Midwife, Ms B

A Health Trust

A Report by the

Deputy Health and Disability Commissioner

(Case 06HDC18721)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Ms A	Consumer
Mr A	Consumer's partner/complainant
Ms B	Provider/midwife
Ms C	Midwife
Ms D	Midwife
Ms E	Breastfeeding kaiawhina
Ms F	Midwife
Ms H	Midwife
Ms G	Midwife
Dr I	Obstetrician
Mr J	Hospital midwife
Dr K	Obstetrician
Ms L	The District Health Board's Manager — Maternity Services
Mr M	General Manager, the Trust
Dr N	DHB Clinical Head of Obstetrics & Gynaecology
A maternity clinic	Maternity Clinic/The Health Trust
The Trust	A health trust
A rural hospital	A rural hospital
The Public Hospital	A public hospital

Complaint

On 12 December 2006 the Commissioner received a complaint from an advocate on behalf of Ms A and Mr A about the services provided to Ms A by midwife Ms B. The following issues were identified for investigation:

- *The appropriateness of the care independent midwife Ms B provided to Ms A during her pregnancy in 2006.*
- *The appropriateness of the care independent midwife Ms B provided to Ms A during her labour and delivery in September 2006.*
- *The appropriateness of the care a Health Trust provided to Ms A in 2006.*

An investigation was commenced on 16 February 2007.

Information reviewed

Information was received from:

- Ms and Mr A
- Ms B
- Mr M
- Dr I
- Dr K
- Ms L
- Mr J
- Ms C

Ms A's public hospital clinical records and the computerised records from the health trust were obtained and reviewed. Independent expert advice was obtained from midwife Ms Tungane Kani.

Information gathered during investigation

Overview
Ms A was expecting her first baby, and engaged the services of independent midwife Ms B. Ms B provided a minimal antenatal service to Ms A, did not offer any of the usual routine testing, and did not adequately document any of the consultations, making scant diary notes only. She claims that this was because Ms A preferred a natural approach, specified no clinical intervention, and did not want any records kept.

Ms B went on leave the week that Ms A's baby was due, and arranged for another midwife to check on Ms A. When Ms B returned from leave, Ms A was three weeks past her delivery date. Ms B visited Ms A the next day. Induction of labour was discussed in general terms, but Ms B did not inform Ms A of the potential risk to the baby of being so far overdue, or that she should see an obstetrician.

That evening the baby stopped moving. Ms B admitted Ms A to the local rural hospital for an assessment. Ms B examined Ms A at the hospital and was unable to locate a fetal heartbeat. Ms A was transferred to a public hospital in a larger centre (the Public Hospital) where an ultrasound scan confirmed that their baby had died. Ms A's labour was induced by the Public Hospital obstetric staff and, after a long and difficult labour, the baby was delivered the same day.

The Public Hospital maternity staff asked Ms B to produce her antenatal records for Ms A. Ms B said that she would arrange for the Trust administrator to transcribe her diary notes into the computer and forward the records to the Public Hospital. Ms B

made 35 entries directly after the birth into Ms A's Trust computer records and a further 29 entries during the five following months.

Background

Ms A, a health professional in her thirties, was expecting her first baby on 5 September 2006. Early in her pregnancy Ms A asked a colleague to recommend a Lead Maternity Carer[1] (LMC). Ms B was recommended. Ms B was one of the four midwives employed by a healthcare trust (the Trust) to provide care to women in the area. Ms A interviewed Ms B and recalled, "She was very, very confident and reassuring about everything and spoke at great length about how many years experience she had working in hospitals including [a large public] Hospital." Ms A said that she had a real interest in Māori culture and was keen to learn some of the cultural practices around pregnancy and childbirth. Ms A stated that Ms B "made me think that going with her was a very safe option".

Birth plan

There is discrepancy about the date of the first antenatal visit. Ms A believes she completed the "Birth-plan ideas" section of her Whanau Midwives Confidential Maternity Record in the first month of the pregnancy, specifying that she wanted to have her baby at home with her partner, Mr A, as her support person. She noted that she intended to keep the placenta and would like Mr A to cut the umbilical cord and tie the cord with a muka (flax cord). Ms A did not consent to having students involved in her care.

Ms B stated that her usual antenatal practice is to explain to the mother all the testing that is part of midwifery care. The usual birth plan discussion she has with her clients covers early and established labour, contractions, waters breaking, a show and movements of the baby. Ms B provided Ms A with a homebirth DVD to watch at home. She recalled that they discussed "other skills of 'knowing' that labour is progressing (birth sounds, descent of babe, contractions and physical changes to body) as opposed to using routine internal examinations to determine progress". Ms B said that Ms A did not want "clinical care" and declined to have routine antenatal blood pressure and urinalysis tests performed. Ms B stated, "I assumed [Ms A] was being fully informed during her antenatal care as she is a health professional who is an intelligent woman and had just completed her studies in health."

One of the midwives employed by the Trust, Ms D, stated that she was introduced to Ms A at about this time. Ms B told her that Ms A and Mr A liked the idea of a homebirth/waterbirth. Ms D said she thought that Ms B was the "best option" of

[1] A Lead Maternity Carer refers to the general practitioner, midwife or obstetric specialist who has been selected by the woman to provide her complete maternity care, including the management of her labour and birth.

midwife for Ms A given that homebirth/waterbirth was Ms B's preferred delivery option.

Ms A and Mr A stated that while they sought a natural approach to childbirth they did not wish to "forsake the use of conventional medicine when its use was appropriate". They believe that Ms B was opposed to conventional medicine. She actively discouraged them from taking up testing options such as ultrasound scanning. She told them that scans are harmful to the baby. However, Ms A chose to have an ultrasound scan at 20 weeks. She said, "I'm just that sort of person. … I have to know that things are OK." Ms A stated, "We didn't know all the tests that can be done, why they are done and how they are done. We trusted her."

GP assessment

On 26 January 2006, Ms A saw her general practitioner because she had been experiencing intermittent vaginal bleeding. The GP ordered routine maternity blood tests for her and insisted that she take one month of sick leave from work because of a risk of miscarriage. The blood test results, reported to the GP that day, showed no abnormalities with the exception of the glucose, which was slightly elevated. Ms A took sick leave for the whole of that month.

Antenatal care

The Trust uses the "Profile" computer database system for staff to record their consultations with clients. Every consultation or telephone call is recorded as an "Encounter". Ms B's initial consultation with Ms A was recorded in the computer as occurring on 1 March. The record noted that they discussed the midwifery service the Trust team could provide and that two of the midwives also worked at the Trust as LMCs. Ms A was given an information pack and blood test request forms for routine blood screening and, because Ms A reported some earlier vaginal bleeding, a routine antenatal ultrasound scan was booked for her at the rural hospital for 20 April. Ms A was to contact Ms B when she decided whether to engage her as her LMC.

Ms A and Mr A expressed concern that Ms B did not record her consultations with them contemporaneously. They state that the first visit was not on 1 April, but in January. They recall that the meeting on 1 March centred on discussion about Ms A's time off work in February. During the time she was off work in February Ms A referred repeatedly to the information in her Bounty pack, which indicates that she must have obtained the book before 1 March.

Ms A recalls that Ms B listened to the baby's heartbeat at the 1 March visit and made a brief note in the Whanau Midwives Confidential Maternity Record under the heading "Antenatal Visits". Ms B's record for that visit calculated the pregnancy to be "13+" weeks, and that the fetus had a "strong + regular heart beat". Ms B also noted that the scan had been booked.

According to the computer record of the follow-up visit on 14 March, Ms B performed a comprehensive assessment, noting Ms A's estimated date for delivery of

5 September. Ms B noted that she performed a urine test that day which was negative for glucose and protein. She discussed with Ms A the type of care she wanted throughout her pregnancy. Ms B recorded that Ms A "would like a natural approach and home birth/water birth".

Ms B stated that Ms A said that she did not want her to keep any records of the antenatal consultations.

Ms A does not recall meeting Ms B on 14 March. She said that the only urine test she had was on 26 April, a home visit when Mr A was present. Ms A said that the only time antenatal blood tests were discussed was when her GP suggested that serial blood tests might be useful in light of earlier concerns about miscarriage. She said, "At no other time throughout the pregnancy did [Ms B] suggest or encourage antenatal blood tests." Ms A stated that Ms B's claim that she did not want any antenatal records kept is "absolutely ludicrous". She said, "Why on earth would anybody not want things recorded?"

Ms A had an ultrasound scan which reported that it was a single pregnancy of "around 20½ weeks". The scan confirmed the estimated delivery date of 5 September. No fetal abnormalities were detected.

According to the computer record, the next visit was rescheduled and took place on 26 April at the antenatal clinic. The record notes that a urine test performed at that visit was normal, that Ms A was reporting fetal movements, and her nausea had settled. Ms A was busy with work and study, beginning her day at 4am and returning home at 5.30pm, which she found "stressful at times". The record noted that Ms B listened to the baby's heart with a pinard[2] and gave Ms A a pamphlet article on scanning. Ms B noted, "Husband is keen to meet with us so next appointment has been scheduled for a home visit."

Ms A says that this record is incorrect. To illustrate, Ms A said that her day started at 5.30am, not the hour stated by Ms B. When Ms B visited Ms A at home on 26 April, Mr A was at home and Ms B brought Ms E, who is a breastfeeding kaiawhina, to meet them. They watched the DVD of the 20 April ultrasound scan. She said, "[I]t would not make sense for [Ms B] to be providing [scanning] information after the ultrasound scan had already been conducted."

There are two further computer antenatal records regarding Ms B visiting Ms A, on 31 May and 10 July. The record of the July visit noted that Ms B, Ms A and Mr A discussed home birth. Ms A and Mr A advised Ms B that they wanted testing done "as and when they request it". They asked her to leave a pinard with them so that Mr A could listen to the baby's heartbeat. Ms A was noted to be tired in July, and Mr A was

[2] A pinard stethoscope which is placed on the mother's abdominal wall to listen to the fetal heart sounds.

worried about her "tiredness and the stress of travelling away to [another area] and job and study". Ms A's blood pressure was measured at 114/72, within the normal range.

Ms A and Mr A made an appointment to see Ms B at the Maternity Centre on 27 July, because Ms B had failed to keep the appointment scheduled for 24 July and did not contact them to reschedule.

According to the computer record, Ms B's appointment with Ms A for 13 August to be rescheduled to 19 August because Ms A was in [another area]. Ms A said that she was not in [another area] on this date, and she has no record of an appointment for 13 August in her diary.

The computer record for a visit on 25 August noted:

> "**Antenatal Check**
>
> [Ms and Mr A] well. Baby moving lots and growing well. Listened to baby's heartbeat and FHH — 150 bpm [beats per minute]. Baby was active at time of listening. … [Mr A] happy that he had found a stone to cut baby's pito [umbilical cord]. [Ms A] has already completed her Ipu [container] for the whenua [placenta]. She is walking daily to the beach, now that she has finished work. Taking time to enjoy her pregnancy in this time with her baby."

September 2006
Ms B recorded that she visited Ms A on 6 September noting, "now 40+1 day today" (one day past her estimated delivery date). According to the record, Ms B had a detailed discussion with Ms A about the family history of aunts going well past their estimated delivery dates. The record states, "Given this history, [Ms A] not keen to be induced at present."

