Midwife, Ms B

A Report by the

Health and Disability Commissioner

(Case 06HDC02499)

Parties involved

Ms A	Consumer
Baby A	Ms A's baby
Ms B	Provider/Midwife
Ms C	Midwife
Ms D	Midwife
Dr E	Consultant Obstetrician
Dr F	Paediatrician

Complaint

On 27 February 2006, the Commissioner received a complaint from Ms A about the services provided by midwife Ms B. The following issue was identified for investigation:

- *The adequacy and appropriateness of care provided by midwife Ms B to Ms A on 26 June 2005.*

An investigation was commenced on 16 June 2006.

Information reviewed

Information from:

- Ms A
- Ms B
- A District Health Board
- Accident Compensation Corporation (ACC)

Independent expert midwifery advice was obtained from Mrs Nimisha Waller.

Information gathered during investigation

Background
In June 2005, Ms A was an 18-year-old woman in her first pregnancy. Her lead maternity carer (LMC) was Ms B, who was a midwife employed by a District Health

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Board (the DHB). Ms B qualified as a midwife in 1996, and birthed an average of 60 women per year.

No complications were encountered during Ms A's pregnancy.

25 to 26 June 2005

Ms A's labour commenced on the evening of 25 June, and Ms B attended her at home at 7.45pm. Ms A's cervix was 2–3cm dilated. Ms B advised Ms A to stay at home as she was not yet in established labour.

Ms A's labour developed over the evening. At 12.16am, she was taken by her partner to the delivery unit at a public hospital. On arrival, Ms B performed a cardiotocograph and administered intravenous antibiotics as she was found to be Group B Strep positive during her pregnancy.

Ms A's labour continued to progress, and at 3am Entonox gas was given for her pain. Ms B performed regular observations of the baby's heart rate.

At 6.45am, Ms A's membranes broke, and Ms B increased the monitoring of the baby's heartbeat to every 15 minutes. Around 7.15am, Ms A started pushing, and at 7.30am the baby's head was seen (a "peep"). At 7.50am, his heart rate was 110. However, soon after 8am, Ms B had difficulty hearing the heartbeat, and asked for assistance from two midwife colleagues, Ms C and Ms D. Ms B stated:

> "[Ms C] came in and tried to find the heartbeat with no success. She said to me to call the obstetrician and I said please just find the heartbeat as I was sure it was there. I went out to get the mini scanner to help [Ms C] find the heartbeat. Midwife [Ms D] was there and I asked her to try. She tried with the Doppler and thought she heard the heartbeat at 110 beats per minute.
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> She suggested a scalp electrode and I was so pleased because I thought now we would know what the baby's heartbeat was. [Ms C] had asked again for me to call the obstetrician. My rationale for not calling the obstetrician immediately was that I wanted some concrete information to give him. As soon as the scalp clip was on, it showed the [baby's] heart recovering from a deep deceleration of 64 beats per minute recovering to 99 [beats per minute]. At that time I immediately fastpaged [the] obstetrician and paediatrician and alerted [the neonatal unit] to the seriousness of the situation and returned to the room.
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> [Ms A] had made some progress by this time and [Ms D] said to [Ms A] you have to push this baby out. [Ms A] pushed effectively twice and we saw excellent progression of the head. [Ms C] suggested that I do an episiotomy. I hesitated and [Ms A] pushed again and the baby was born."

In response to a direct question why she hesitated to perform an episiotomy, Ms B stated:

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> "I was educated at a time when episiotomies had fallen out of favour and were hardly done. In my experience as a student I had never seen an episiotomy. As a caseloading midwife I had seen only two episiotomies which were performed by an obstetrician. I was weighing up in my mind whether I had to do this or if the baby would be born and whether I should ask [Ms C] to do this or whether I should do it myself and then the baby was born. I had decided that if the baby was not born on the next push I would have cut the episiotomy under [Midwife] [Ms C]'s supervision."

In response to the provisional opinion, Ms B stated that there was an interval of between one and a half to two minutes from the time an episiotomy was suggested, to the birth of the baby.

