Midwife, Ms B

A Report by the

Deputy Health and Disability Commissioner

(Case 15HDC00369)

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Executive summary

1. In 2014 Ms A (then aged 20 years) was pregnant with her first child. She engaged a self-employed, community-based midwife, Ms B, as her lead maternity carer (LMC) and planned on having a home birth.

2. Ms B saw Ms A regularly throughout the pregnancy, which progressed routinely until Month1[1], when at an antenatal visit Ms A's blood pressure was noted to be raised. Ms B requested that Ms A have a blood test to determine whether there were signs of developing pre-eclampsia, but she did not offer Ms A a consultation with an obstetrician.

3. On 8 Month2, at 39 + 3 weeks' gestation, Ms A began experiencing contractions and contacted Ms B, who arranged for Ms A and her partner, Mr A, to meet a back-up midwife at the birthing centre. At 1.15pm the back-up midwife assessed Ms A and performed the initial midwifery cares until Ms B arrived to take over at 6.30pm.

4. At 8.40pm Ms A's membranes ruptured spontaneously, with clear liquor draining. The labour continued and, at 10.05pm, the labour notes record that Ms A was pushing with contractions. By 10.45pm Ms A was pushing but becoming very distressed. Ms B stated that at 10.55pm she discussed with Ms A and Mr A the option of transferring to the public hospital, owing to Ms A's distress.

5. Ms B asked a birthing centre staff midwife, Ms D, to assist and to provide a second opinion. Just before midnight, after Ms A had been pushing for approximately 1 hour and 50 minutes without progress, Ms D carried out a vaginal examination to assess Ms A's progress, and documented that it was difficult to tell whether Ms A's cervix was 8cm dilated or whether only a swollen anterior lip of cervix remained. Ms D said that she discussed the option of transfer and consultation with an obstetrician, and the option of staying in the birth centre and allowing time for the anterior lip to pass.

6. Ms B said that at 2.20am there were no clinical indications that secondary care was required, and she discussed progress, options, and whether Ms A was "still ok to stay in primary care". Ms B said that Ms A wished to remain at the birth centre.

7. Ms A cannot recall a conversation about transferring to hospital having taken place throughout the labour. Mr A stated that as far as he was aware there was no discussion about a transfer, nor were options given, and he and Ms A were of the impression that there was "no need to go to [the public hospital]". Mr A said that they were never told that there was any concern about Ms A's progress in labour.

8. At 3.50am, 3 hours and 45 minutes after the previous vaginal examination, Ms B performed a further examination, noting the "thin lip of the Cervix with Caput++[2]", and said that it was difficult to determine whether there was vaginal wall swelling or whether it was the cervix. These details are not documented. Ms B said that at this point the situation was no longer primary and required consultation.

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[1] Relevant months are referred to as Months 1-2 to protect privacy.
[2] Caput succedaneum is an oedematous swelling formed on the presenting portion of the baby's head, caused by pressure during birth.

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9. At 4.50am Ms A was transferred to hospital via ambulance, and at 5.10am her care was handed over to the obstetric team. Ms B was given an epidural, and a Ventouse delivery was attempted before a decision was made to convert to a Caesarean section. At 8.11am the baby was delivered.

10. Following delivery, Ms A suffered a post-partum haemorrhage. Despite efforts made to arrest the haemorrhage, the bleeding continued. As Ms A was haemodynamically unstable, a hysterectomy was performed as a life-saving measure.

Findings

11. It was found that Ms B failed to discuss with Ms A the requirements of the *Guidelines for Consultation with Obstetric and Medical Related Services* (*Referral Guidelines*) when Ms A's blood pressure increased antenatally. Ms B also did not discuss the option of an obstetric consultation in light of Ms A's slow progress in labour, or the risks that the slow progress could pose to her and her baby. This was information that a reasonable consumer in Ms A's circumstances would expect to receive. Accordingly, Ms B breached Right 6(1) of the Code of Health and Disability Services Consumers' Rights (the Code).

12. Adverse comment was made about Ms D who, while providing midwifery care to Ms A, should have communicated clearly about the *Referral Guidelines* and the options available to Ms A. In addition, Ms D should have documented the discussions she had with Ms A.

13. Adverse comment was also made about the DHB for not undertaking a formal review of this event under the 2012 Health Quality & Safety Commission Severity Assessment Code (SAC) matrix.

Recommendations

14. It was recommended that Ms B provide a written apology to Ms A. It was also recommended that Ms B organise a Special Midwifery Standards Review and report back to this Office on the outcome, and that she undertake training on the requirements of the *Referral Guidelines* and report back to this Office on the outcome.

15. It was recommended that the Midwifery Council of New Zealand consider whether a review of Ms B's competence is warranted.

16. It was recommended that Ms D undertake further training on documentation and report back to this Office on the outcome.

Complaint and investigation

17. The Commissioner received a complaint from Ms A about the services provided to her by her lead maternity carer (LMC), midwife Ms B. The following issue was identified for investigation:

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Whether registered midwife Ms B provided Ms A with an appropriate standard of care in 2014.

18. This report is the opinion of Rose Wall, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

19. The parties directly involved in the investigation were:

Ms A	Consumer/complainant
Mr A	Consumer's partner
Consumer's mother	
Ms B	Provider/LMC/self-employed midwife
Ms C	Provider/self-employed midwife
Ms D	Provider/birthing centre staff midwife

20. Information from the DHB was also reviewed.

21. Independent expert advice was obtained from registered midwives Bridget Kerkin and Lorna Davies. Obstetric advice was obtained from obstetrician and gynaecologist Dr Ian Page.

Information gathered during investigation

Background

22. Ms A (then aged 20 years) was pregnant with her first child. Ms A booked with a self-employed community-based midwife, Ms B, as her lead maternity carer (LMC). That day, Ms A's blood pressure was recorded as normal at 105/58mmHg.

23. HDC has been provided with information about the care Ms B provided to Ms A, including the labour and birth notes completed contemporaneously; a retrospective note written by Ms B on 9 Month2; and a separate document containing reflective notes, which was prepared retrospectively and provided to HDC on 4 May 2015. Ms B also provided other information to HDC.

Antenatal care

24. Ms B saw Ms A regularly throughout the antenatal period. Generally, Ms A's pregnancy progressed normally. On 4 Month1, Ms A reported decreased fetal movements, but an assessment, which included a CTG,[3] was reassuring. On 16 Month1, Ms A's blood pressure taken during a routine antenatal visit had increased from her booking blood pressure, but was within the normal range at 120/80mmHg.