Ms A stated that induction was not discussed or offered at this appointment. Ms B examined her to assess the baby's position and stated that labour was unlikely to start for another couple of weeks, and that this was "perfectly normal" given the family history. Ms A and Mr A were planning to leave for Mr A's mother's funeral. Ms B informed them that she would be going [away] "for a while" because her granddaughter had been born. Ms A was unaware until this meeting that Ms B would not be available around the time her baby was expected. Ms B told them that they could contact her on her mobile and that if labour started they were to call her and she would drive back. Ms A recalled Ms B giving her instructions on how to deliver the baby herself "if nobody could reach her in time".

There is discrepancy in the information provided about the handover of care of Ms A when Ms B took leave in September.

Ms B advised that she held a staff meeting on 11 September to hand over to interim manager Ms D. Ms B planned to be on leave until 24 September. She advised that Ms A was the only client she had who was due and asked Ms D to provide cover while

she was away. Ms A had met Ms D at the antenatal clinic. Ms B left the following plan for Ms D:

"

1. [Ms A] 40+6 days (EDD 05/09/06)
2. Doesn't want induction
3. Wants a homebirth and a water birth
4. Needs the Birth Pool to be dropped off
5. [Ms A] is travelling to a tangi — [family member]
6. [Ms A] will phone to make an appointment with [Ms D] on her return (she has all the contact numbers)
7. [Ms D] to contact me if [Ms A] goes into labour (as I wanted to try and make it back for the birth)."

Ms D stated that Ms B visited her at home at 9pm on 11 September to tell her that she was taking leave and would be away for 10 days. Ms D said that she was "shocked to say the least as it was unexpected and at such short notice". Ms D said that in rural practice leave needs to be planned in advance. The midwives' caseloads are significant, particularly in September, and the midwifery team at that time was extremely stretched. Ms B's handover to Ms D was only about Ms A and that she was approaching the 41st week of her pregnancy. Ms B told Ms D that ultrasound confirmed that Ms A's estimated date of delivery was 5 September, but did not provide Ms D with any clinical records. Ms B advised Ms D that Ms A had a "strong family history of post-dates 42−43 weeks and had decided that she would not deliver until 23rd [September]".

Ms D expressed her concern in leaving the pregnancy so long and still to be offering a homebirth/waterbirth so far out of town. Ms A's house was 50 to 60 minutes north of town. Ms D reminded Ms B that she was not experienced or comfortable working in a homebirth situation with a woman having her first baby so far out of town. She said she was concerned that she did not know much about Ms A's history and had no notes of a plan for Ms A. Ms D also expressed her concerns when Ms B informed her that she was not to carry out any blood pressure readings or monitor with a sonicaid as the couple wished the husband to do this himself. Ms D told Ms B that she was very stretched with her busy caseload of ten women, and asked, "Will this mean I have to do more visiting over and above my current workload?" Ms B told her that she would be needed only if contacted by the couple. She said that Ms A was attending a funeral and would contact her if they needed a visit. Ms B assured Ms D that Ms A would be fine and would probably not deliver until after her return from leave.

Ms D stated that over the three days following her conversation with Ms B she delivered five babies and felt extremely stretched. She was informed by the receptionist that Ms A had telephoned to ask if Mr A could pick up the birthing pool.

On 14 September, Mr A called into the Trust office to uplift the birthing pool. He was anxious because Ms A was nine days overdue and the pool had not been delivered. Trust staff were not able to give Mr A a date for Ms B's return.

The following day, Ms D telephoned Ms A to check on her. Ms A recalls Ms D asking, "Everything's alright isn't it?" "You're feeling well aren't you?" "Baby's kicking a lot isn't he?" Ms D offered to call to see Ms A on 17 September. Ms A advised Ms D to telephone first as she might be out walking, and did not want to miss her visit.

Ms D confirmed that she telephoned Ms A and offered her a visit on 17 September when she would be following up one of her own women who lived ten minutes from Ms A's house. Ms D said that she did not visit her client as planned on 17 September, because one of her young first-time mothers was in early labour and she wanted to stay close to her. Ms D said that she was tired and went home for a rest while she had the chance. She said, "It was only on my return that I remembered the proposed visit with [Ms A] and [Mr A]. I have no excuse for not remembering to telephone other than being very tired and busy."

The computer record shows that Ms D recorded her contacts with Ms A on 14 and 15 September. She noted that Mr A would uplift the birthing pool from the maternity clinic on 14 September and that she spoke to Ms A the following day to organise a visit for 17 September. She recorded that Ms A asked her to telephone first as they might not be home, said she was "fine" and asked when Ms B would be returning.

Ms A stated that she waited in all day for Ms D to call to say she was on her way. Ms D did not call and did not visit and had no further contact with Ms A. Ms D did not record her reason for not keeping this appointment or a plan to reschedule. In her response to the provisional opinion, Ms A asked, "Why did the staff of the [maternity clinic] service fail to communicate and co-ordinate with each other?"

On 23 September Ms B returned and contacted Ms A to arrange a visit for that day. Ms A recalls that Ms B said she was "happy that bubs had waited". Ms B's record of that visit to Ms A, who was 18 days past her estimated delivery date, was:

> "**Antenatal Check**
>
> Visited [Ms A] today at her home. Dates now 42+4 days. Fully discussed induction process and concerns of whenua and how long this would last. Discussed options to see consultant or travel to [Public Hospital] for induction. After listening to baby's heartbeat and feeling a good amount of liquor around baby the whanau felt good about this process. Due to family history [Ms A] and [Mr A] still keen to maintain a natural focus and wait to go into labour. Declined induction process and wanted to wait. Although anxious, I have informed them that I will continue to care for them in their decision."

Ms A stated that Ms B's record does not "in any way reflect the truth". She said that Ms B did not express any feelings of anxiety about how far overdue the pregnancy was. She emphasised to Ms A that it was perfectly normal for her to be so far overdue given her family history. The couple asked about the risks of going overdue. Ms B minimised this and told them that their baby was moving well and had a strong heartbeat.

Ms A recalls that she asked about induction, and said that "[Ms B] proceeded to make it sound as awful as possible, stating that the procedure was very unpleasant and was harmful to the baby." Ms A said that Ms B was very dismissive of any medical interventions, tending to ridicule them and portray them as heavy-handed and unnecessary.

Ms A stated that at no time did Ms B discuss the possibility of stillbirth. The couple did not know that there was a risk that the baby might die as a result of the pregnancy continuing for so long. Ms A said that they "relied on [Ms B's] professional judgement".

Ms B stated that in addition to the information she shared with her, Ms A had read a lot of literature. Ms B said, "I assumed she was well informed." She said she trusted Ms A's decision to decline all clinical care and maintain a natural approach. Ms B stated, "[I] feel I was supporting her wishes by continuing to provide care and feel now this was an error in judgement. It is usual practice for me to support wahine whether they accept or decline consultant review and induction of labour." Ms B denied denigrating secondary clinical care. She said, "I find this allegation as an insult to my integrity. Quite to the contrary I do acknowledge the skills of secondary care staff at [the Public Hospital]."

Ms B did not make any further appointments. Ms A recalls her saying that she would wait to hear that labour had started.

26 September 2006

On the morning on 26 September Ms A walked on the beach. The baby was moving well and she had had a "show"[3] Ms A telephoned Ms B to inform her of progress. The computer record noted that Ms A was "happy things were beginning to happen" and asked Ms B to visit the next day so that "we could give things time to happen".

On the evening of 26 September 2006, Ms A became concerned that her baby had stopped moving. She telephoned Ms B to tell her about her concerns for her baby. Ms A recalled that Ms B told her she was having dinner with friends and would have a shower and change before coming to assess her.

[3] A "show" is the common term for the release of the cervical plug that forms during pregnancy. It consists of a mucous, often blood-streaked vaginal discharge and indicates the beginning of cervical dilation.

Ms B arrived at Ms A and Mr A's home accompanied by midwife Ms F and another woman.

Ms A stated:

> [Ms B] got me to lie down so that she could have a listen for a heartbeat and she made this huge show of, 'Is it OK to use the Doppler machine?' And I got the feeling that she was actually putting on a show for the other women and making it out that we had never allowed her to use it but she'd always wanted to."

Mr A said:

> "She had a go … and then [Ms F] had a go as well and then the other lady had a go as well and [they] couldn't hear anything."

Mr A said that he drove Ms A to the rural hospital and Ms B followed in her car. He said that the drive took him about 45 minutes.

The Rural Hospital

The computer record notes that the "whanau" [family] arrived at the rural hospital at approximately 11.05pm and that Ms A was immediately seen by staff midwife Ms H, who was unable to detect the baby's heartbeat. Ms B tried, unsuccessfully, to locate fetal heart movement using a CTG.[4]

Ms B recorded in Ms A's District Health Board Treatment and Progress Notes:

> "26/09/06 43 weeks by scan and LMP [last menstrual period] date.
>
> [Ms A] visited @ home after receiving a phone call that baby's movements had not happened at the usual time in evening. Baby's movements had been last felt just after lunch. Had ? show last evening about 2300hrs [11pm]. Membranes intact, had cramping pains. At home visit palpated babe.
>
> - fundus = term
> - abdo = soft
> - long lie
> - cephalic presentation
>
> Listened via pinard unable to auscultate baby's heart beat. Advised to transfer to [rural] Maternity Hospital. Followed [Ms A] and [Mr A] into hospital."

Ms B telephoned the Public Hospital and spoke with on-call obstetric consultant Dr I to inform her of the findings. Ms B told Dr I that Ms A, who was 43 weeks' gestation,

[4] A cardiotocograph or CTG is the external electronic monitoring of the fetal heart rate. A CTG can indicate any abnormalities in fetal heart rhythm, which may indicate fetal distress. The Doppler unit converts fetal heart movements into audible beeping sounds and records this on graph paper.

had declined an induction. Ms A reported that evening that that she had felt no fetal movement at the usual time. She had had a show but was not in labour. Ms B said that she was unable to find a heartbeat on assessment.

Dr I recalled that when Ms B telephoned her from the rural Maternity Hospital about Ms A, she advised that there had been no fetal movements felt since the previous evening and that she had been unable to detect a heartbeat. Dr I did not state that she knew at that stage that Ms A was in the 43rd week of her pregnancy. Dr I advised Ms B to arrange for Ms A to be transferred to the Public Hospital Delivery Unit.

Travel to Public Hospital
Ms A had asked whether helicopter transfer was a possibility, and Ms B discussed this with Dr I. Dr I advised that transfer by helicopter was not warranted in the circumstances. Ms A said that when she was told that they would travel to the Public Hospital by car she knew there was "no hope" for the baby.

Mr A and Ms A sat in the back of Ms B's car for the trip. Mr A, who is a mechanic, said that he was concerned about the roadworthiness of the car and their safety because one of the tyres on Ms B's car was "not far from going bang". He said that the tyre was so worn that the casing had separated and he could feel the back of the car shaking. Mr A and Ms A were also concerned when Ms B's attention was often diverted while driving when she sent and received a number of text messages during the trip. She stopped twice at service stations to "top up" her mobile phone.

Public Hospital
Ms A was admitted to the Public Hospital Delivery Unit at 2.20am on 27 September by staff midwife Ms G. Ms G noted the position of the baby in the pelvis, and Ms A's baseline vital recordings of blood pressure, pulse and temperature, which were all within the normal range. She then notified Dr I that Ms A had arrived.

Ms B stated that she handed the care of Ms A to secondary services "upon admission". She noted that Ms A and Mr A asked her to deliver the baby. She told them that she had to drive home, but would be back to assist with the labour and delivery when Ms A's labour had established. Ms B asked the staff midwife to contact her when Ms A was in labour. Ms B left the Public Hospital shortly afterwards.

