Ms B, Midwife

A Report by the
Health and Disability Commissioner

(Case 12HDC01097)

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Executive summary

1. Mrs A, aged 34 years at the time of these events in 2011, was pregnant with her first child. Mrs A's lead maternity carer (LMC) was registered midwife Ms D, and her back-up midwife was Ms B.

2. Between 32 weeks' and 40 weeks plus five days' gestation, Mrs A had five growth scans due to concerns regarding the growth rate of her baby. On four occasions the results of the growth scans were normal, but on one occasion the result indicated that her baby's growth was not progressing at a steady rate.

3. Over the following four days, two cardiotocographs (CTGs)[1] were performed to assess the baby's heartbeat. The results of both CTGs were normal.

4. Mrs A was approximately 41 weeks plus two days' gestation. Following an assessment by an obstetrician at the public hospital, Mrs A was booked in for an induction in three days time.

5. Also, Ms D handed over Mrs A's care to Ms B, as Ms D was not going to be available over the weekend prior to the induction.

6. At approximately 4am on Sunday, the day before Mrs A was due to be induced, Mrs A telephoned Ms B to discuss her concern that she had not felt her baby move at any time on Saturday or that morning. Ms B advised Mrs A to go back to bed, to have an early breakfast in the morning, and to call her back afterwards if she still had not felt the baby move. Mrs A telephoned Ms B after she had had her breakfast and advised Ms B that she still had not felt her baby move.

7. Mrs A and Ms B arranged to meet at the hospital at approximately 10.30am. On examination by the on-call consultant, Mrs A was advised that her baby had died. Mrs A gave birth to a stillborn baby boy the following day.

Findings

8. The advice Ms B gave to Mrs A in the early hours of Sunday was inappropriate, particularly given Mrs A's additional risk factors regarding concerns about the baby's growth, and the fact that Mrs A was overdue. The standard of care provided by Ms B to Mrs A was a severe departure from expected standards and in breach of Right 4(1)[2] of the Code of Health and Disability Services Consumers' Rights (the Code).

9. Ms B will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994, for the purpose of deciding whether any proceedings should be taken.

[1] Cardiotocography (CTG) is a technical means of recording the fetal heartbeat and the uterine contractions during pregnancy, typically in the third trimester.

[2] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

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Complaint and investigation

10. The Commissioner received a complaint from Mr and Mrs A regarding the care provided to Mrs A by midwife Ms B. The following issue was identified for investigation:

- *The appropriateness of the care provided by Ms B to Mrs A in 2011.*

11. An investigation was commenced on 29 July 2013. The parties directly involved in the investigation were:

Mrs A	Consumer/Complainant
Mr A	Complainant
Ms B	Registered midwife/Provider

12. Information was also reviewed from:

Dr C	Obstetrics registrar
Ms D	Registered midwife
The District Health Board	Provider
The Midwifery Council of New Zealand	Regulatory authority

13. Independent midwifery advice was obtained from registered midwife Ms Stephanie Vague (**Appendix A**).

Information gathered during investigation

Background — LMC Ms D

14. In the second half of 2011 Mrs A, aged 34 years, was pregnant with her first child. She was generally healthy.

15. Mrs A had her first appointment with her lead maternity carer, registered midwife Ms D, at 10 weeks' gestation. Mrs A's ultrasound scans at 11, 12, and 19 weeks were normal.

16. At 32 weeks' gestation, Mrs A saw Ms D for a routine antenatal visit. As Mrs A's fundal height[3] measured the same as two weeks previously, Ms D ordered a growth scan. On 7 October 2011 the growth scan was carried out and the fetal size reported as satisfactory.

17. At 36 weeks plus one day gestation Mrs A saw Ms D for her next routine visit. Ms D noted in Mrs A's midwifery notes:

[3] The distance from the top of the uterus to the pubic bone, measured in centimetres. The fundal height is used to indicate fetal growth.