25. On 23 Month1, Ms A's blood pressure taken during a routine antenatal visit was noted to be 140/100mmHg, which is raised.[4] Ms B did not document any specific follow-up

[3] Cardiotocograph — a recording of the fetal heartbeat and uterine contractions.

[4] See Lowe SA, Brown MA, Dekker G, et al, *The SOMANZ Guideline for the Management of Hypertensive Disorders of Pregnancy*. SOMANZ; 2008, reviewed in 2014. These guidelines are the

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in relation to the raised blood pressure, or that she had any discussion with Ms A in relation to this, and noted only "bloods" in the antenatal care record. Ms B recorded that a urinalysis[5] showed that the protein/sugar levels were "N" (normal).

26. Ms B told HDC that her usual practice if a woman's blood pressure were outside the normal range was to reassess it at a later time, either during the appointment or at a follow-up time. Ms B said that Ms A reported no oedema and no headaches. However, Ms B requested that Ms A have a blood test to determine whether there were signs of pregnancy-induced hypertension[6] or developing pre-eclampsia.[7] Ms B said that it is her usual practice to explain the symptoms of concern and the required referral practice should the symptoms develop.

27. On 24 Month1, Ms A had blood tests, including liver function tests, which were normal, with the exception of a lowered ferritin.[8] A mid-stream urine test showed that Ms A had protein "+" in her urine. On 30 Month1, Ms A's blood pressure was still raised at 120/100mmHg. The antenatal care record states that the urine protein/sugar levels were "N" (normal).

28. On 4 Month2, Ms A began to experience uterine tightenings. She contacted Ms B, who reassured her, and they discussed the signs of labour.

29. On 6 Month2, Ms A had a routine antenatal appointment. Ms B performed a CTG, which was reassuring. No other concerns were noted.

8 Month2

Labour begins

30. On 8 Month2 at 12.30pm, Ms A (now 39+3 weeks' gestation) contacted Ms B advising her that she was experiencing contractions. Ms B, who had just arrived home from another delivery, arranged for her back-up midwife, Ms C, to meet Ms A at the birthing centre. Ms A was accompanied by her partner, Mr A, and her mother.

31. At 1.15pm, Ms C assessed Ms A and performed a CTG, which was reassuring. At 1.40pm, Ms C performed a vaginal examination (VE), noting that the cervix was dilated to 6cm and the fetal head was at station –1,[9] in a right occipito-lateral position (ROL).[10] Ms C recorded in the labour and birth notes that Ms A had a history of latent labour over the previous two to three days and had been experiencing regular pains

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recommendations of a multidisciplinary working party convened by the Society of Obstetric Medicine of Australia and New Zealand. SOMANZ states on its website that the information contained in the guidelines section is for general information only and is designed to be educational, and is not intended to be, and is not, a complete or definitive statement on any area of medical practice or procedure. SOMANZ defines hypertension in pregnancy as systolic blood pressure greater than or equal to 140mmHg and/or diastolic blood pressure greater than or equal to 90mmHg.

[5] A dipstick test of the urine.

[6] High blood pressure.

[7] High blood pressure and protein in the urine during pregnancy.

[8] A protein that stores iron.

[9] The fetal station is the relationship of the presenting part (head/buttocks/feet) to the maternal ischial spines (assessed vaginally). It is measured in centimetres above (–) or below (+) the ischial spines.

[10] The back of the head is towards the mother's right and the baby faces towards her left side. Some rotation of the head is required from this position before the baby can deliver.

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since 4.30am. Ms C noted that Ms A was experiencing "strongly palpable contractions", which were irregular and were 2:10 (two in ten minutes). Ms A's blood pressure was 130/80mmHg and her pulse 98 beats per minute (bpm).

32. Ms A continued to labour, with Ms C monitoring the fetal heart rate (FHR) intermittently.

33. At 5.20pm, Ms C noted that Ms A's contractions were 3–4:10 and "very strong". Ms C then performed a VE, noting that the cervix was dilated to 7cm, and the fetal head was just above "the spines"[11] in a right occipito-anterior (ROA)[12] position.

Ms B arrives

34. At approximately 6.30pm, Ms B arrived and took over Ms A's care. At 7.30pm, it is noted in the labour and birth notes that Ms A was becoming distressed.

35. At 8.40pm, the labour and birth notes record that Ms A's membranes ruptured spontaneously, with clear liquor draining. Ms B then performed a VE, noting that the cervix was 9cm dilated and the fetal head was at station +1, indicating that it was well engaged in the pelvis. The position of the fetal head (ie, ROA/ROL) is not documented.

36. At 10.05pm, the labour and birth notes record that Ms A was pushing with contractions. In her reflective notes, Ms B said that Ms A was quite anxious and was pushing involuntarily with some of the contractions, but was not actively pushing.

37. At 10.45pm, Ms B documented in the labour and birth notes that she tried "feeling inside while [Ms A] [was] pushing", but that Ms A became very distressed, so Ms B stopped. In her reflective notes, Ms B said that she was trying to feel whether the baby was moving with the contractions.

38. At 10.55pm, it is noted in the labour and birth notes that Ms A's contractions had "spaced out". In her reflective notes, Ms B said:

> "I discussed at this time with [Ms A and Mr A] if they wanted to transfer from the birth centre. All of [Ms A's] and the baby's observations were within normal range. It was my recommendation that we transfer due to [Ms A's] distress. She was quite insistent that she did not want to transfer to [the public hospital]."

39. Ms B told HDC that the lack of contemporaneous documentation "is due to the discussion being an offer of transfer not a recommendation for transfer to the public hospital". She said she told Ms A that should pain relief be required, a transfer would always include an obstetric review.

[11] Ischial spines are felt as bony prominences that generally can be palpated at about a finger-length into the vagina.

[12] Right occipito-anterior (ROA) is a normal position for the fetal head in labour. The back of the baby's head is slightly off centre in the pelvis with the back of the head towards the mother's right thigh.