Clinical records
Ms B did not make any notes in the Public Hospital clinical notes at this time, and did not provide the hospital obstetric staff with any antenatal records for Ms A. Ms B stated that she believed at that time that the notes had been left in Ms A and Mr A's car. She informed the hospital staff that "there was not much written in them". She said that she knew every detail of [Ms A]'s care and could give accurate antenatal information as required.

CT scan
At 2.50am Dr I examined Ms A and performed an ultrasound scan. Ms A complained that Dr I did not provide them with sufficient information. She believes that Dr I was

unable to fully inform them about the situation they were facing because the scan she performed only confirmed that the baby's heartbeat had stopped, and did not check the baby's position or size. Ms A stated, "She did not take the extra minute or so required to establish what his position was" and "a huge amount of physical and emotional trauma and suffering may have been avoided had [Dr I] been more thorough".

Dr I stated that the purpose of the scan was to determine whether or not the baby had died. She said that prior to commencing the scan, she palpated Ms A's abdomen to determine the lie and presentation of the baby. The purpose of the examination was primarily to guide where to place the ultrasound probe, but was also important to plan later management. Dr I said that from the scan she observed that the baby was in a longitudinal lie with the head presenting. She looked for the fetal heart but found that there was no cardiac activity and observed that the baby was not moving. This confirmed that the baby had died. Dr I discontinued the scan, as no further information was necessary, and recorded her findings.

Informed consent
Ms A stated that she and Mr A were denied the opportunity to make informed choices. Dr I did not discuss with them the relative advantages and disadvantages of a Caesarean section versus a vaginal birth. She told them that she believed it would be "better" for Ms A's body "to go through a normal labour". Ms A stated that this was disempowering and appeared not to take into account the emotional stress of going through a labour knowing that the baby was not alive.

Dr I stated that after she discontinued the scan she explained to Ms A and Mr A that their baby had died. She said that, as is her usual practice, she told them that when they were ready she would be available to ask any questions and to discuss their options. Dr I then left the room to give them some privacy and to spend some time together.

Later, Dr I met with Ms A and her partner. They wanted to know how to proceed. She explained that the baby was head first and that there were no contraindications to Ms A having a trial of labour and a trial of vaginal delivery. Dr I explained that it is her usual practice in these circumstances to offer the parents the options of either waiting overnight, or longer if they wanted to return home for a while, or the option of being induced. Dr I described the process of induction of labour, including the use of prostaglandin gel, artificial rupture of the membrane, and a Syntocinon infusion. Dr I believed that Ms A and Mr A did not want to delay the induction. However, Ms A asked her to avoid rupturing the uterine membrane, if possible.

Induction of labour
At 4.20am Dr I recorded that Ms A and Mr A agreed to the induction of labour. Dr I recorded her examination of Ms A and the insertion of a 2mg prostaglandin vaginal pessary to induce labour. She noted her plan for Ms A to lie flat for 30 minutes and to be given pain relief as required. Dr I recorded that she would review Ms A again at 10.30am or before if asked to do so by the midwives.

At 5am Ms G noted that Ms A was left to "try to get some sleep", that she and her partner were aware of the plan of care and were to call if they had any needs or questions.

Hospital facilities
Ms A complained that the Public Hospital maternity facilities were "inadequate". She said that the room they were assigned did not have bathroom/toilet facilities and she had to make her own way down the corridor to use a shared toilet. She recalls that the distance was quite daunting. She could not understand why they were not given the adjacent vacant room that had toilet facilities. Ms A was experiencing significant labour pains and bleeding heavily at various times. The corridor was a public space and she felt "demoralised, demeaned and humiliated as a result of the poor facilities".

The District Health Board Maternity Services Manager Ms L stated that the maternity unit was designed many years ago and the sanitary facilities are located around the middle of the unit. Two bathrooms service the eight delivery rooms in the unit, and the women have to walk between their rooms and the facilities. Ms L stated that there is another bathroom with a toilet and a large bath, but this was occupied at the time Ms A was in labour. Another room has a shower and a toilet, but this room has no natural light and is mainly used just for showering. The room that was assigned to Ms A was chosen because of its distance from the other birthing rooms, to provide her with some privacy from the other labouring women.

Once it was realised that Ms A was inconvenienced by using the ward toilet opposite the other room, she was directed to use the toilet opposite her room.

Labour
Ms A complained that Dr I checked on her only once to confirm that her cervix was dilating sufficiently after inducing her labour at 4.20am.

At 8am midwife Mr J took over the care of Ms A. He recorded his initial impressions and at 9am recorded her vital signs. At 10am Mr J noted that Ms A's contractions were painful and that she was feeling "some pressure" and was up to the toilet frequently.

At 10.20am Dr I recorded in the clinical records that she had reviewed Ms A, noting that she was free of pain between contractions, which were becoming distressing and occurring three to four times every ten minutes. Dr I performed a vaginal examination

and noted that the baby's head was at station -2 going to -3[5] and that the cervix was stretching to 5cm dilatation with bulging forewaters.[6]

At 10.30am Mr J gave Ms A pain relief, pethidine 100mg, and then contacted Ms B to advise her of the status of Ms A's labour and ask her to bring Ms A's antenatal records with her when she came. Ms B advised that she was already on her way and that the notes were in her "other car" and that she would arrange to have the notes faxed to the Public Hospital.

Mr J noted that Ms A was using nitrous oxide for additional pain relief, and that her contractions were easing and she wanted to try the bath for comfort.

At 11.20am Ms A's uterine membrane spontaneously ruptured while she was in the toilet, draining blood-stained liquor.

At 1pm, Mr J recorded that Ms A's pain was increasing. He discussed this with Dr I, who advised giving a further 100mg of pethidine. Mr J noted that Ms A's contractions were strong and regular, occurring five times in 10 minutes and lasting 60 seconds. He also recorded her vital signs, which remained within the normal range.

Dr I reviewed Ms A again at 2.30pm. She recorded that she performed a vaginal examination which revealed that Ms A's cervix had dilated to 8cm and the baby's head was at -2. Dr I recorded that the side of the baby's face was presenting. She had felt, during the examination, one of the baby's eyes and an ear. She noted her plan to reassess Ms A in three hours or before if requested to do so by the midwife, and ordered pain relief for Ms A.

Mr J recorded that Ms B arrived at the delivery suite at 3pm. He continued to monitor and document the progress of Ms A's labour.

Ms B stated that she arrived back at the Public Hospital at approximately 2.30pm on 27 September 2006. She said:

> "Care had already been handed over the secondary services upon admission of the 27/09/06 at approximately 0200hrs. I did not 'take over' care when I returned to [the public Hospital] and have never provided secondary care [there]. I was attending to [Ms A] and [Mr A] as a support person as requested by them. I only provide primary care midwifery and have an access agreement for primary care ([the rural] Hospital)."

[5] "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 at 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).

[6] A bulge in uterine membrane preceding the presenting part, containing uterine liquor.

Ms B advised Mr J that she was acting as support only. She said, "At times I felt obligated to provide care as the staff midwife kept going in and out of the room and left most of the cares to me."

At 4.15pm, Mr J noted that Ms A was feeling a strong urge to push. He stated:

> "There were no concerns until an hour after second stage, by which time [Ms B] was the prime carer. I went into the shower cubicle frequently to check on progress. I was asked by [Ms A] several times just to leave them be and he would call, if he needed me. Despite this, I would enter the shower and ask how things were, and … take observations.
>
> I asked [Ms B] and [Ms A] several times if they would like me to call [Dr K] for an opinion as to how things were progressing and each time this request was refused after discussion between all of us. In view of the fact that the baby was dead and [Ms A] seemed to be coping well with her labour, I agreed with this plan."

At 5pm Dr I handed over to obstetric consultant Dr K. She briefed him on the circumstances of Ms A's admission and that intrauterine death had occurred at 43 weeks' gestation. Dr I told Dr K that Ms A's labour was progressing well and her LMC would call for assistance if it was needed.

Delivery
At 5pm Ms B informed Mr J that the baby's head was "on view", and at 5.47pm he recorded Ms B's observation that the delivery was "gradually progressing". Mr J stated:

> "I had been checking on progress a number of times and eventually, after about three hours of pushing, urged [Ms A] to move to the delivery room mainly so we could try a change of position to see if that would aid progress. [Ms A] acquiesced but moving her was difficult and she elected to walk [there]. She did have a partially born face presentation and sitting in a wheelchair would have been difficult, I think the only reason I gained consent was because [Ms A] was becoming exhausted, and had endured considerable pain in her attempts to bear this baby naturally."

Ms A stated that Ms B refused to call an obstetrician "even though it was clear that the situation soon became well beyond her level of expertise". She said that Ms B repeatedly said, "What's HE [i.e., the obstetrician] going to do?" Ms A stated that it was Mr J who eventually insisted on seeking such intervention.

Ms B stated that at about 7.30pm, Mr J suggested consultant review. She recalls asking, "What would he do?" implying that the consultant's role needed to be explained to Ms A and Mr A. She said that it was not her intent to block a consultant review. She recalls that Mr J did not explain anything. He left the room and returned a

short time later to inform them that he had spoken to the consultant, who had suggested intravenous (IV) fluids. Mr J introduced a luer and started the IV fluids.

Mr J stated that as soon as Ms A was settled into the delivery room he introduced an intravenous line and started an infusion of normal saline at a rate of 250ml per hour. The clinical records show that the intravenous line was established at 8pm. Mr J does not recall having any difficulty introducing the intravenous line.

Ms B explained to Ms A and Mr A what was happening. Ms A was pushing with every contraction, and the baby's head was visible as far as the top his forehead.

At this time, Ms B said that she was "soaking wet from the shower" and told Ms A and Mr A that she needed to change her clothing. She left to change into a patient gown.

While Ms B was away, Mr J examined Ms A and recommended to her that an episiotomy would assist the delivery of the baby's head. He recalls that this suggestion was initially refused. He asked Ms A and Mr A why they would not consent to this procedure. Their response was that they believed that it would cause an uncontrolled tear to the perineum. Mr J explained the procedure and assured Ms A and Mr A that episiotomy prevented uncontrolled tearing. He obtained their consent to perform the procedure and, at 8.10pm, infiltrated the perineum with 15mls of 1% lignocaine (local anaesthetic) and prepared to perform the incision.

Dr K stated that he received a call from Ms A's delivery room at approximately 8.10pm, advising him that although she was pushing well and the perineum distending with a facial presentation, the midwife could not deliver the baby. Dr K arrived in Ms A's room about five minutes later.

Mr J recalls that when Dr K arrived in the room he asked why the episiotomy had not been performed. Mr J performed the episiotomy and said that he was surprised how easily the head was delivered once the episiotomy was performed.

Mr J attempted for several minutes to complete the delivery, observed by Dr K. However, shoulder dystocia[7] prevented him from delivering the baby's body. Mr J said, "I could not get the shoulders to rotate and deliver. It was at this time that the skin on the baby's neck tore with my efforts to apply traction." Mr J asked Dr K to take over.

