in the "older style of writing". Ms C's notes "do not fulfil the New Zealand College of Midwives Standards for practice" and would be met by her peers with mild to moderate disapproval.

I agree that the notes recording the labour show little sign that Ms C engaged with Ms A. In my opinion, Ms C had ample time during those four hours to document the details of Ms A's labour and of any discussion that had taken place about aspects of the delivery. By not recording the discussions, Ms C has left herself open to the allegation that Ms A was not given sufficient information regarding her care. Health professionals whose evidence is based solely on their subsequent recollections (in the absence of written records offering definite proof) may find their evidence discounted.

As noted above (under "Episiotomy") it is unclear whether Ms C explained that she was about to perform an urgent episiotomy and obtained Ms A's consent (even in the form of a nod to indicate acquiescence). Ms C insists that she did inform Ms A, who agreed. Ms C also said that it was not practical for her to take off her gloves to document that Ms A had given consent to an episiotomy. I accept that it would be unusual to write this decision in the notes at the time, but I see no reason why a retrospective note could not be made, recording that an episiotomy had been undertaken after an explanation, with the consumer's consent.

There is no evidence in the written documentation provided by Ms C that she provided Ms A with the information she needed. I am not persuaded that Ms C provided Ms A with sufficient information for Ms A to be able to give an informed consent to an episiotomy and ecbolic. Accordingly, in my opinion Ms C breached Rights 4(2) and 6(1) of the Code.

Actions taken

Ms C has approached the New Zealand College of Midwives for educational material relevant to the circumstances of this case, and has reflected on her practice in light of these events and the information provided by the College. She has sought assistance to improve her documentation practices and arranged to have her documentation practice audited.

Recommendations

I recommend that Ms C:

- apologise to Ms A for her breaches of the Code;
- undertake further training in management of the third stage of labour/delivery of the placenta.

Follow-up actions

- A copy of this report will be sent to the Midwifery Council of New Zealand and the New Zealand College of Midwives.
- A copy of this report, with details identifying the parties removed, will be sent to Women's Health Action, the Federation of Women's Health Councils of Aotearoa, and the Maternity Services Consumers Council, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.