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40. In contrast, Mr A told HDC that he does not recall there being any discussion regarding transfer at that time. In response to the provisional opinion, Ms A and Mr A said that Ms B did not discuss with them that they needed to transfer. They stated that the word "hospital" was used but they were not told that they needed to go there, and they were not told that Ms A's or the baby's life could be in danger. They stated: "[I]t was only said as a passing comment as if you were talking with a friend about what you'd been doing that day." Ms A's mother does not recall any conversation about transferring to hospital having taken place throughout the time they were at the birthing centre.

41. At 11pm, Ms B documented that she had "[r]equested staff midwife in to assist for second pair of eyes [and] new energy". In her reflective notes, Ms B stated:

> "Because [Ms A] wanted to remain at the birth centre I recognised that I needed some support so I sought a second opinion. I left the room and talked to the birth centre staff about what was happening with [Ms A] and sought some suggestions to help support [Ms A] in her desire for a primary birth. [Ms A] was anxious and was requiring lots of reassurance."

Ms D

42. Ms D, a staff midwife employed at the birthing centre, told HDC that part of her role as a staff midwife was to assist LMC midwives with advice and, if required, clinical skills or quick breaks. Ms D said that at 11.50pm Ms B asked her to come into Ms A's room to give assistance and a fresh perspective.

43. Ms D said that Ms A had been pushing for approximately 1 hour and 50 minutes, and Ms B wanted to do a VE to assess progress. However, Ms A was very reluctant to have a VE because she found them very painful.

44. Ms D told HDC that she explained to Ms A that a VE was important to assess progress and to ascertain whether it was appropriate for Ms A to be pushing. Ms D said she explained that this was important because Ms A had been pushing for almost two hours with little or no sign of progress, and that this was considered to be slow and of concern.

45. It is documented in the labour and birth notes that at 11.50pm there was a discussion with Ms A about carrying out another VE to assess whether her cervix was fully dilated, but that Ms A was "reluctant" to undergo a VE. Ms D documented that she "explained [the] need for the true picture of progress with VE".

46. In her reflective notes, Ms B stated: "[At 11.50pm,] [d]ue to [Ms A] declining the VE, I offered transfer in light of how [Ms A] was responding to the situation. Again [Ms A] declined to transfer." In a retrospective note dated 9 Month2, Ms B recorded: "[Ms A] became quite distressed [at] the mention of Transfer." However, neither the information provided to Ms A, nor this discussion, is documented in the contemporaneous clinical records. Ms B said that when she suggested a transfer, Ms A became very upset, including begging Mr A to support her and not let her go to the hospital. Ms B told HDC that she suggested a transfer because undertaking a VE is more comfortable with suitable pain relief. She said, "I didn't document as this was a

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suggestion," and added that, in hindsight, she should have documented that Ms A had declined.

9 Month2

47. At 12.05am, Ms D attempted a VE, and documented in the labour and birth notes that she had to stop the VE because of Ms A's distress. Ms D then reattempted the VE, noting that the "outer labial tissues [were] swollen", and that the baby's head was positioned 1cm above the spines rather than the previous finding of 1cm below the spines. She documented: "[It is] difficult to tell if a swollen anterior lip or if [Ms A] is 8cm [dilated] as exam was painful for [Ms A]. No meconium[13] present. No caput[14] or moulding[15] felt."

48. At 12.10am, Ms D documented in the labour and birth notes that she discussed the assessment findings with Ms A and Mr A, and that "[Ms A was] definitely not wanting to transfer". Ms D also documented that there was no evidence of any fetal distress.

49. Ms D said that she explained to Ms A and her family what an anterior lip is and how this could affect the labour, in that it could slow progress by making the cervix swell up rather than stretch open. Ms D said she explained that this can make women feel like pushing even though the cervix is not completely open, and that the presence of an anterior lip alone does not compromise a baby's well-being, provided that it is managed appropriately.

50. Ms D stated:

> "[T]he option to transfer and consult with an Obstetrician was discussed and made available to [Ms A] as was the option of staying in the birth centre and allowing time for the anterior lip to pass. Management options of an anterior lip were discussed such as giving some time refraining from pushing and using breathing techniques to 'breathe through, not push through contractions'. Discussions were had about trying different positions to help the cervix reduce in swelling and further dilate. The use of IV [intravenous] fluids to help labour progress was recommended."

51. Ms D said that pain relief options such as Entonox gas and an epidural were discussed, and it was made clear to Ms A and her family that, although the labour was slow, there was no sign of fetal distress, and that:

> "though an obstetric consultation was recommended, it was also a feasible option to stay on at the birth centre provided that both [Ms A] and the baby showed no sign of compromise and that the anterior lip resolved within a reasonable time

[13] Fetal bowel motion. It is normally retained in the infant's bowel until after birth, but sometimes it is expelled into the amniotic fluid prior to birth. Meconium in the amniotic fluid may be a sign of fetal distress.
[14] A diffuse swelling of the scalp caused by the pressure of the scalp against the dilating cervix during labour.
[15] Where the bones of the fetal head move closer together or overlap to help the head fit through the pelvis. Significant moulding (with caput) can be a sign of head–pelvic disproportion.

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frame. This was a conversation that was had between [Ms A], [Ms B], [Ms A's] family and myself. At this stage, [Ms A] was very upset at times and vocal during contractions. She said repeatedly that she did not want to go to the hospital."

52. Ms D told HDC that it was very clear that Ms A was declining transfer to the public hospital and an obstetric consultation at that point in her labour. Ms D stated that the refusal is evident in her documentation, in which she noted: "Findings discussed with [Ms A] and family — [Ms A] definitely not wanting to transfer and no fetal distress evident." Ms D said: "In depth documentation of the conversation regarding the option of transfer was not evident and upon reflection and further study, I realise that my documentation should have been more exact."

53. HDC asked Ms B whether she discussed with Ms A the option of an obstetric consultation as per the *Referral Guidelines*.[16] Ms B responded that she discussed with Ms A the option of transferring from the birthing unit, and that Ms A was adamant that she did not want to transfer. Ms B noted that she should have documented Ms A's decline to transfer, and further advised that, in her view, the diagnosis of an anterior lip of cervix alone would not necessarily constitute an indication for transfer.

54. Mr A stated that as far as he is aware there was no discussion about a transfer, nor were options given, and he and Ms A were of the impression that there was "no need to go to [the public hospital]".

55. Mr A said that they were never told that there was any concern about Ms A's progress. He stated that, at the antenatal appointments, they had been told about the possible problems that could require transfer to hospital during labour, but "because the midwives at [the birthing centre] didn't advise of a need to go to hospital [he and Ms A] thought everything was fine".