Ms A recalls that Dr K tugged "violently" to try to deliver the baby. This caused her considerable pain and, despite her requests, she was not offered any pain relief. She

[7] Shoulder dystocia is where the baby's shoulders are too broad to enter and be delivered through the pelvic outlet. It is most apt to occur in women with diabetes, multiparas and in post-date pregnancies. The problem is often not identified until the head has been born. The condition may be suspected earlier if the second stage of labour is prolonged, if there is arrest of descent or the head appears on the perineum and retracts instead of protruding with each contraction.

said that Dr K's efforts to deliver the baby "ripped the skin off [his] shoulders". She believes that Dr K did not tell her and her partner what was happening and they felt that he was not listening to them.

Dr K stated that when he entered Ms A's room he asked the midwife why an epidural anaesthetic had not been recommended. He was told that Ms A had refused all anaesthesia, including an epidural.

Dr K stated:

> "I advised [Ms A] that I needed to examine her and try and deliver the baby. In terms of pain relief [Ms A] was using Nitrous oxide and had 100mg of Pethidine administered at 10.20am and 1.05pm (as indicated in the charts prescribed by [Dr I]). Her perineum was also infiltrated with local anaesthetic by the midwife prior to the episiotomy. On examination I found that the shoulders were lying transversely and tried to rotate the baby, however, it was difficult due to laxity of the baby, and the patient was in distress. I indicated that she should be taken to theatre for delivery under anaesthesia as all attempts to deliver the baby were not successful and painful. This was agreed to and I spoke with the anaesthetist to arrange theatre for the delivery. …
>
> I did not discuss the analgesia with [Ms A] before the examination as I was aware from the notes that it was being managed and also it was the priority to establish why there were difficulties delivering the baby."

The clinical records show that intravenous Syntocinon, to augment the uterine contractions, was commenced at 6mls per hour at 8.25pm, and Plasmalyte (a blood expander) was started. At this time a McRobert's manoeuvre[8] was tried, unsuccessfully, to deliver the baby's shoulders. Ms A was transferred to theatre.

The anaesthetist commenced the anaesthetic in theatre at 8.29pm. Dr K effected the manual vaginal delivery at 8.55pm on 27 September 2006.

The Medical Certificate of Causes of Fetal and Neonatal Death recorded the time and circumstances of the baby's delivery, that he weighed 4365gms (10lbs 1oz), and had died two days before delivery.

The placenta was sent to the hospital pathology laboratory for routine post-mortem examination. The pathology report, sent to Dr I and Ms A's general practitioner, stated that no specific pathological abnormalities were found.

Postnatal care

At 11.30pm on 27 September, Ms B weighed and measured the baby — finding him to be 4365gm, which she recorded in the Trust computer records, incorrectly, as

[8] McRobert's manoeuvre may assist in delivering the baby's anterior shoulder. The woman is positioned with her thighs sharply flexed on her abdomen which widens the pelvic outlet.

equating to 9lbs 1oz. Ms B performed a karakia [incantation/prayer] for the baby. She discussed with Ms A and Mr A whether they would consent to a post mortem being performed, and arrangements for the funeral. Ms A and Mr A were unable to make any decisions at that time. Ms B removed the intravenous cannula from Ms A's arm and left them to try to sleep.

Ms A complained that Dr K failed to provide her with the necessary follow-up information when he saw her on the morning of 28 September. He did not give her sufficient information about preventing lactation except to advise her to wear a tight brassiere for three days. He also did not provide any information about haemorrhoids and how to treat them, or how to promote healing of the episiotomy.

Dr K stated that he saw Ms A at 9.30am on 28 September. She had no unusual bleeding and told him that her pain was under control. He does not recall, and did not record, that Ms A reported any other complaints such as haemorrhoids. He confirmed that he advised her to wear a tight bra continuously for several days for milk suppression. He told Ms A that suppression of lactation by medication is not recommended. Dr K recalls that he then told her that she should have blood tests to ascertain whether there were any rare causes for her baby's death. He told her that if she agreed to this testing, the obstetric house surgeon would explain the protocol to her and, at her postnatal review in six weeks' time she would be advised of the results of the tests. Dr K explained that any questions she had about what had happened during her pregnancy and delivery and future pregnancies could be discussed at the postnatal review. He said that although he was aware from the notes that Mr J had had a long discussion with Ms A and Mr A about post mortem, he mentioned the role of a post mortem in finding a cause for the baby's death.

Dr K's record of this discussion is in the clinical notes. Mr J recorded that he discussed post mortem with Ms A, and that the likelihood of "placental degradation" being the likely cause death was discussed. Ms A and Mr A did not consent to a post mortem.

Clinical record — follow-up action
Mr J stated that on 28 September he asked Ms B to provide Ms A's antenatal notes. He said, "She stated she had very few A/N [antenatal] notes, mostly in her diary and that it was not a priority for her to gather that information at this time. It would be available at a later date."

Ms B stated that at about 10.30am on 28 September, as she was leaving home, she received a phone call from Mr J asking when she would arrive at the Public Hospital because Ms A and Mr A were ready to leave. Ms B told him she expected to be there at about 1.30pm. Ms B arrived at the hospital at 2.30pm and gave Ms A the "handheld" notes she had requested. Ms B advised Mr J that Ms A had her notes. Ms B told him that she would have the Trust administrator enter the notes from her diary into their computer system and send the records to the Public Hospital.

Mr J advised Ms B that the DHB Maternity Services General Manager Ms L wanted to speak with her when she arrived at the hospital. He recalled that Ms B replied that this meeting would have to take place "at another date". Ms B recalls that as she was leaving the hospital she met Ms L in the corridor. Ms L asked her to write up her notes for Ms A's labour. Ms B said that she was surprised by the request but consented to do so. Ms B said that she did not receive a call from Ms L to schedule an appointment for a meeting, but she was aware that Ms L would be attending a meeting at the rural Hospital maternity unit and planned to give her notes on Ms A to her at the meeting.

Ms B advised the DHB that "[d]ocumenting notes was not an essential part of what [Ms A] required of me, hence brief notes in my diary were taken. … I do not accept that the documentation is inadequate in this situation."

Ms B's diary notes
Ms B's diary entries relating to her visits to Ms A are as follows:

15 March 2006
"EDD BP 110/60 [other words are illegible]."

27 March 2006. This page does not appear to have any notation relating to Ms A.

20 April 2006
"[Ms A] back from [illegible] Water 538 29 [home]. Cancelled until Wed next week"

24 May 2006
"[Ms A] letter"

31 May2006
"✓ [Ms A] A/N[9] [symbol indicating lie of the baby][10] FHR[11] 144, well, DVD, H20"

27 July 2006
"[Ms A] A/N well, FHH[12] 144, GFMS = dates"

25 August 2006
"[Ms A] ✓GFMS[13], FHH 150, pool next visit, pito ✓ stone = dates [symbol indicating lie of the baby]"

23 September 2006

[9] Antenatal
[10] Symbol representing the fetus in a cephalic (head first) position
[11] Fetal heart rate
[12] Fetal heart heard
[13] Good fetal movements

"[Ms A] AN 42+4[14], IOL[15] declined, whanau Hx[16], GFMS D [symbol indicating lie of the baby] well, whanau disc"

26 September 2006

1200 — "[Ms A] phone called."

"2030 [Ms A] called, tx WBH[17] SB[18] "

There was an "Antenatal Visit" entry by Ms B in the maternity record book, not dated, which notes Ms A's blood pressure as 118/82 and her pulse as 88 beats per minute (bpm). Ms B recorded only two appointments at the rear of Ms A's maternity record book.

The Trust documentation policy

Ms B said that a quality improvement policy was implemented that specified that all consultations with clients were to be recorded in the Trust's patient profile system immediately after the visits or within 24 hours of the consult. She stated that in her role as the Trust maternity manager she had quarterly discussions with the midwifery team concerning notes and training. Ms B stated that the midwifery team offer their clients the choice of holding their own notes. This is the preferred option for the midwives and is supported by more than 99% of the clients. Ms B stated that having handheld notes complies with the documentation requirements of section 88 of the Ministry of Health's New Zealand Public Health & Disability Act 2000.

Audit of Trust computer records

On 27 February 2007 an audit was conducted of Ms B's recording of her antenatal consultations with Ms A. The audit found that between 11.34am and 3.16pm on 5 January0 Ms B made 35 entries in Ms A's records. There were 29 further entries between then and five months later, made by Ms B and midwives Ms D and Ms F.

The computer record does not correspond with Ms B's diary notes in relation to dates and information recorded.

Additional information

The District Health Board

Mr J said that Ms A and Mr A had planned a non-interventional home birth. He said that as events unfolded, they still wished to have as normal a birth as possible. Mr J said that he believed that the information provided to Ms A and Mr A by Ms B about the dangers of a prolonged pregnancy and obstetric and midwifery procedures "seemed very inaccurate".

[14] 42 weeks and 4 days' gestation

[15] Induction of labour

[16] History

[17] Transfer to Public Hospital

[18] Still birth

Dr I stated that the labour and delivery of a stillborn baby is a very sad and difficult time. She said that she did her best to provide Ms A with the best possible care and advice. Dr I said that she regrets that Ms A and Mr A felt disempowered throughout this time. She informed them of her findings and believes that they were involved in all decisions made, including when and whether Ms A underwent an induction and what pain relief she had during her labour.

The Public Hospital Maternity Unit Manager Ms L said that she was required to meet with Ms B to discuss the care she provided to Ms A, in particular that the pregnancy had continued to 43 weeks and 3 days' gestation with no midwifery care documented for the last 17 days. She said she offered to meet individually with Ms B to allow her the right to reply prior to any assumptions being made about her practice. However, Ms B declined to meet one-to-one with Ms L. Ms L informed Ms B that an investigation was being undertaken and that she was required to produce her antenatal, obstetric and medical history for Ms A. Ms B provided this information two months later in an electronic form. Ms B was informed that her Access Agreement with the DHB was suspended.

Midwifery Council
On 27 April 2007, the Midwifery Council advised that Ms B's practising certificate expired and she has not sought to renew it.

Follow-up of complaint
On 6 December 2006, Ms L and Dr N co-signed a letter to Ms A and Mr A to thank them for their letter dated 29 October 2006 outlining their concerns about the services provided to them by Ms B and the Public Hospital. Dr N stated in his opening paragraph:

> "Could we please first offer our condolences for the stillbirth you have recently suffered, and secondly apologise for the time it has taken to reply to your letter. You raised many points, which we have had to investigate and consider, all of which take time."

Ms L and Dr N went on to address the issues identified in the letter, under the following headings: respect and dignity, proper standards, communication, information, informed choice and desired outcomes. They concluded by noting that Ms A and Mr A had an appointment on 21 December to meet Dr N at the rural hospital's Outpatient Clinic, and that they would be happy to discuss matters further at that meeting.

On 30 January 2007, Ms A and Mr A wrote to Dr N to advise that they were not satisfied with the responses to their complaint, in the letters of 6 December 2006 and 3 January 2007 or during the meeting on 28 December 2006.

The Trust
The Trust Chief Executive Officer Mr M advised that Ms B was employed as a midwife by the Trust in August 2004. Ms B's job description was to contribute to the

midwifery service of the trust by providing the highest quality women-focussed care in accordance with New Zealand midwifery standards of practice. He said that as part of her job description, Ms B, among other things, was "to provide informed consent in all midwifery care; communicating effectively and clearly with patients and their families and working with the highest quality standards of practice by ensuring that documentation was up to date and complete at all times and meeting the requirements of the documentation guidelines".

Mr M said that Ms B came to the Trust highly recommended and, after a year of working for the Trust, she was appointed Tamariki Ora Manager. Her primary role was to provide clinical and professional leadership for the Tamariki Ora staff, and to act as a professional role model, mentor and support person for staff.