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> "Planning to meet with back up midwife [Ms B]. Measurements just above 10th centile. Growth scan ordered. Discussed follow up if concerns with this scan."

18. Having again measured Mrs A's fundal height, Ms D remained concerned about the baby's growth rate. A scan was undertaken that day and the results were again within the normal range.

19. At 37 weeks' gestation Mrs A met with registered midwife Ms B for a routine visit, as Ms D was unavailable. Ms B recorded in the midwifery notes: "Met in clinic as backup midwife … active baby rolling … had growth scan last week — baby 3kgs."

20. At 38 weeks plus one day gestation Mrs A saw Ms D for a routine visit. Ms D recorded in the midwifery notes:

> "Fundal Height 33cm today same as 2 weeks ago … growth scan ordered. [Mrs A] met with [Ms B] last week, Nil further concerns, [Mrs A] monitoring babies [sic] movements and will call LMC if reduced."

21. At 38 weeks plus four days' gestation Ms D sent a request to the assessment unit (the Unit) at the local public hospital asking for advice as to whether Mrs A required further follow-up because the results of the latest growth scan (taken at 38 weeks plus one day gestation) showed that the baby's abdominal circumference measurements were no longer increasing at a steady rate. At 38 weeks plus six days' gestation, before the Unit responded to Ms D's request, Mrs A had a further routine visit with Ms D. Ms D recorded in the midwifery notes that Mrs A had reported that, while the baby was still active, there were not as many active periods as usual. Ms D referred Mrs A for review at the Unit that day.

22. The Unit undertook a review of Mrs A including a CTG. Clinical notes state:

> "CTG — reassuring. Very sensible. Not too concerned re FM [fetal movements] … Back to LMC care, LMC to organise growth scan at 40wk."

23. When Mrs A was 39 weeks plus six days' gestation. Mrs A reported to Ms D that her baby was active. Ms D ordered a follow-up growth scan, as advised by the Unit, for the day following Mrs A's due date. The results of the scan were normal.

24. At 40 weeks plus five days' gestation Mrs A saw Ms D again, as her estimated due date had passed. Ms D carried out a CTG and a "stretch and sweep".[4] Ms D noted that the readings from the CTG were "reassuring". Ms D referred Mrs A to the Unit for a "post-dates assessment", which was booked for 41 weeks plus two days' gestation (a Friday).

25. When Mrs A was 41 weeks two days' gestation, she attended the post-dates assessment at the Unit. A CTG taken that day was normal. Following her CTG, Mrs A met with obstetrics registrar Dr C. Dr C booked Mrs A for an induction at 41 weeks

[4] A "stretch and sweep" involves a doctor or midwife inserting a finger into the vagina past the cervix and sweeping around the neck of the uterus to try to induce labour.

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plus five days' gestation (Monday), as this was the earliest available date for an elective induction.

Midwifery care handed over to Ms B

26. Also at 41 weeks plus two days' gestation (Friday), Ms D handed over Mrs A's care to Ms B for the weekend, as she was not going to be available. Ms B told HDC that Ms D advised her of the following at the handover:

- Mrs A had been seen at the Unit that day and had had a scan. The result of the scan was normal.
- Mrs A was booked for an induction when she would be 41 weeks plus five days' gestation.
- Mrs A had received regular growth scans during her pregnancy and "she had been seen by the team at the hospital several times".

27. Ms B advised that although she was aware that Mrs A had had growth scans, she was not made aware of any potential fetal growth or well-being issues at the time of handover.

Sunday

28. On Sunday, at approximately 4am, Mrs A telephoned Ms B to advise that she had not felt her baby move at any time on Saturday or that morning. Ms B advised Mrs A to go back to bed, and suggested that she have an early breakfast in the morning and call her back afterwards if she still had not felt the baby move, as "sometimes they will move after eating something sweet".