56. Mr A said that he recalls being told that the lip of the cervix was "catching", and that subsequently Ms A stopped pushing. He said that he asked the midwife whether the problem would resolve itself, "but the midwife was hesitant to tell him of this likelihood". He stated that there was never a time when the midwives said that there was a difficulty with the birth.

57. At 12.35am, Ms D documented in the labour and birth notes that she and Mr A had a "brief talk about the likelihood of the anterior lip going and things going well", and that Ms A continued to be very distressed.

58. At 1.10am, Ms D took over Ms A's care so that Ms B could have a rest.

59. Ms D stated that management strategies for the anterior lip were in action, such as changes of maternal position, use of Entonox to breathe through contractions without pushing, and the use of IV fluids. She said that the FHR remained reassuring, Ms A's observations were within normal limits, and a clear clinical management plan had been put in place. Ms D stated: "I did not consider there to be any need or clinical

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[16] The *Guidelines for Consultation with Obstetric and Medical Related Services (Referral Guidelines)* (see paragraph 88 below).

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indication to call [Ms B] back from her break, or any need to discuss [Ms A's] care with another clinician."

60. Ms D took bloods for a complete blood count and a "group and save",[17] and commenced IV fluids.

Ms B returns

61. At 2.20am, Ms B returned and resumed care. Ms B said that her plan for care, developed in consultation with Ms D, was to give time for the anterior lip to disappear, use Entonox for pain relief, wait for contractions to re-establish following IV fluids, and encourage Ms A to breathe through the urge to push. Ms B said that they decided to perform a VE "in a shorter time" to determine progress and/or the need for transfer. Ms B stated: "[Ms A] was made aware that Obstetric review was part of the transfer process."

62. Ms B stated in her reflective notes that when Ms D handed over, "there was no concern with how labour was progressing". Ms B also stated in the reflective notes that she, Ms A, and Mr A:

> "Discussed progress to now — possibility of anterior lip — not being full dilated and optimal fetal positioning. We discussed options from here and if they were still ok to stay in primary care, there were no clinical indications that secondary care was required at this point. [Ms A wished] to remain at the birth centre."

63. Ms B documented in the labour and birth notes: "[Ms A and Mr A] much more comfortable after discussion [and plan] for care. I understand it has been a long process for getting to now." No further details of this discussion are recorded contemporaneously.

64. In a retrospective note dated 9 Month2, Ms B recorded:

> "The discussion & plan at 2.30[am] about ongoing care involved being clear with [Ms A] & [Mr A] that we could not continue on without transferring by a certain time. Although there had been no clinical indication of concern for either [Ms A] or the baby, progress had definitely slowed."

65. As stated above, Mr A denied that there was a discussion about transferring to the public hospital, or any discussion about what options were available. Mr A said that they were never told that there was any concern about Ms A's progress.

66. Ms B later told HDC:

> "Given that my colleague's VE indicated less dilatation than my earlier VE, I wanted to allow for the possibility that my initial assessment was incorrect and therefore we are unable to confirm if [Ms A] was 9cm for 5.5 hours."

[17] A "group and save" allows for blood cross-matching if there is a possibility of the patient requiring surgery and/or a blood transfusion.

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67. At 3.50am, 3 hours and 45 minutes after the previous VE, Ms B performed a further VE, noting in the labour and birth notes that a "thin lip" of cervix was still present, with "Caput ++". In her reflective notes, Ms B stated that there was a lot of negotiation to get Ms A to agree to the VE at 3.50am, as she would agree, then decline. Ms B stated:

> "I was unhappy about the findings of this VE as there was Caput present. Station 0, Fully dilated with ?Anterior lip. It was difficult to determine baby's lie. I queried if it was vaginal wall swelling or cervix. It was difficult as [Ms A] was upset."

68. These details are not documented in the labour and birth notes.

69. At 3.50am, Ms B documented in the labour and birth notes that she had a discussion with Ms A about transferring to the public hospital, and that Ms A was reluctant to transfer, "as she ha[d] been when previously discussed". Ms B also stated in her reflective notes that at 3.50am Ms A remained reluctant to transfer to the public hospital:

> "… although I have stressed at this time that I am unhappy with the findings of the VE. I strongly recommend transfer as situation is no longer primary and requires consultation."

70. At 4.10am, Ms B documented in the labour and birth notes that she had attempted to contact the public hospital, and that the call was answered after three attempts. Mr A said that there was no discussion about the transfer, and that it was "more of [Ms A's] decision to transfer". He stated that they requested to be transferred but only knew the transfer was actually happening when the ambulance arrived at the birthing unit. He felt that the midwives did not communicate well with him and Ms A.

Transfer to the public hospital

71. At 4.50am, Ms B was transferred to the public hospital via ambulance, arriving at 5.10am. Ms B handed over care to the obstetric team. Ms A was assessed by an obstetric registrar who noted that the cervix was fully dilated, and the baby was in a "?OP"[18] position at station +1 with caput.

72. An epidural was sited. Ms B stated in her reflective notes that Ms A was "very distressed" because she had not wanted an epidural and "was scared of this procedure". Ms B said that she stayed with Ms A while the epidural was placed, then told Ms A that she was leaving and would not return for the birth, but would visit postnatally. Ms B then left.

73. At 6.55am, Ms A was noted to have frank haematuria,[19] and the baby was assessed to be in a deflexed OP position at station +1. A decision was made to trial a Ventouse delivery.[20]

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[18] Occipito-posterior, where the back of the baby's head is against the mother's back. This position can make delivery more difficult.

[19] Blood in the urine.

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74. At 7.40am, a Ventouse delivery was trialled in theatre. However, after two pulls with no descent of the baby's head, the decision was made to convert to a Caesarean section. The operation report states that there was a "[h]igh lower segment incision however due to uterine contraction and deeply impacted OP head delivery of the head was extremely difficult and only achieved after GTN (nitroglycerin)[21]". At 8.11am, the baby was delivered weighing 3,520gm.