Ms B's job description listed the key accountabilities, which included:

"

- Ensuring documentation is up to date and complete at all times, meeting the requirements of the documentation guidelines. …
- Ensuring care provided is evidence based. …
- Communicating effectively with colleagues, other members of the multi-disciplinary team and external agencies. …
- Providing the woman and her family with education and information regarding management of her pregnancy and through to the postnatal period. …
- Providing midwifery care that reflects the NZCOM standards of practice and SAH Philosophy of Midwifery.
- Practising in a way that reflects the medico-legal and ethical responsibilities of the midwife. …
- Maintaining a high level of personal competence and professionalism in work performance, appearance, attitude and conduct."

Mr M advised that the Trust developed a Client Referral Policy that sets out when a referral should be made and the process. It includes a comprehensive referral guidelines document. The Trust also provided all staff with training in the Profile Client Management System (CMS). The CMS was specifically designed to enable any of the Trust's health care providers to access a patient's profile so that anyone dealing with a patient could immediately identify the previous care provided and any unresolved issues. The midwives, including Ms B, attended Profile training in February 2006. It was Ms B's responsibility, as a manager, to ensure that all staff complied with the requirement that they record all contacts with their patients into the system. Mr M stated:

> "[The Trust] therefore expected [Ms B] to enter any appointments she had with her patients (including [Ms A]) onto the CMS system. This information would either be entered at the time of the appointment if it were on site, or alternatively shortly after the consultation off site. … I have concerns about apparent retrospective recording by [Ms B]."

Mr M advised, "[T]he Trust is doing everything within its power to ensure that its midwives meet the highest professional standard and as part of an on-going comprehensive external audit is looking closely at the issues raised by [Ms A]."

Antenatal education

Ms A stated that the Trust does not provide a series of antenatal classes as other maternity facilities do, but provides "a single one-off class". Ms A stated that the purpose of the class "seemed to be to reassure the first-time parents that everything would be fine and nothing would go wrong". Ms A and Mr A said that they had hoped to receive advice about how to care for their baby when he was born, and were surprised to be told that it was not necessary to be taught these skills because it was "all instinctive".

Ms A stated that there was no structure to the antenatal classes. It was left up to the parents attending to ask questions. She said that at the classes she attended only one woman had previously had a baby. The other mothers "didn't know anything about anything". She said they were "desperate to be told what to expect". There was a big emphasis on home births. Ms A stated that it was all "very much about how hands off is the best policy". She recalls being told: "[Y]ou won't have an infection because the fluid keeps coming out in one direction … there's no infection that can come back the other way." She said that the response of the midwives to the question about what would happen if you were overdue was, "Don't even worry about it … Baby will come out sooner or later. … Baby's got to come out sometime."

Mr M advised that there is no funding for antenatal classes in this town. Midwife Ms C stated that the classes take the form of a "group discussion". Ms C said that it is an informal gathering of pregnancy clients, usually women having their first baby. The sessions are a "one off", not a series. Attendance is by information provided by each client's LMC.

Ms C said:

> "The main aim of the morning talk is to initiate discussion, allay fears and build confidence. Specific issues, i.e. Induction of labour, post-term pregnancies are not discussed at length. This is a separate discussion each client should have with their own LMC."

Ms C said that the service promotes normal midwifery care and natural birth in the primary setting. Since this complaint, Ms C has facilitated two more sessions. However, the Trust has no policy or protocol for formal, structured antenatal sessions, and there is no plan to apply to the DHB for an antenatal class contract.

Independent advice to Commissioner

Expert advice was obtained from independent midwife Ms Tungane Kani, and is attached as Appendix 1.

Responses to Provisional Opinion

Ms A and Mr A
Ms A and Mr A responded to the provisional opinion by reiterating a number of their concerns about the service provided to them by Ms B and the Public Hospital's maternity unit. Ms A and Mr A's response included the following comments:

> "I find it interesting to read about [Ms D's] concerns about our plans to have a home birth. It is unfortunate — in the extreme — that at no time did she share her concerns with us. We had been assured by [Ms B] that our birth plan was safe and appropriate. At no point did anyone from the [maternity] service alert us to the potential dangers of our plan to have a home birth, given our particular circumstances.
>
> If [Ms D] felt that she was too 'stretched' to add us to her caseload, then she should have made alternative arrangements. … Why did the staff of the [maternity] service fail to communicate and co-ordinate with one another? …
>
> The reason we made our complaint was to try to prevent further senseless tragedies from occurring. We continue to miss our son and feel the pain of his loss sharply, every single day of our lives."

Ms B
Ms B stated:

> "We have all spent the past year reflecting on this whole review process whereby much of the outcome being predetermined well before the HDC process of review has been completed. The political, personal and professional learning has been life changing.
>
> In terms of professional development I have undertaken a NZQA upskilling in a paper at Massey University, the current enrolment is for Leadership and Communication in Adult Education and Training. …
>
> I have also undertaken a NZQA Quality Review Training of 2 days and received a certificate for this. I have also undertaken 120+ hours of peer reviews in clinical quality processes such as documentation of policies, guidelines and procedures under the supervision of the Quality Review

Manager/Coordinator. I still have one more review of 40 hours to complete under supervision of the coordinator …

I have also undertaken tikanga waananga [customer workshops] under the cultural supervision of Te whanau o Ngati Aapakura. These waananga [workshops] are held monthly at various [marae] under the supervision of kaumatua and kuia [Māori elders].

I have enrolled in the Turanga Kaupapa that is recognised as points towards professional development by NZMC and NZCOM. Turanga Kaupapa will be presented at [a] Hui in [date]. …

As a public health servant I respectfully apologise for the loss and pain and I seek a just and dignified outcome for the entire quality review process of the HDC. The loss of the stillbirth has been a significant loss at all levels to family, whanau and community and I see your earliest response to bring closure and healing for 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;

Other standards

The New Zealand College of Midwives published the *Midwives Handbook for Practice* (2005), which states:

> "Standard one
>
> The midwife works in partnership with the woman.
>
> Criteria
> The midwife:
>
> - Recognises individual and shared responsibilities
> - Facilitates open interactive communication and negotiates choices and decisions
> - Shares relevant information within the partnership …
>
> Standard two
>
> The midwife upholds each woman's right to free and informed choice and consent throughout the childbirth experience.

Criteria
The midwife:

- shares relevant information, including birth options, and is satisfied that the woman understands the implications of her choices …
- clearly states when her professional judgement is in conflict with the decision or plans of the woman …

Standard three

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

Criteria
The midwife:

- collects and compiles information from the first visit for antenatal care or at the first formal contact with the woman …
- documents her assessments and uses them as the basis for on-going midwifery practice.

Standard four

The midwife maintains purposeful, ongoing, updated records and makes them available to the woman and other relevant persons.

Criteria
The midwife:

- reviews and updates records at each professional contact with the woman
- ensures information is legible, signed and dates at each entry
- makes records accessible and available at all times to the woman and other relevant and appropriate persons with the woman's knowledge and consent."

Relevant guidelines

The Ministry of Health's section 88 of the New Zealand Public Health & Disability Act 2000, appendix 1, 'Guidelines for Consultation with Obstetric and Related Specialist Medical Services (Referral Guidelines) are **attached** as Appendix 2.

Opinion

This report is the opinion of Deputy Health and Disability Commissioner Tania Thomas, and is made in accordance with the power delegated to her by the Commissioner.

Opinion: Breach — Ms B

Rights 4(1) and 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code) states 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 accepted midwifery competence performance criteria which includes the following issues — that the midwife: "shares relevant information, facilitates open, interactive communication and clearly states when her professional judgement conflicts with the woman's plans or decisions".

In 2006, the Māori midwifery group Nga Maia published *Turanga Kaupapa*, which states that the "midwife is a key person with a clear role and shares with the wahine [woman] and her whanau [family] the goal of a safe, healthy, birthing outcome".

Services provided
Ms A and Mr A stated that while they sought a natural approach to their pregnancy and childbirth, they did not intend to "forsake" the use of conventional medicine when its use was warranted. They complained that Ms B actively discouraged them from taking up testing options, failed to keep antenatal appointments, did not conduct adequate antenatal examinations and did not accurately record the details of her antenatal visits.

The Midwives *Handbook for Practice* identifies decision points for midwifery care. The first decision point in pregnancy, which is timed to occur within the first 16 weeks of pregnancy, notes that this timing allows for a comprehensive health assessment to be made. The assessment should include taking a medical and obstetric history from the woman, a physical examination to include a check of the woman's blood pressure, urine, and blood antibodies, and an assessment of uterine size. At this time the birth plan should be commenced to identify the woman's choices for pregnancy and childbirth care.

On 26 January 2006, Ms A consulted her medical practitioner, who ordered routine maternity blood tests and suggested that she take leave over February because of intermittent vaginal bleeding. Ms A believes she saw Ms B for the first time, and completed her birth plan, in January. However, Ms B's first record of meeting Ms A was on 1 March 2006. Ms B's record of that meeting was a general discussion about

the service that she and the Trust midwifery team could provide. She noted that Ms A was given a form for antenatal blood tests, that a scan was booked for 20 April, and Ms A was to decide whether to accept Ms B as her LMC. This was confirmed at the follow-up check on 14 March. According to the computer record of this visit, Ms B checked Ms A's blood pressure and urine and performed a physical check, palpating her abdomen. The expected date for the birth was recorded as 5 September 2006.

At subsequent visits, Ms B did not perform any of the accepted routine antenatal examinations. She listened to the baby's heart rate at most visits with a pinard and noted the fetal movements. However, she checked Ms A's blood pressure only three times, and did not assess her weight gain or test her urine for protein.[19]

My independent midwife, Ms Tungani Kani, advised that the professional standards of midwifery practice give clear guidance for the expected care and how this is implemented. The midwife is expected to collate and document comprehensive assessments of the woman and the baby's well-being throughout the pregnancy. These assessments should include a check of the mother's blood pressure and urine. The presentation and lie of the baby, its size and heart rate should be routinely checked and recorded. There should also be discussion about the social and emotional aspects of birth and postnatal care. Midwifery care is planned with the woman.

There is discrepancy about the choices Ms A made about her antenatal care. Ms B said that Ms A declined "clinical care" and routine antenatal assessments such as blood pressure and urine tests. She assumed that this was because Ms A was a "fully informed" health professional. Ms B stated that she believed she was supporting Ms A's decision to decline all clinical care and maintain a natural approach. She said, "I feel now this was an error of judgement."

Ms A denies that she and Mr A declined all clinical care. She said they did not know "all the tests that can be done, why they are done and how they are done". Ms A gave an example of the ultrasound scan, which was performed on 20 April, and said that she wanted to have the scan. Ms A described herself as a person who has to "know things are OK". She said that Ms B "actively discouraged" them from taking up testing options and advised that such medical interventions were harmful to the baby.

On 11 September Ms B went on leave for two weeks and handed over the care of Ms A to another independent midwife, Ms D. Ms B stated that she formally handed over the care of Ms A to Ms D at a meeting on 11 September, providing a comprehensive care plan. Ms D disputes this. She said that Ms B called at her house at 9pm to inform her that she was going to be away for 10 days and wanted her to be available should Ms A call. Ms D was not familiar with Ms A's history and was not provided with any clinical records. Ms D also informed Ms B that she did not have the necessary

[19] The presence of protein in the urine (proteinuria) may occur in the obstetric conditions pre-eclampsia and eclampsia, conditions that can, in serious cases, result in convulsions and present a considerable risk to the mother and baby.

experience and confidence to deliver a first-time birth at home so far from the hospital.