29. At 9am that morning Mrs A telephoned Ms B after she had had her breakfast and advised Ms B that she was still concerned, as she still had not felt her baby move. Mrs A told Ms B that she wanted to go to the hospital, as otherwise she would be worried all day. Ms B agreed to meet Mrs A at the hospital.

30. Ms B advised HDC that, at the time of that conversation, she had been about to telephone Mrs A herself to suggest meeting her at the hospital.

31. At approximately 10.30am Mr and Mrs A and Ms B met at the hospital. On examination by the on-call obstetric consultant, Mrs A's baby was found to have died. Mr and Mrs A were advised and proceeded to induction of labour. The following day, Mrs A gave birth to a stillborn baby boy.

Other information obtained

Mrs A

32. Mrs A told HDC that the impact of these events on her family has been "immense". Ms B has apologised to Mrs A for the standard of care she provided to Mrs A in 2011.

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Ms B

Response to the complaint

33. In her response to HDC, Ms B stated that "it is quite out of character for me not to respond immediately to a woman in such circumstances and this has never happened before in my career". She further stated: "My only explanation is that I was awoken out of a deep sleep and my advice was not correct as a result." Ms B acknowledged that "this is no excuse".

34. Ms B wrote to Mrs A following the birth stating:

> " I would like to sincerely pass on my condolences and sorrow to you and your husband after the loss of your baby. I acknowledge the deep pain that you must be feeling and want to say how sorry I am for your family's loss.
>
> I would like to say that I am deeply sorry for not meeting you at the hospital after you phoned me at 4am. I acknowledge that this was the wrong decision and that I made a mistake and caused undue anxiety for you both…"

35. Ms B said that she now uses a fetal movement guideline sheet for expectant parents. In addition, Ms B said that she and her colleagues have a new sticker on the front of their clients' maternity notes book, which states the following:

> "Please call your midwife if your baby's movements have been reduced or changed from their normal pattern. If you have not had 10 movements from baby in two hours when lying down and monitoring then please contact your LMC."

Ms B advised HDC that she is now "more vigilant when people phone [her] with reduced movements." She stated that she completed a postgraduate certificate of midwifery in 2012 and is committed to increasing her knowledge of midwifery.

Relevant standards

36. Competency 2.8 of the New Zealand College of Midwives Competencies for Entry to the Register of Midwives provides that a midwife "recognises and responds to any indication of difficulty and any emergency situation with timely and appropriate intervention, referral and resources".

Opinion

Introduction

37. Prior to 41 weeks plus two days' gestation, midwifery care was provided to Mrs A by her LMC, Ms D. No concerns were raised about the standard of care provided to Mrs A by Ms D, and my investigation did not extend to the care provided by Ms D.

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38. I note also that my role does not extend to determining the cause of death of the baby. My role is to assess the quality of care provided to Mrs A by Ms B in light of the information regarding potential risk factors that was known to Ms B at the time the care was provided.

Breach — Ms B

Summary of facts

39. At 37 weeks' gestation Mrs A was seen by Ms B for the first time for a routine visit as her LMC, Ms D, was not available. When Mrs A was 41 weeks plus two day's gestation, Ms D formally handed over Mrs A's care to Ms B, as Ms D was going to be unavailable for the following two days.

40. During handover, Ms D told Ms B that Mrs A was booked for an induction, at 41 weeks plus five days' gestation.

41. Ms B told HDC that she was not aware of any potential fetal growth or well-being issues at the time of handover. However, Ms B also said that Ms D told her at handover that Mrs A had received regular growth scans during her pregnancy, and that she had "been seen by the team at the hospital several times".

42. Concerns regarding the baby's growth rate are noted in Ms D's midwifery notes on several occasions, particularly at 32 and 38 weeks' gestation, and these notes were available to Ms B while acting as Mrs A's back-up midwife.