75. Following delivery, Ms A suffered a post-partum haemorrhage due to an atonic uterus.[22] Ms A was administered a bolus of Syntocinon,[23] a Syntocinon infusion, a bolus of Syntometrine,[24] a rectal dose of misoprostol,[25] and three boluses of carboprost.[26]

76. The bleeding continued, so a Bakri balloon[27] was inserted. At that time, Ms A's blood loss was estimated to be over 2.5 litres. The bleeding continued despite the Bakri balloon, and so Ms A underwent a laparotomy. As Ms A was haemodynamically unstable, a hysterectomy was performed as a life-saving measure.

77. Ms B recorded in the postnatal care plan that she had received a telephone call from the public hospital core staff to tell her that Ms A had been taken to theatre for a hysterectomy, and to ask her to return to support Mr A.

78. On 17 Month2, Ms B visited Ms A at home, and continued to make postnatal visits until Ms A was discharged on 29 Month2. At that time, the baby was "a well robust baby" and breastfeeding well.

Ms A — further information

79. Ms A told HDC that she does not remember as many of the events as Mr A does , and that the decisions made, including to transfer to hospital, were made by Mr A, as she was "too exhausted and out of it" to make decisions for herself.

80. Ms A said:

> "The outcome of this has impacted our lives immensely, so much so that we have only just recently been able to talk about it. I am left with feelings of guilt as I am always thinking about the fact that I can no longer have children and it is impacting my life with my son … No one has told us why it happened, if it could

[20] Ventouse is a method to assist delivery of a baby using a vacuum device.
[21] A uterine relaxant.
[22] "Atonic" means "loss of muscular tone or strength to contract". An atonic postpartum haemorrhage is characterised by excessive bleeding when the uterus is not well contracted after the delivery, and is soft, distended, and lacking muscular tone.
[23] Syntocinon contains oxytocin and works by stimulating rhythmic contraction of the uterus during labour and after delivery.
[24] Syntometrine contains two active ingredients, ergometrine and oxytocin. Ergometrine increases the amplitude and frequency of uterine contractions and uterine tone, which in turn impedes uterine blood flow.
[25] Misoprostol is a synthetic prostaglandin used to treat postpartum bleeding in some circumstances.
[26] Carboprost is indicated for the treatment of postpartum haemorrhage due to uterine atony that has not responded to conventional methods of management.
[27] A silicone, obstetrical balloon designed to treat postpartum haemorrhage.

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have been prevented and no one has taken responsibility for what has happened to myself and my partner."

Responses to provisional opinion

81. Responses were received from the DHB, Ms A and Mr A, Ms D, and Ms B. The responses have been incorporated into the "information gathered" section of the report where appropriate.

Ms D

82. Ms D stated that she had no further comment to make.

Ms B

83. Ms B submitted that the *Referral Guidelines* are not fixed rules, and variation from the guidelines is permissible within the terms of the guidelines.

84. Ms B stated that the majority of New Zealand midwives would have acted as she did in the circumstances. She said that it would be unhelpful and perhaps unfair to find her in breach of the Code when an expert had found her care to have been reasonable.

The DHB

85. With regard to whether the event would have an SAC 2 rating, the DHB considered that it could have been rated moderate on the Consequence Table and rated unlikely (event may occur at some time in the next two to five years) on the Likelihood Scale, and therefore the event could be classified as an SAC 3.

86. The DHB said that in 2014 "there was not a culture where an LMC would report an incident and then join with the DHB to review and investigate".

87. In addition, the DHB noted that as its staff did not feel that they had contributed to Ms A's prolonged period of first and second stage of labour (which was the underlying cause of her post-partum haemorrhage), it was not likely to happen again in the next two years and, to them, their care had been appropriate and so there was no incident to report.

Standards

Referral guidelines

88. The *Guidelines for Consultation with Obstetric and Medical Related Services* (*Referral Guidelines*) provide guidelines for circumstances in which an LMC must recommend a consultation with a specialist, or the transfer of clinical responsibility to a specialist.[28] The *Referral Guidelines* require that the woman must be informed that a

[28] The *Referral Guidelines*, to be used in conjunction with the Maternity Services Notice 2007, were compiled by the Ministry of Health with input from an expert working group including midwifery, obstetrics, paediatrics, and anaesthetics representatives, as well as consumer representatives. The aim is

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consultation is warranted in certain circumstances. Under "Consultation", the guidelines state:

> "The LMC must recommend to the woman (or parent(s) in the case of the baby) that a consultation with a specialist is warranted given that her pregnancy, labour, birth or puerperium (or the baby) is or may be affected by the condition. Where a consultation occurs, the decision regarding ongoing care, advice to the LMC on management, and any recommendation to subsequently transfer care must involve three-way conversation between the specialist, the LMC and the woman. This should include discussion of any need for and timing of specialist review."

89. The *Referral Guidelines* also require consultation with obstetric services in the case of "[n]ew hypertension presenting after 20 weeks with no significant proteinuria".

90. With regard to a woman declining a referral, the *Referral Guidelines* state:

> "In the event that a woman declines a referral, consultation or transfer of clinical responsibility, the LMC should:
>
> - advise the woman of the recommended care, including the evidence for that care
> - explain to the woman the LMC's need to consider discussing her case with at least one of the following (ensuring that the woman's right to privacy is maintained at all times): — another midwife, GPO [General Practitioner Obstetrician] or GP — an appropriate specialist — an experienced colleague/mentor
> - share the outcomes of the discussion and any resulting advice with the woman
> - document in the care plan the process, the discussions, recommendations given and decisions made, and the woman's response.
>
> If, after this process, resolution satisfactory to the LMC and the woman has not been reached, the LMC must decide whether to continue or to discontinue care. If the LMC decides to continue care, she or he should:
>
> - continue making recommendations to the woman for safe maternity care, including further attempts at referral
> - engage other practitioners as appropriate for professional support (eg, secondary obstetric service, other midwives)
> - continue to document all discussions and decisions."

91. Under the conditions and referral categories, code 5021 of the category "Consultation" refers to a prolonged first stage of labour, and defines this as being:

> "> 2 cm [dilation of the cervix] in 4 hours for nullipara and primipara. Slowing in progress in labour of second and subsequent labours. Take into consideration

to improve the safety and quality of maternity care and to ensure that women are referred by their LMC to the most appropriate level of care for their particular condition.

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descent and rotation of fetal head, and changes in strength, duration and frequency of contractions."