Ms D telephoned Ms A and arranged to visit on 17 September. The visit did not take place and Ms A was not contacted again until Ms B returned from leave on 23 September.

My expert, Ms Kani, advised that when Ms B took leave in September 2006, leaving Ms A, who was 41 weeks' gestation, to her colleague's care, she should have had a more decisive plan of action. Ms Kani stated that decision point six (42 weeks) is timed to allow the midwife to critically assess the woman and her baby with a view to referral if there are concerns about the pregnancy being prolonged. The assessment is based on a history of the woman's well-being and the baby's movements, as well as an examination of the mother to assess the presentation, lie and descent of the baby, liquor volume and heart rate. A CTG should be performed, and the mother's blood pressure taken and urine tested for protein. The LMC should discuss with the mother her options for additional care and support, agree on subsequent decision points and check whether adequate support networks have been arranged. Ms Kani stated that Ms B should have ensured that Ms A had another visit which included a full assessment and a CTG, not just a telephone call.

Referral to obstetric specialist
The Ministry of Health's section 88 of the New Zealand Public Health & Disability Act 2000, appendix "Guidelines for Consultation with Obstetric and Related Specialist Medical Services (Referral Guidelines)" states that prolonged pregnancy, that is a pregnancy that has gone past 41 weeks, is a level 2 referral. That means that the LMC must recommend to the woman that a consultation with a specialist is warranted.

When Ms B saw Ms A on 23 September, she recorded in her diary that Ms A's pregnancy on that date was 42 weeks and 4 days. Ms B indicated by means of a diagram that she assessed the baby to be in a normal position in the pelvis and that there were "GFMS" — good fetal movements seen. According to the computer record (entered retrospectively), Ms B discussed with Ms A and Mr A the option of seeing a consultant at the rural hospital or travelling to the Public Hospital for an induction. Ms B recorded, "IOL [induction] declined." She also noted that Ms A and Mr A were "still keen to maintain a natural focus" and wait until labour started. Ms Kapu recorded that she was "anxious", but would "continue to care for them in their decision". Ms Kapu made no further arrangements to visit Ms A, who assumed that she was waiting for her labour to start. Ms A's baby died on 26 September 2006.

Ms A stated that Ms B's record of this appointment "does not in any way reflect the truth". Ms A recalls that Ms B "went to pains" to reassure them that it was normal to be so far overdue. Ms A asked about induction and was told that the procedure was very unpleasant and harmful to the baby. They were not offered an appointment to see an obstetrician. Ms A stated that it was not until after the baby died that she became

aware that it was routine practice for all women who go 10 days past their due date to be seen by an obstetrician.

Ms Kani advised that the referral guidelines clearly state that when a pregnancy has gone past 41 weeks, an LMC *must recommend* to the woman or parents that a consultation with a specialist is warranted, and that the pregnancy, labour, birth and baby may be affected if the pregnancy continues. I accept that there was discussion between Ms B, Ms A and Mr A about induction. However, there is no evidence that Ms B recommended that they see an obstetrician to further discuss induction and the risks of continuing with the pregnancy. Accordingly, Ms B did not provide Ms A with services that complied with professional standards, and therefore breached Right 4(2) of the Code of Rights.

Provision of information
As previously discussed, Ms A and Mr A did not know that routine antenatal tests should be done. They described themselves as "desperate to know" and had attended the single "one-off" antenatal class provided by the Trust midwives. They were disappointed that there was no structure to the class and that when they asked questions about risk factors such as going overdue they were provided with platitudes. The Trust is not funded to provide antenatal classes. The purpose of the informal meetings run by the midwives is to initiate discussion to build parent confidence.

It is a sad indictment of the standard of the care provided by their LMC that Ms A and Mr A attended a meeting with other mothers "desperate to know". They should have had this information provided to them by their midwife. They did not know that it was a considerable risk to go three weeks past due dates, and that Ms B should have recommended that they see an obstetrician. Although Ms A knew about induction of labour and would have preferred not to have the procedure, she would have consented had she known about the degree of risk to her baby. I do not accept that it was reasonable for Ms B to assume that because Ms A was a health professional she would be fully informed about the process of pregnancy and childbirth.

In another opinion,[20] the Commissioner said that a reasonable patient would want to be adequately and appropriately informed of any risks. The Commissioner stated, "It cannot be assumed by health professionals that patients have an understanding of the significance of their personal history and understand their risk factors, in the absence of full explanation."

As mentioned earlier, there is discrepancy about the discussions that took place between Ms A, Mr A and Ms B on 23 September. Ms A had been given a herbal remedy by a friend to hasten the onset of labour. Ms B discouraged her from taking any herbal remedy, saying that this would "drug the baby". Ms A stated, "She never spelt out that there was any risk that [the baby] might die as a result of the pregnancy continuing for so long."

[20] Opinion 03HDC00837, 2 December 2003, page 27.

Ms Kani advised that there is a lack of evidence that Ms B provided unbiased information in making decisions regarding her midwifery care. She stated that it is usual practice at 41 weeks for a mother to be referred to an obstetrician for a consultation so that she is known to the secondary care services. Then, if she has not delivered at 42 weeks the mother can be reassessed with a view to induction. Ms Kani stated that "any declining of treatment then made by the client could be truly said to have been made with full information being provided to her and her partner and then perhaps a further waiting could be negotiated".

The paucity of Ms B's notes and her inadequate explanations and reasoning for her clinical decisions, her failure to perform routine antenatal checks of maternal blood pressure and urine, and to advise Ms A when she passed her due date of the risks involved and that she should consult an obstetrician with a view to discussing induction, lead me to prefer the evidence of Ms A and Mr A. I do not accept that Ms A was responsible for determining the inadequate standard of care Ms B provided. Ms B was an experienced midwife who was well aware of the professional standards. She failed to comply with those standards and to provide Ms A with a service with reasonable care and skill, breaching Rights 4(1) and 4(2) of the Code of Rights. Additionally, Ms B did not provide Ms A with the information that a reasonable consumer would expect to receive, and therefore breached Rights 6(1)(a) and 6(1)(b) of the Code.

Record keeping

The New Zealand College of Midwives *Handbook for Practice* states that one of the midwife's performance criteria is that the "midwife maintains purposeful, ongoing, updated records and makes them available to the woman and other relevant persons". Ms Kani advised that the criteria for Standard Four of the *Handbook for Practice* also requires the midwife to review and update the records at each professional contact with the woman, and ensure that the information is legible, signed and dated at each entry.

Medical records are essential to guide future management, and should be accurate and legible, and contain all the information relevant to the client's care. It is in both the client's and the practitioner's best interests to keep records of the consultations, as it is this record that enables appropriate treatment plans and continuity of care.

Ms Kani stated:

> "The most obvious omission in the antenatal services provided — is the absence of documentation and clinical recordings which support the Midwifery care that [Ms B] provided."

When Ms A was admitted to the Public Hospital, Ms B was asked to provide the antenatal notes. Ms B provided two explanations for not being able to produce the records. She said that the notes had "inadvertently been left in another car". She also stated that Ms A had possession of her "handheld" records, but when it became

obvious that this was not the case Ms B advised the hospital midwife that "there was not much written" in the notes. She said that this was because Ms A had "consented to only one entry in her handheld notes". Ms B informed the hospital midwife that she "knew every detail of [Ms A's] care and could give accurate antenatal information as required".

Ms B's diary entries were very brief, in some cases only a word or two. Ms B stated that "documenting notes was not an essential part of what [Ms A] required of me, hence brief notes in my diary were taken". Ms A refuted Ms B's statement about her wish to have no information recorded. The antenatal record book retained by Ms A, the "Whanau Midwives Confidential Maternity Record" has scant information apart from Ms A's recording of her birth plan ideas. Ms B made only two brief clinical entries in the book and two appointment dates.

On 28 September, Mr J asked Ms B to provide Ms A's antenatal records. Ms B told Mr J that she had "very few" antenatal notes, that they were "mostly" in her diary and she would provide them at a later date. She said she would ask the Trust administrator to transcribe her diary notes into the computer and make this record available to the Public Hospital. Ms B did not provide this information until two months later, when she produced a detailed computer record of her antenatal consultations with Ms A and the discussions they had about the progress of the pregnancy. Ms A disputes the accuracy of the records and believes that the inaccuracies demonstrate that Ms B made retrospective entries into the computer.

An audit of Ms A's computerised clinical records show that the bulk of the entries were made about a week after the birth. Retrospective recording of clinical records is permitted if the records are annotated as such. These were not recorded as retrospective. By not clearly labelling her records as "retrospective", Ms B acted contrary to the standards outlined in the 2002 NZCOM[21] Consensus statement and the NZCOM Handbook for Practice.

Ms B stated that she was able to enter the record using her diary and her memory. I am not convinced that Ms B had sufficient information in her diary to enable her, weeks and months after the events, to accurately recollect and record the detail she did. The number of discrepancies that Ms A and Mr A identify illustrates why clear detailed notes made at the time, or as soon as is practical afterwards, are so important. As noted by the High Court, it is through the medical record that health professionals have the power to produce definitive proof of a particular matter. Health professionals whose evidence is based solely on their subsequent recollections (in the absence of written medical records offering definitive proof) may find their evidence discounted.[22]

[21] New Zealand College of Midwives.

[22] *Patient A v Nelson-Marlborough District Health Board* (HC BLE CIV-2003-2004-14, 15 March 2005).

Ms B's record of Ms A's pregnancy did not meet the professional standard. I am concerned about the manner of Ms B's retrospective recording of her consultations with Ms A. In my view these records are a self-serving attempt to prove that she provided an appropriate standard of care. Accordingly, Ms B breached Right 4(2) of the Code.

Care during labour
Ms Kani noted that Ms B stated that Ms A and Mr A asked her to deliver their baby and that she agreed to provide them with support and advocacy. Ms Kani advised that Ms B provided Ms A with support. However, Ms B was deficient in her role as Ms A's advocate. She should have recognised earlier the delay in the progress of the labour and sought support from secondary services when it became clear that she had reached the limit of her expertise.

Ms B handed over the care of Ms A to the Public Hospital secondary services at about 2am on 27 September when Ms A was admitted. Ms B left the hospital at this time. She asked the hospital staff to call her back when Ms A's labour was established. Obstetrician Dr I performed an ultrasound scan at 2.50am which confirmed that the baby had died. She informed the parents of this and gave them information about their options for delivering their baby. When Ms A and Mr A consented to an induction of labour, Dr I administered a prostaglandin vaginal pessary at 4.20am to induce labour. Ms A's labour proceeded normally until about 2.30pm, when Dr I performed a vaginal examination to assess progress and found that the baby was a facial presentation. Dr I ordered pain relief for Ms A and advised the hospital midwife, Mr J, who was supporting Ms A, that she would assess progress again in three hours or sooner if there were any problems.

Ms B returned to the Public Hospital at 3pm. She said she advised Mr J that she was acting in a support role only, but "felt obligated to provide care" because Mr J left her to provide most of the care to Ms A. Mr J was clear that Ms B was Ms A's prime carer.