My consideration

43. My midwifery expert advisor, Ms Stephanie Vague, advised that Ms B's advice to Mrs A in the early hours of Sunday, to go to sleep and call her back in the morning after she had eaten breakfast, would not be regarded as appropriate midwifery care for any woman seeking advice in these circumstances, regardless of the presence or absence of any additional risk factors in relation to the pregnancy. Ms Vague advised:

> "I believe that it would be considered reasonable practice to promptly investigate a woman's concerns regarding decreased movements by their baby. I would consider that [Ms B's] actions in not responding immediately to fully assess the baby's wellbeing is a severe departure from the expected standard of midwifery care."

44. At the time of Mrs A's phone call to Ms B, Ms B was on notice of the following factors that should have lowered her threshold in terms of responding to Mrs A's concerns:

- Mrs A was overdue: Ms D advised Ms B at handover that Mrs A was booked for an induction, when she would be 41 weeks plus five days' gestation.

- Mrs A had a suggested history of slower than normal growth of the baby. The concerns during the antenatal period regarding the growth rate were adequately documented by Ms D, as was the history of the baby's movements. These notes were available to Ms B as back-up midwife. I also note that Ms D directly

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informed Ms B at handover that Mrs A had received regular growth scans during her pregnancy, and she had been seen by the team at the hospital several times.

45. I agree with my expert's advice and consider that, even in the absence of the above risk factors, Ms B's advice to Mrs A was suboptimal. I consider that, given that Ms B was on notice of such risk factors, Ms B's response to Mrs A's concerns on the Sunday morning was a severe departure from accepted standards.

46. I consider that, in failing to respond to Mrs A's concerns in a timely and appropriate manner, Ms B did not meet competency 2.8 of the New Zealand College of Midwives (NZCOM) Competencies for Entry onto the Register of Midwives, with regard to responding to any indication of difficulty and any emergency situations. Ms B failed to appreciate the seriousness of Mrs A's report that she had not felt her baby move for almost 24 hours, and failed to respond appropriately.

Conclusion

47. I consider that the advice Ms B gave to Mrs A in the early hours of Sunday was inappropriate, and displayed a lack of care and skill. This was particularly so given the additional risk factors regarding concerns about the baby's growth, and the fact that Mrs A was overdue. The standard of care provided by Ms B to Mrs A was a severe departure from accepted standards and in breach of Right 4(1)[5] of the Code.

Recommendations

48. In my provisional opinion I recommended that Ms B:

- Organise a special Midwifery Standards review through the New Zealand College of Midwives (NZCOM), particularly focused on responding to fetal distress.
- Organise a competence review through the Midwifery Council of New Zealand (MWCNZ).
- Obtain supervision from NZCOM to oversee her proficiency regarding recognising fetal distress. Ms B is to provide HDC with staged reports from her supervisor at two-monthly intervals, for a total period of 12 months from the date of my final decision
- Reflect on her failings in this case and provide a written report to HDC on her reflections and the changes she has made to her practice as a result of the case.

<u>Response to the provisional opinion</u>

49. In response to the provisional opinion Ms B advised that as a result of the incident involving Mrs A, she underwent a Competence Review with MWCNZ, in December

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2013. As a result of that review MWCNZ placed conditions on Ms B's practice, including being subject to a period of supervision. MWCNZ has also required Ms B to undergo further education, to be completed by 31 March 2015.

In light of the fact that Ms B has already undergone a Competence Review with MWCNZ subsequent to these events, I have amended the recommendations made in my provisional opinion. I now recommend that Ms B:

- Provide a written report to HDC within one month of completing the further training required by the MWCNZ. That report should set out:
    - a detailed explanation of the steps that she has taken as a result of the MWCNZ review;
    - her reflection on her failings in this case; and
    - the changes she has made to her practice as a result of this investigation and as a result of the MWCNZ review.

Follow-up actions

50.
- Ms B will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.
- A copy of the final report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Midwifery Council of New Zealand, the New Zealand College of Midwives, and the District Health Board, and they will be advised of Ms B's name.
- A copy of the final report with details identifying the parties removed, except the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

The Director of Proceedings decided not to issue proceedings.