Midwives Handbook for Practice

92. The College of Midwives' publication *Midwives Handbook for Practice* (2008) states:

"The midwife:

…

2.6 identifies factors in the woman/wahine or her baby/tamariki during labour and birth which indicate the necessity for consultation with, or referral to, another midwife or a specialist medical practitioner;

…

2.15 shares decision making with the woman/wahine and documents those decisions."

Opinion: introduction

93. Ms A is distressed and disappointed to have had a hysterectomy at 20 years of age. It is reasonable that she has complained to this Office seeking an explanation about what happened to her.

94. It has been difficult and time-consuming to ascertain what happened and, with regard to some matters, I have been unable to make factual findings because of the conflicts in the evidence and lack of detailed contemporaneous documentation.

95. I have received independent midwifery advice from two registered midwives, and also advice from an obstetrician on the obstetric care provided.

Opinion: Ms B — breach

Management of raised blood pressure

96. Ms A was pregnant with her first child. Her pregnancy was normal, with the exception of an elevated blood pressure first noted on 23 Month1. Ms B recorded that day that the protein and sugar levels in the urine were normal. Ms B arranged for Ms A to have blood tests and a mid-stream urine test the following day. The urine test showed that Ms A had some protein[29] in her urine and, with the exception of a lowered ferritin, the blood tests were within normal limits.

[29] Protein was 1+.

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97. On 30 Month1, Ms A's blood pressure was still raised at 120/100mmHg. The antenatal care record states that the urine protein and sugar levels were normal that day.

98. Ms B said that her usual practice if a woman's blood pressure were outside the normal range was to reassess it at a later time, either during the appointment or at a follow-up time. Ms B said that Ms A reported no oedema or headaches. However, Ms B requested that Ms A have a blood test to determine whether there were signs of pregnancy-induced hypertension or developing pre-eclampsia. Ms B said that it is her usual practice to explain the symptoms of concern and the required referral practice should those symptoms develop.

99. Ms B did not document any specific follow-up in relation to the ongoing raised blood pressure, or that she had any discussion with Ms A in relation to this. My first expert midwifery advisor, Lorna Davies, advised that Ms B appropriately followed up the high blood pressure reading with bloods for pre-eclampsia.

100. However, my second expert midwifery advisor, Bridget Kerkin, noted that pre-eclampsia is an unpredictable disease that can develop and deteriorate rapidly, and that the reading Ms B documented on 23 Month1 constituted a blood pressure of potentially considerable concern. Ms Kerkin further advised that the guidelines for the management of hypertensive disorders of pregnancy recommend that "closer monitoring of pregnant women with an increment in blood pressure of ≥30 mmHg systolic and/or 15 mmHg diastolic is appropriate".

101. Ms Kerkin advised:

> "The blood pressure would have ideally been checked again, at least once, and at least an hour after the initial assessment. There is no record of a follow-up blood pressure assessment before the next visit dated [30 Month1]."

102. The *Referral Guidelines* require consultation with obstetric services in the case of "[n]ew hypertension presenting after 20 weeks with no significant proteinuria".[30] There is no evidence that Ms A was offered this consultation. In my view, Ms B should have offered Ms A a consultation with an obstetric service, and I am critical that she did not do so. If Ms B had reason to believe that Ms A's hypertension was not of concern, she should have clearly documented why, what the discussions had been with Ms A about these results, and the ongoing plan for monitoring of Ms A's blood pressure.

Labour

Introduction

103. On 8 Month2, at 4.30am, Ms A (39+3 weeks' gestation) began feeling regular uterine contractions. The progress of Ms A's cervical dilation and the descent of the fetal head were as follows:

[30] SOMANZ defines hypertension in pregnancy as a systolic blood pressure greater than or equal to 140mmHg and/or a diastolic blood pressure greater than or equal to 90mmHg.

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- 8 Month2 1.40pm — 6cm, descent station –1 (on admission)
- 8 Month2 5.20pm — 7cm, descent "just above spines" — station 0 (1cm over 3 hours 40 minutes)
- 8 Month2 8.40pm — 9cm, descent station +1 (2cm over 3 hours 20 minutes)
- 9 Month2 12.05am — 8cm or swollen anterior lip present, descent –1 (unclear if any progress over 3 hours 25 minutes)
- 9 Month2 3.50am — thin lip present, dilation and descent not recorded.

104. Thus, Ms A's dilation increased by no more than 1cm over the seven hours after the 8.40pm VE.

1.15pm–6.30pm

105. At 1.15pm, Ms A met back-up midwife Ms C at the birthing centre. Ms C performed a VE at 1.40pm and found that Ms A's cervix was dilated to 6cm (descent –1), and again at 5.20pm when her cervix was dilated to 7cm (descent just above ischial spines). Ms A's blood pressure was 130/80mmHg and her pulse 98bpm.

106. All other assessment findings for mother and baby were reassuring during this time.

107. Ms Davies said that the progress between 1.40pm and 5.20pm was not substantial, but she considered that there was some progress, both in terms of dilatation and descent of the presenting part. She said that most midwives would have waited a few hours to review progress. Ms Kerkin advised that the change of 1cm dilation in 3.5 hours "represents reasonably slow progress", but may be a normal pattern of labour for some women.

Progress in labour by 8.40pm

108. At 6.30pm, Ms B took over Ms A's care. Ms A's membranes ruptured at 8.40pm and Ms B performed a VE, which determined that Ms A's cervix was 9cm dilated and the fetal head was at station +1. Ms Davies advised: "This would indicate a steady progression from the previous VE and in my opinion most midwives would not see any reason to consider seeking an obstetric consultation in these circumstances." Ms Kerkin also said that consultation with a specialist was not necessarily indicated at 8.40pm.

Monitoring of vital signs between 8.40–11.50pm

109. Between 8.40pm and 11.50pm, Ms B documented Ms A's response to contractions, and behaviours such as positional changes. Ms B also regularly recorded the FHR, but did not assess Ms A's vital signs, which had not been recorded since 1.15pm.

110. Ms Davies advised that a number of assessments were carried out during the labour, and the pattern of uterine contractions was observed and Ms A's behavioural cues were picked up. Ms Davies stated: "These assessments appear to have been carried out in an appropriate manner and were as timely as possible under the circumstances as the client would not always consent to assessment."