At 5pm Dr I handed over to the on-call obstetrician, Dr K, and briefed him about Ms A. At 5.45pm Mr J became concerned that Ms A had been pushing for three hours and suggested that she move from the labour room to a delivery room where there was more room to try a change of position, which might aid progress. Mr J also advised Ms A that she needed intravenous fluids. He introduced an intravenous line and commenced the fluids.

At about 7.30pm Mr J suggested calling in Dr K to assess Ms A. Ms B was reluctant to have Dr K involved and encouraged Ms A to continue to push as the baby's forehead was just visible. At this time Ms B decided to leave the delivery room to change her clothing because she was wet from standing in the shower earlier with Ms A. Mr J examined Ms A and advised her that she needed an episiotomy to deliver the baby's head. Ms A and Mr A were reluctant to agree to this procedure, but Mr J convinced them of the necessity. Mr J called for Dr K.

When Dr K arrived in the delivery room he instructed Mr J to perform the episiotomy. Mr J attempted for some minutes to deliver the baby, but he was big and his shoulders were stuck. Dr K took over but was also unable to deliver him. The attempts were painful and distressing for Ms A, who had been given only pethidine and a local anaesthetic. She was transferred to theatre for a general anaesthetic so that the delivery could be completed. The events were extremely traumatic for Ms A and Mr A.

Ms Kani advised that Ms B "should have recognised earlier the delay in progress and sought support from secondary services when it became clear she had reached the limit of her expertise". Ms Kani commented that Ms A was transferred to the Public Hospital for secondary care from an obstetrician and secondary care midwifery services. She said that in these circumstances it is usual practice to have a three way conversation which includes the mother, her whanau, the obstetrician and support staff and the LMC. The woman is fully advised of her situation, and allowed time to give informed consent and agree to a plan for her care and decide who is to be responsible for delivering that care and monitoring her progress. All of this should be documented in her clinical notes. This did not happen in this case. Ms Kani stated:

> "In view of the outcome of this event for [Ms A], her partner and [the baby] — I would consider that the provider's peers would view [Ms B's] conduct with moderate−severe disapproval."

I support this opinion. Accordingly, I find that Ms B did not provide Ms A with a service with reasonable care and skill or that complied with professional standards, and therefore breached Rights 4(1) and 4(2) of the Code.

Opinion: No Breach — The Trust

Direct or vicarious liability
Under section 72(3) of the Health and Disability Commissioner Act 1994 (the Act), an employing authority, in this case, the Trust, may be vicariously liable for the acts or omissions of an agent. As Ms B's employer, the Trust is vicariously liable for Ms B's breach of the Code unless it can show that it took reasonable steps to prevent it.

Ms B breached Rights 4(1) and 4(2) of the Code. Her contract with the Trust clearly outlined her role and responsibilities towards her clients, and that she was expected to comply with NZCOM's professional standards. Policies were in place to guide staff in relation to referral to related medical services. The Trust provided staff with training in their client information systems, and expected that Ms B would comply with the system. I am satisfied that Ms B's omissions were outside the control of the Trust.

Accordingly, in my opinion the Trust did not breach the Code and is not vicariously liable for Ms B's breaches of the Code.

Ms A was also concerned about an apparent lack of communication and coordination between the maternity clinic staff. Contrary to Ms B's statement, it appears that she did not hand over Ms A's care at a staff meeting, but visited Ms D at home to do this the evening before she went on leave. This was not acceptable practice. However, I am not convinced that Ms B's actions would be representative of the entire maternity clinic staff. I take assurance from Mr M's comment that the Trust is reviewing its overall service in an "on-going comprehensive external audit" in response to the issues raised by Ms A.

Other comment

Ms A also complained about the service the Public Hospital provided to her during her labour and the delivery.

Ms A stated that Dr I did not conduct an adequate ultrasound examination of the baby, and that if she had done so and determined his correct position, the traumatic circumstances of his delivery would have been avoided. Ms A and Mr A also felt that they were denied the opportunity to make informed choices about their options for the management of the labour and delivery. Ms A believes that she was not treated with respect and dignity and felt disempowered. She stated that Dr I did not discuss with them the relative advantages and disadvantages of a Caesarean section versus a vaginal delivery. She said that when Dr I advised her that it was better for her to go through a normal labour, she did not consider the emotional impact of delivering a dead baby.

Dr I stated that she palpated Ms A's abdomen to determine the baby's position before she performed the scan. This was essential for the correct placement of the ultrasound probe, but was also an important part in planning later management. She said that the primary purpose of the scan was to determine whether or not the baby was still alive. When she confirmed that the baby had died, Dr I told his parents and then gave them time to grieve in private before she returned to advise them on the next steps and answer any questions they might have. Dr I provided Ms A and Mr A with information about methods of inducing labour and, when she gained their consent, commenced the induction process. Contrary to Ms A's recollection, Dr I monitored her progress during the early stages of her labour. She physically examined Ms A again at 2.30pm (when she discovered the facial presentation) and handed over to Dr K at 5pm.

I am satisfied that the service Dr I provided to Ms A was reasonable in the circumstances.

Ms A and Mr A were also concerned about the maternity unit facilities, in particular the inappropriate sanitary facilities. Ms A stated that she felt "demoralised, demeaned and humiliated" by the situation she found herself in.

This was a very traumatic time for these parents. Ms A was an employee of the Board, and the maternity staff were mindful of this. This factor, together with the tragic circumstances, influenced the choices staff made in accommodating Ms A. They tried to provide her with as much privacy as possible during her labour, and the room they gave her, although affording privacy meant that Ms A had to walk down the corridor to the toilet. As soon as staff realised that Ms A was distressed by these circumstances, other arrangements were made.

Ms L explained that the maternity unit at the Public Hospital is old, and the layout of rooms is not desirable.

Ms A's labour was difficult. Mr J stayed on past the end of his shift to care for Ms A. He supported Ms B, monitored the progress of the labour, and called Dr K when it became apparent that medical intervention was required to deliver the baby. However, it remains that this was a long, difficult and particularly distressing delivery. There were aspects of the care that could have been improved upon, such as communication about choices for labour management, the choice of labour room and the delay in referring to secondary services. However, I am satisfied that these matters were largely influenced by the decisions made by Ms B.

Follow-up actions

- 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 this report will be sent to the Midwifery Council of New Zealand, with a recommendation that a competence review of Ms B's practice be considered.

- A copy of this report, with details identifying all parties removed, will be sent to a midwifery group and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

The midwife was referred to the Director of Proceedings who decided to take a disciplinary proceeding against her. On 22 June 2009 the Health Practitioners

Disciplinary Tribunal found the midwife guilty of professional misconduct. It held that her conduct amounted to malpractice and negligence and in many instances her conduct amounted to acts or omissions that would bring discredit to the midwifery profession.

In its penalty decision the Tribunal cancelled the midwife's registration. She was ordered to pay $10,000 in costs. The Tribunal also imposed a condition that in the event that she seeks re-registration she undergo a specified course of education set by the Midwifery Council of New Zealand in order to satisfy the Council that she meets the competencies for entry to the Register. The Tribunal also recommended that in the event that she seeks re-registration, consideration be given to her practising under supervision for 18 months, following re-registration.

The Tribunal's full decision can be found at:

http://www.hpdt.org.nz/Default.aspx?tabid=218

Appendix 1

Confidential

06HDC18721

Health & Disability Commissioner

Expert Witness Report

Provided by TM Kani — Midwife

November 2007

Medical/Professional Expert Advice 06HDC18721

Ko Takitimu te Waka

Ko Whakapunake te Maunga

Ko Ruakituri, Ko Hangaroa Ko Kaitarahae nga awa e rere tonu ana ki te Wairoa Hōpupu Hōnengenenge Mātangi Rau

Ko Ngāti Kahungunu, Ko Rangitāne, Ko Ngāti Pakeha ngā Iwi

Ko Ngāti Hinehika, ko Te Hika o Papauma ngā hapū

Ko Tuarenga te Whare Tupuna

Ko Hine Korako te Whare Kai

Ko Te Reinga te Marae

Ko au tēnei e tu atu nei he uri o rātou ma e mihi kau atu ki a koutou

Tenā koutou tenā koutou tenā tātou katoa.

E te mokopuna [baby], moe atu ra i te moenga o ou matua tupuna ki te kainga tūturu mo te tangata.

Kahuri.

I, Tungane Kani have been asked to provide an opinion to the Commissioner on case number 06HDC18721.

I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

I am a Registered Midwife. I hold a Diploma of Comprehensive Nursing from Hawkes Bay Polytechnic 1991 and a Diploma of Midwifery from Wellington Polytechnic 1995. I have been practising as a Midwife since 1996. Three years as a Homebirth Midwife for Community Birth Services in Rangitane from Takapau, Dannevirke and surrounding districts through to Palmerston North. From there I worked as a Case loading LMC in the Wairoa Hospital, a remote rural primary care hospital for approximately 5 years in total where the birthing population was 90−98% Maori. I have also had periods of working as a Tamariki Ora Well Child Nurse in Dannevirke for Te Kete Hauora o Rangitane and in Wairoa for Kahungunu Executive. I am currently working in Gisborne where I was employed by the Tairawhiti DHB as a case loading Team Midwife, now working with a team of Ngā Māia Midwives based in Kaiti and employed by Ngāti Porou Hauora. I am an active registered member of Ngā Māia o Aotearoa since graduating as a Midwife, and a current member of NZCOM. I am an Indigenous Māori Midwife who was also taught by my Kuia Mei Tipoki and her brother Tihema Charles Cooper who was a Traditional Birth Attendant of our whānau hapū tikanga pertaining to pregnancy and childbirth.

Listed below are the sources of information I was provided with by the Commissioner for the reviewing of this case.

Supporting Information

- Letter of complaint from [Ms A] and [Mr A] to the Commissioner, dated 7 December 2006, marked with an 'A'. (Pages 1 to 29)
- Copy of letter to [Ms A] and [Mr A] from [the] District Health Board Obstetric & Gynaecology Clinical Head [Dr N], dated 6 December 2006, marked with a 'B'. (Pages 30 to 32)
- Copy of [Ms A] and [Mr A's] letter to [Dr N], dated 30 January 2007, marked with a 'C'. (Pages 33 to 35)
- Copy of [Ms A's] clinical records received from [the] DHB, dated 15 February 2007, marked with a 'D'. (Pages 36 to 87)
- Response from obstetrician [Dr I], received 14 March 2007, marked with an 'E'. (Pages 88 to 91)
- Response from [the] DHB Maternity Manager [Ms L], dated 15 March 2007, marked with an 'F'. (Pages 92 & 93)
- Response from obstetrician [Dr K], dated 20 March 2007, marked with a 'G'. (Pages 94 to 102)
- Response from hospital midwife, [Mr J], marked with an 'H'. (Pages 103 to 107)
- Response from [the Trust CEO Mr M], dated 30 March 2007, marked with an 'I'. (Pages 108 to 144)

- Letter from [the Trust midwife Ms C], dated 29 July 2007, marked with a 'J'. (Page 145)
- Response from [Ms B], dated 12 April 2007, marked with a 'K'. (Pages 146 to 226)
- Further response from [Ms B], dated 12 April 2007, marked with an 'L'. (Pages 227 to 267)
- Typed transcript of interview conducted with [Ms A] and [Mr A] on 31 July 2007, marked with an 'M'. (Pages 277 to 309)
- Clinical records received from [Ms A] on 15 February 2007, marked with an 'N'. (Pages 310 to 357)

Purpose
To provide independent expert advice about whether midwife [Ms B] provided an appropriate standard of care to [Ms A].