Appendix A — Independent Midwifery advice to the Commissioner

The following expert advice was obtained from midwife Ms Stephanie Vague:

"Dear Commissioner,

I have been asked to provide advice to you during your preliminary assessment of case number C12HDC01097. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

My qualifications are Registered Midwife 1979; Registered General and Obstetric Nurse, 1974 and Master of Health Science (Midwifery) (Hons) (Auckland University of Technology, 2004). I have worked as an employed midwife in secondary and tertiary hospitals, as a Senior Lecturer in the undergraduate midwifery programme at Auckland University of Technology (AUT) and as Lead Maternity Carer. I am currently self-employed as a midwife working casual shifts at Auckland Hospital and part-time assessment work at AUT.

I am a member of the New Zealand College of Midwives (NZCOM). I have been a Midwifery Standards Reviewer and am nominated as an expert midwifery advisor by NZCOM. I also work for the New Zealand Midwifery Council as a competence assessor and reviewer from time to time.

I have been asked to advise whether I consider the care provided by Midwife [Ms B] to [Mrs A] was appropriate.

Sources of Information

- Copy of [Mrs A's] complaint
- Copy of [Ms B's] response dated 25 September 2012
- Copy of [Ms B's] letter to [Mrs A] dated 1 June 2012
- Copy of [Mrs A's] midwifery notes from [Ms D]

Summary of Events

[Ms B] was providing back-up care for her midwifery partner, [Ms D], who had the weekend [prior to the induction] off.

[Mrs A] was 41 weeks and 4 days gestation, in her first pregnancy. She was booked for an induction of labour on [Monday]. [Mrs A] phoned [Ms B] at 4am on [Sunday] because she was concerned about her baby's decreased movements over a period of several hours.

[Ms B] advised [Mrs A] to go back to bed, have breakfast and call her if she still did not feel the baby moving after eating. When [Mrs A] called back at 9am to report no change and her continuing concern, [Ms B] agreed to meet her at the hospital at 10.30am.

Once at the hospital, [Ms B] was unable to hear the baby's heartbeat and subsequently the baby's death was confirmed.

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Response to Advice Requested

A baby's movements are regarded as a useful marker of its wellbeing by pregnant women and midwives alike. Women are asked about the nature of baby's movements at every antenatal assessment and most become quite attuned to their baby's patterns.

[Ms B] has stated that she was wrong not to respond to [Mrs A's] concern at 4am on [Sunday]. Her advice to go back to sleep and call again after eating breakfast would not be regarded as appropriate midwifery care for any woman seeking advice. In this case, [Mrs A] was overdue and had a suggested history of slower than normal growth in her pregnancy. Both these factors are additional risk factors and would lend further weight to the need for a timely and comprehensive assessment of the baby's wellbeing.

[Ms B] stated in her letter to [Mrs A] that she has instituted changes to her practice in the light of extra education through a study day on fetal surveillance and attendance at a technical skills workshop. Technical skills workshops are a 2 day educational package which all practising midwives must attend over their three year [registration] cycle. The workshops provide updates to skills such as adult and neonatal resuscitation and some obstetric emergency scenarios. In addition, Midwifery Council requires specified areas relating to midwifery care to be taught nationally. In the current three year cycle, assessing the wellbeing of the fetus was one such area which Midwifery Council identified. Consequently all midwives, by the end of 2013, should have attended this cycle of technical skills workshops and have been updated on the most current evidence based research on this subject. There may have been changes to midwifery practice as a result of the latest evidence, including the way in which women are asked to monitor their baby's movements.

Regardless of the changing nature of practice, however, I believe that it would be considered reasonable practice to promptly investigate a woman's concerns regarding decreased movements by their baby. I would consider that [Ms B's] actions in not responding immediately to fully assess the baby's wellbeing is a severe departure from the expected standard of midwifery care.

Stephanie Vague"

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