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111. Ms Kerkin said that, in general, Ms B’s documentation during this period indicated that she was attentive to Ms A’s labour process. However, Ms Kerkin said that, ideally, Ms B should have assessed Ms A’s blood pressure, pulse, and temperature at least once during this time, particularly given Ms A’s history of elevated blood pressure during pregnancy. Ms Kerkin advised that this omission in assessment represents a mild departure from accepted practice, as it would be seen by Ms B’s peers as a missed opportunity to assess Ms A’s well-being holistically.

112. In my view, it was important to monitor Ms A’s vital signs regularly during her labour, and I am critical that this did not occur.

Obstetric consultation

113. The *Referral Guidelines* state that the LMC must recommend to the woman that a consultation with a specialist is warranted when there is a prolonged first stage of labour. This is defined in the *Referral Guidelines* as being:

> “> 2cm [dilation of the cervix] in 4 hours for nullipara and primipara. Slowing in the progress of labour for second and subsequent labours. Take into consideration descent and rotation of fetal head, and changes in strength, duration and frequency of contractions.”

114. At 11.50pm, Ms B wanted to do a VE to assess progress, but Ms A was very reluctant to have a VE because she found them very painful. In her reflective notes, Ms B stated: “Due to [Ms A] declining the VE I offered transfer in light of how [Ms A] was responding to the situation. Again [Ms A] declined to transfer.” Ms B then asked Ms D to give assistance and a fresh perspective. However, Ms B remained the LMC responsible for Ms A’s care.

115. At 12.05am, Ms D performed a VE and noted that the baby’s head was positioned 1cm above the spines rather than the previous finding of 1cm below the spines. She documented that it was “difficult to tell if a swollen anterior lip or if [Ms A was] 8cm [dilated] as exam was painful for [Ms A]”.

116. Ms Kerkin advised that Ms A’s dilation at 12.05am “represent[ed] a significantly concerning lack of progress”.

117. Ms D discussed the assessment findings with Ms A and Mr A, and documented that Ms A did not want to transfer to the public hospital. Ms D recorded that there was no evidence of any fetal distress. Ms D said that Ms A, Ms B, and Ms A’s family were present during the conversation, and that Ms A said repeatedly that she did not want to go to the hospital. Ms D said she explained to Ms A and her family what an anterior lip is, how it could affect the labour, and that the presence of an anterior lip alone does not compromise a baby’s well-being, provided that it is managed appropriately. Ms D said that pain relief options such as Entonox and an epidural were discussed, and it was made clear to Ms A and her family that, although the labour was slow, there was no sign of fetal distress.

118. Ms D told HDC that she informed Ms A that, although an obstetric consultation was recommended, it was also a feasible option to stay on at the birthing centre provided

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that both Ms A and the baby showed no sign of compromise and that the anterior lip resolved within a reasonable time frame.

119. Mr A recalls being told that the lip of the cervix was "catching", but he denied that there was a discussion about transferring, or any discussion about what options were available.

120. Ms B stated that when she returned at 2.30am she was not concerned about Ms A's progress. Ms B said that she "discussed options from here and if [Ms A and her family] were still OK to stay in primary care", and she told Ms A that there were no clinical indications that secondary care was required at that point. Ms A wanted to remain at the birthing centre.

121. At 3.50am, 3 hours and 45minutes after the previous VE, Ms B performed a further VE, noting in the labour and birth notes that a "thin lip" of cervix was still present, with "Caput ++". Ms B stated:

> "I was unhappy about the findings of this VE as there was Caput present. Station 0, Fully dilated with ?Anterior lip. It was difficult to determine baby's lie. I queried if it was vaginal wall swelling or cervix. It was difficult as [Ms A] was upset."

These details are not documented in the labour and birth notes.

122. At 3.50am, Ms B documented in the labour and birth notes that she had a discussion with Ms A about transferring to the public hospital, and that Ms A was reluctant to transfer, "as she ha[d] been when previously discussed". Ms B also stated in her reflective notes that at 3.50am:

> "[Ms A remained reluctant to transfer to the public hospital] although I have stressed at this time that I am unhappy with the findings of the VE. I strongly recommend transfer as situation is no longer primary and requires consultation."

123. At 4.10am, Ms B documented in the labour and birth notes that she had attempted to contact the public hospital, and the call had been answered after three attempts. Mr A said that there was no discussion about the transfer, and that it was "more of [Ms A's] decision to transfer". He said that they requested to be transferred but only knew the transfer was actually happening when the ambulance arrived at the birthing unit. He feels that the midwives did not communicate well with him and Ms A.

124. At 4.50am, Ms B was transferred to the public hospital via ambulance, arriving at 5.10am. Ms B handed over care to the obstetric team.

125. Ms Davies advised that prior to 3.50am there was no real indication for a transfer to secondary care, and a transfer "was certainly not an urgent consideration". However, Ms Kerkin advised that there had been a significantly concerning lack of progress by 12.05am, and that when Ms B resumed Ms A's care at 2.30am, a discussion about the need for assessment of Ms A's progress and a plan for her ongoing care was indicated.

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126. Ms Kerkin advised that if Ms A and Mr A were not informed of the significance of the lack of progress, and the recommendation to consult, Ms A could not have made an informed decision about her ongoing labour care, and that would represent a moderate departure from accepted practice.

127. Ms B has not claimed that she advised Ms A of the recommendations in the *Referral Guidelines* to consult at any time. When asked by HDC whether she discussed with Ms A the option of an obstetric consultation as per the *Referral Guidelines*, Ms B responded that the only discussion she had with Ms A was about transferring from the birthing unit.

128. Mr A denies that there was a discussion about transferring to the public hospital, or any discussion about what options were available. In particular, Mr A said that they were never told that there was any concern about Ms A's progress.

129. Both Ms D's and Ms B's accounts confirm that Ms A was not told that her lack of progress in labour was concerning. Although it is documented that transfer for pain relief was discussed, there is no documented evidence in relation to the recommendation in the *Referral Guidelines* to consult, or that either Ms D or Ms B discussed the option of Ms A remaining at the birth centre and having an obstetric consultation by telephone.

130. Despite the differing views of my experts about the actions that needed to be taken at different times, and the points at which the *Referral Guidelines* were applicable, I consider that communication between midwife and woman should be an iterative process. Ms B did not inform Ms A about the recommendations in the *Referral Guidelines* at any time. In addition, Ms B did not make a documented plan for Ms A's ongoing management should she continue to fail to progress, discuss that with her, and record the advice given and Ms A's response.