Complaint
The appropriateness of the care independent midwife [Ms B] provided to [Ms A] during her pregnancy in 2006

- The appropriateness of the care independent midwife [Ms B] provided to [Ms A] during her labour and delivery on 26/27 [September] 2006.
- The appropriateness of the care [the Trust] provided to [Ms A] in 2006

Expert Advice Required

To advise the Commissioner whether in your opinion midwife [Ms B] provided [Ms A] with services of an appropriate standard. In particular:

These are my responses to the following questions:-

1. ***Did [Ms B] provide an adequate antenatal service to [Ms A]? If not, please comment on what else she should have done.***

   In the "Midwives Handbook for Practice" (NZCOM) — the professions Standards of Practice give clear guidance for the expected standard of care and how this is implemented.

- Standard 3 "The midwife collates and documents comprehensive assessments of the woman and/or baby's health and wellbeing."
- Standard 4 "The midwife maintains purposeful, on-going, updated records and makes them available to the woman and other relevant persons".
- Standard 5 "Midwifery care is planned with the woman".
- The most obvious omission in the antenatal services provided — is the absence of documentation and clinical recordings which support the Midwifery care that she provided. Followed by the lack of evidence of the sharing of unbiased information in making decisions regarding her midwifery care.

- "provides information from her knowledge and experience; provides access to a variety of other information services; supports the woman in seeking out information" — (p 17 Standard Five, criteria 1−3).

What are the guidelines that apply to the management of a prolonged pregnancy?

The Midwives Handbook for Practice identifies "decision points for Midwifery care" — ie times when there ought to be an assessment during pregnancy and childbirth.

- "The fifth decision point in pregnancy — 38 weeks. This timing provides for continuing assessment and evaluation. **Information shared** — from history: woman's wellbeing, baby's movements. From examination: blood pressure, assessment of presentation, lie and descent, assessment of size of baby, baby's heart rate. From tests: urinalysis for proteinuria. **Health Information and Education** — discuss emotional and social aspects of birth and postnatal care, including self-care; confirm birth plan and support people; discuss first breastfeed and the importance of skin to skin contact; confirm postnatal support systems; discussion about prolonged pregnancy"
- "The sixth decision point in pregnancy — 42 weeks. This timing allows the midwife to critically assess the woman and her baby with a view to referral if concerns are held about the pregnancy being prolonged. **Information shared —** From history — woman's well-being, baby's movements. From examination — blood pressure, presentation lie and descent of baby, assessment of liquor volume, baby's heart rate. From tests — urinalysis for proteinuria, cardiotocograph (CTG). **Health information and education** — discuss options for additional care and support, check support networks in place, subsequent decision points agreed on with the woman.
- From the Guidelines for Consultation with Obstetric and Related Specialist Medical Services (Referral Guidelines), Prolonged Pregnancy 4024 is a Level 2 referral ——description: 41 weeks, > 41 weeks — assessment, discussion and plan.
- Level 2 = The LMC **must recommend** to the woman (or parents 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 clinical roles/responsibilities must involve a three way discussion between the specialist, the LMC and the woman concerned.* In most cases the specialist will assume ongoing responsibility and the role of the primary practitioner will be agreed between those involved. This should include discussion about timing of transfer back to the primary practitioner.

2. Did [Ms B]'s recording of her antenatal assessments of [Ms A] meet the standards?

No.

3. Please comment on [Ms B]'s retrospective documentation into [the Trust's] Profile system.

From Criteria for Standard Four — "The midwife: reviews and updates records at each professional contact with the woman; ensures information is legible, signed and dated at each entry; makes records accessible and available at all times to the woman and other relevant and appropriate persons with the woman's knowledge and consent; ensures confidentiality of information and stores records in line with current legislation."

When documentation is entered retrospectively it is accepted practice that this is done as soon as is practicable, is dated, timed, signed and documented as being written in retrospect.

4. What should [Ms B] have done when [Ms A] went past her due date?

In my experience it would have been usual practice at 41 weeks for [Ms A] to have been referred to an obstetrician for a consultation as to where to proceed with her care so that she became known to the secondary care services; and that had she not delivered by 42 weeks she be reassessed with a view to induction of labour. Any declining of recommended treatment then made by the client could truly be said to have been made with full information being provided her and her partner and then perhaps a period of further waiting could be negotiated.

[Ms B] left [Ms A] to her colleague's care at this stage of her pregnancy — 41 weeks. [Ms B] knew that she would be away on "urgent leave" until [25th September] when [Ms A] would then be over 42 weeks. I feel that a more decisive plan of action should have been made to at least have ensured that [Ms A] had another visit and full assessment including a CTG rather than just a phone call; as recommended in decision point six — while [Ms B] was away.

5. Was [Ms B's] management of [Ms A's] labour appropriate?

- [Ms B] does not hold an access agreement to provide midwifery care at [the Public] Hospital. She had agreed to provide support and advocacy to [Ms A] and her partner.
- Therefore in these circumstances [Ms B] has provided appropriate support — however in her role as [Ms A's] advocate she was deficient. She should have recognized earlier the delay in progress and sought support from secondary services when it become clear that she had reached the limit of her expertise.

6. Was [Ms A] appropriately referred to secondary services? If not, please comment on what else should have done and the guidelines that apply.

- [Ms A] was transferred to [the Public] Hospital for secondary care services under the care of an Obstetrician and the Secondary Care Core Midwifery Services. In these circumstances the usual practice is to have a three way conversation which includes the woman and her whānau, the Obstetrician and Core Support Staff and the LMC in which the woman is given a full explanation of her situation allowing time for informed consent to occur, an agreed plan for her care, and an agreement as to who is responsible for her care and who will monitor her progress. All of this should be clearly documented in the woman's hospital notes. This does not appear to have happened or to have been documented as having happened. The facility should have a stamp that states clearly handover to secondary care has occurred.
- "Guidelines for Consultation with Obstetric and Related Specialist Medical Service (Referral Guidelines)" classify Intrauterine Death as a Level 3 Referral 4010.
- "Level 3: The LMC **must recommend** to the woman (or parents in the case of the baby) **that the responsibility for her care be transferred** to a specialist given that her pregnancy, labour, birth or puerperium (or the baby) is or may be affected by the condition. *The decision regarding ongoing clinical roles/responsibilities must involve a three way discussion between the specialist, the LMC and the woman concerned.* In most circumstances the specialist will assume ongoing responsibility and the role of the primary practitioner will be agreed between those involved. This should include discussion about timing of transfer back to the primary practitioner."

If, in answering any of the above questions, you believe that [Ms B] did not provide an appropriate standard of care, please indicate the severity of her departure from that standard.

To assist you on this last point, I note that some experts approach the question by considering whether the providers' peers would view the conduct with mild, moderate, or severe disapproval.

In view of the outcome of this event for [Ms A], her Partner and [the baby] — I would consider that the providers' peers would view [Ms B's] conduct with moderate−severe disapproval.

Are there any aspects of the care provided by [Ms B] that you consider warrant additional comment?

No.

Kua tuhia ahau ēnei kōrero i runga i te aroha, te tika me te whakapono no ngā tupuna i tuku iho. Ma te Kaihanga o ngā mea katoa tātou katoa e manaaki. Ka mutu.

Tungane Kani, Midwife

1. Guidelines for Consultation with Obstetric and Related Specialist Medical Services (Referral Guidelines); Ministry of Health, 2007.
2. Midwives Handbook for Practice, New Zealand College of Midwives; 2005.
3. Turanga Kaupapa; Ngā Māia, 2006 (attached).

Reference

Whakapapa

The wahine and her whānau is acknowledged

Karakia

The wahine and her whānau may use karakia

Whanaungatanga

The wahine and her whānau may involve others in her birthing programme

Te Reo Māori

The wahine and her whānau may speak Te Reo Māori

Mana

The dignity of the wahine, her whānau, the midwife and others involved is maintained

Hau Ora

The physical, spiritual, emotional and mental wellbeing of the wahine and her whānau is promoted and maintained

Tikanga Whenua

Maintains the continuous relationship to land, life and nourishment; and the knowledge and support of kaumatua and whānau is available

Te Whare Tangata

The wahine is acknowledged, protected, nurtured and respected as Te Whare Tangata (the "House of the People")

Mokopuna

The mokopuna is unique, cared for and inherits the future, a healthy environment, wai ū and whānau

Manaakitanga

The midwife is a key person with a clear role and shares with the wahine and her whānau the goal of a safe, healthy, birthing outcome

Appendix 2

Relevant standards

Section 88 of the New Zealand Public Health and Disability Act 2000 (effective from 1 July 2002):

"APPENDIX 1

GUIDELINES FOR CONSULTATION WITH OBSTETRIC AND RELATED SPECIALIST MEDICAL SERVICES

1.0 PURPOSE OF GUIDELINES

This document provides guidelines for best practice based on expert opinion and available evidence. It is the intention that the guidelines be used to facilitate consultation and integration of care, giving confidence to providers, women and their families.

For the purposes of these guidelines, referral to specialist services includes both referral to Secondary Maternity or to a specialist, as defined in this Notice. …

2.0 CIRCUMSTANCES WHERE GUIDELINES MAY BE VARIED

The guidelines acknowledge that General Practitioners, General Practitioner Obstetricians and Midwives have a different range of skills. The guidelines are not intended to restrict good clinical practice. There may be some flexibility in the use of these guidelines:

(a) The practitioner needs to make clinical judgements depending on each situation and some situations may require a course of action which differs from these guidelines. The practitioner will need to be able to justify her/his actions should s/he be required to do so by their professional body.

It is expected that the principles of informed consent will be followed with regard to these guidelines. If a woman elects not to follow the recommended course of action, it is expected that the practitioner will take the appropriate actions such as seeking advice, documenting discussions and exercising wise judgement as to the ongoing provision of care.

(b) It is also recognised that there may be some circumstances where the requirement to recommend consultation places an unnecessary restriction on experienced practitioners, particularly where there is no immediate access to specialist services. The individual practitioner can come to an appropriate arrangement with the specialist.

It is agreed that, in accordance with good professional practice, a practitioner must record in the notes the reasons for the variation from the guidelines.

…

5.0 LEVELS OF REFERRAL

These Guidelines define three levels of referral and consequent action

Level 1
The Lead Maternity Carer **may recommend** to the woman (or parents 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 clinical roles/responsibilities must involve a three way discussion between the specialist, the Lead Maternity Carer and the woman concerned. This should include discussion on any need for and timing of specialist review.* The specialist will not automatically assume responsibility for ongoing care. This will depend on the clinical situation and the wishes of the individual woman.

Level 2
The Lead Maternity Carer **must recommend** to the woman (or parents 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 clinical roles/responsibilities must involve a three way discussion between the specialist, the Lead Maternity Carer and the woman concerned. This should include discussion on any need for and timing of specialist review.* The specialist will not automatically assume responsibility for ongoing care. This will depend on the clinical situation and the wishes of the individual woman.

Level 3
The Lead Maternity Carer **must recommend** to the woman (or parents in the case of the baby) **that the responsibility for her care be transferred** to a specialist given that her pregnancy and labour, birth or puerperium (or the baby) is or may be affected by the condition. *The decision regarding ongoing clinical roles/responsibilities must involve a three way discussion between the specialist, the Lead Maternity Carer and the woman concerned.* In most circumstances the specialist will assume ongoing responsibility and the role of the primary practitioner will be agreed between those involved. This should include discussion about timing of transfer back to the primary practitioner.