131. I have carefully considered Ms B's submission on my provisional opinion. However, I remain of the view that the recommendation in the *Referral Guidelines* was essential information that a reasonable consumer in Ms A's circumstances would expect to receive. In my view, Ms A should have been told that her progress was slow, the risks should slow progress continue, the options available and, in particular, the recommendations in the *Referral Guidelines* for obstetric consultation. Without that information, Ms A could not make an informed decision or be a partner in her own care. I am highly critical that Ms B did not provide Ms A with such information.

Conclusions

132. Ms B failed to discuss the requirements of the *Referral Guidelines* with Ms A when Ms A's blood pressure increased antenatally. Ms B also did not discuss the option of an obstetric consultation in light of Ms A's slow progress in labour, or the risks that the slow progress could pose to her and her baby. This was information that a reasonable consumer in Ms A's circumstances would expect to receive and,

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accordingly, Ms B breached Right 6(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[31]

Opinion: Ms D — adverse comment

133. At around 12.05am, Ms D performed a VE and documented in the labour and birth notes that she had discussed the assessment findings with Ms A and Mr A, and that "[Ms A was] definitely not wanting to transfer". Ms D said that she recommended an obstetric consultation but also told Ms A that it was a feasible option to remain at the birth centre provided that both Ms A and the baby showed no sign of compromise, and that the anterior lip resolved within a reasonable time frame. Ms D said that her conversation involved Ms A, Ms B, and Ms A's family.

134. Mr A denies that there was a discussion about transferring to the public hospital at that time, or that there was any discussion about what options were available. Mr A said that they were never told that there was any concern relating to Ms A's progress.

135. Although it is documented that transfer for pain relief was discussed, there is no documented evidence in relation to the recommendation in the *Referral Guidelines* to consult with a specialist. Both Ms D's and Ms B's accounts confirm that Ms A was not told that her lack of progress in labour was concerning.

136. Neither Ms D nor Ms B discussed the option of Ms A remaining at the birth centre and having an obstetric consultation by telephone. I find that Ms D either did not advise Ms A of the recommendation in the *Referral Guidelines*, or, if she did so, that she did not communicate this adequately. In addition, Ms D did not explain the options available to Ms A, and the risks and benefits of each option.

137. While Ms B was the LMC and so had the responsibility to comply with the *Referral Guidelines*, in my view Ms D also had responsibilities when she discussed Ms A's progress with her after 12.05am. Ms D should have communicated clearly about the *Referral Guidelines* and the options available to Ms A, and documented those discussions. I am critical that she did not do so.

DHB — adverse comment

138. After Ms A's arrival at the public hospital she was seen by a registrar at 5.10am. The CTG was normal and Ms A was fully dilated. Ms A was distressed and felt she needed analgesia, so an anaesthetist was asked to site an epidural.

[31] Right 6(1) of the Code states: "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 …"

HDC

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139. A “combined spinal epidural” was sited at 6.20am. A VE showed that the fetal head was in a deflexed occipito-posterior position with the station at +1. The plan was for a trial of instrumental delivery in theatre.

140. In theatre, a manual rotation was attempted but failed. A Ventouse delivery was then trialled but the delivery was converted to a Caesarean section owing to lack of descent of the baby’s head after two pulls.

141. The baby was born healthy and well. However, following delivery, Ms A suffered a “massive” post-partum haemorrhage due to an atonic uterus and, unfortunately, she required a hysterectomy.

142. I obtained expert advice from an obstetrician and gynaecologist, Dr Ian Page, who considered that it was reasonable to attempt an instrumental delivery initially, because “the basic safety criteria (cervix fully dilated, head engaged [1cm below the spines], position known [occipito-posterior]) had all been satisfied”.

143. Dr Page said that the only risk factors that Ms A had for an atonic post-partum haemorrhage were her prolonged first and second stages of labour.

144. Dr Page advised that the management of Ms A’s post-partum haemorrhage was in line with accepted practice, in that appropriate pharmacological methods were tried initially, and, when they failed, the mechanical option of the Bakri balloon was used.

145. Dr Page stated that the decision to proceed to hysterectomy is always a difficult one. He said:

> “Overall I think the care provided to [Ms A] by the obstetric team was appropriate. The underlying cause of her atonic PPH [post-partum haemorrhage] was the prolonged first and second stage of labour. Whether earlier management of the delay in labour would have altered the outcome is, of course, impossible to prove.”

146. I accept Dr Page’s advice about the care provided by the obstetric team, and I am not critical of the care provided to Ms A at the public hospital.

147. However, Dr Page also noted that in 2012 the Health Quality & Safety Commission distributed a new Severity Assessment Code (SAC) matrix to all DHBs. Based on that matrix, a young woman requiring a hysterectomy following childbirth would be considered to be a moderate rating in the Consequence Table, and the likelihood of recurrence being within the next 1–2 years. This would make it an SAC 2 event, and it should have undergone a formal review process by the public hospital. I am critical that this did not occur, but acknowledge that the public hospital has since taken steps to improve reporting processes.

148. In response to the provisional opinion, the DHB stated that it considers that the event could have been rated as moderate on the Consequence Table and rated unlikely (event may occur at some time in the next two to five years) on the Likelihood Scale and, therefore, the event could be classified as an SAC 3. Regardless, I remain critical that a formal review process was not undertaken by the public hospital.

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Recommendations

149. I recommend that Ms B apologise to Ms A for the failings identified in this report. The apology should be sent to HDC within three weeks of the date of this report, for forwarding.

150. I recommend that Ms B organise a Special Midwifery Standards Review through NZCOM and report back to HDC on the outcome, within three months of the date of this report.

151. I recommend that Ms B undertake training on the requirements of the *Referral Guidelines* and report back to HDC on the outcome, within three months of the date of this report.

152. I recommend that the Midwifery Council of New Zealand consider whether a review of Ms B's competence is warranted.

153. I recommend that Ms D undertake further training on documentation in conjunction with NZCOM and report back to HDC on the outcome, within three months of the date of this report.

Follow-up actions

154. A copy of this report with details identifying the parties removed, except the experts who advised on this case, will be sent to the New Zealand College of Midwives, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, and the birthing centre.

155. A copy of this report with details identifying the parties removed, except the experts who advised on this case, will be sent to the Midwifery Council of New Zealand, and it will be advised of Ms B's name.

156. A copy of this report with details identifying the parties removed, except the experts who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.