Ms B also gave her rationale for not contacting the obstetrician when it was first mentioned by Ms C:

> "I did not call an obstetrician … as I was certain that [Ms C] would find the heartbeat as all had been normal prior to [8am]. When [Midwife] [Ms D] thought she heard the heartbeat … I again thought that I had time to get more definite information for the obstetrician that would have an impact on the urgency of the call to him.
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> …
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> My delay in calling the obstetrician was because I had no strong evidence that the baby was in trouble and I was waiting for something to tell the obstetrician."

Baby A was born pale and unresponsive at 8.36am, and resuscitation was commenced. The obstetrician arrived at 8.37am, and the paediatrician at approximately 8.42am. Once stabilised, Baby A was transferred to the neonatal unit, with a diagnosis of hypoxic ischaemic encephalopathy. He was discharged home after a fortnight, but died three months later.

Accident Compensation Corporation

On 5 April 2006, ACC accepted Ms A's claim for cover of treatment injury. In reaching its decision, ACC obtained expert advice from midwife Ann Yates. She advised:

> "Usual practice would be to obtain obstetric assistance immediately [the] midwife was unable to hear [the] fetal heart. There was [a] delay of 36 minutes between hearing a heartbeat clearly until birth. An episiotomy may have sped up [the] birth in [the] last 10 minutes as well.
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> Intervention by [an] obstetrician may not have changed the outcome. But in all probability an earlier birth may have increased chance of survival."

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Independent advice to Commissioner

The following expert midwifery advice was obtained from Mrs Nimisha Waller:

"I have been asked to provide an opinion to the Commissioner on case number 06/02499, and that I have read and agree to follow the Commissioner's guidelines for Independent Advisors.

My qualifications are RN (includes General and Obstetrics), RM, ADM, Dip Ed (UK) and Master in Midwifery (VUW, 2006). I have been a midwife for 22 years, the last 10 years in New Zealand. I have worked in community and hospital tertiary settings as well as in education both here and in the UK. I am currently a Senior Lecturer in Midwifery at Auckland University of Technology and take a small caseload of women as a Lead Maternity Carer.

The following sources of information that were sent have been reviewed prior to the advice being given:

1. Letter of complaint (pages 1–4);
2. Notification of complaint (pages 5–7);
3. Clinical record (pages 8–138);
4. Information from the DHB (pages 139–145).

I have been asked to provide expert advice to the following:

1. Please comment generally on the care provided by [Ms B] to [Ms A].

If not answered above, please provide the following advice:

2. Did [Ms B] respond appropriately to the changes in the FHR?

3. Please comment on [Ms B's] rationale for not performing an episiotomy.

4. Please comment on [Ms B's] decisions regarding the calling of medical staff during [Ms A]'s labour.

Factual Summary/background

[Ms A] was an 18 year old woman in her first pregnancy. No problems were encountered in the antenatal period. Midwife [Ms B] was [Ms A's] LMC; [Ms B] is employed as a caseloading midwife by [the DHB].

At 7.45pm on 26 June 2005, [Ms B] assessed [Ms A] at her home; following further, stronger contractions, [Ms A] was admitted to the delivery unit. The labour continued as expected overnight.

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At approximately 8am, the baby's FHR could not be heard, and [Ms B] involved other members of the midwifery team to assist her.

Soon after application of a scalp electrode, where bradycardia was recorded, the baby was born without an episiotomy being performed. The baby was pale and unresponsive, and resuscitation was commenced. (The baby died at three and a half months of age.)

My response to the advice required is as follows:

1. Please comment generally on the care provided by [Ms B] to [Ms A].

[Ms A's] labour commenced on the 25th June 2005 and her midwife [Ms B] assessed her at home at 19.45hrs. At this stage [Ms A's] cervix was 2–3cm dilated and 75% effaced. As [Ms A] was not in established labour she was advised to stay at home for as long as possible. This is reasonable advice and care as going into hospital at this stage would not have changed the care [Ms A] received. At 22.30hrs [Ms A] re-contacted [Ms B] as contractions were stronger and more regular. She was advised to stay at home for as long as possible. There is no indication of any concern at this stage for either the mother or the baby and therefore this is reasonable advice particularly as [Ms A] was coping well with the contractions.

At 0016hrs (26th June 2005) [Ms A] arrived in the delivery unit and during this assessment a CTG was commenced. [Ms A] was given the first dose of IV antibiotics as she was found to be Group B Strep positive during her pregnancy. At 0230hrs [Ms A] was resting on the bean bag, contracting every six minutes and the contractions were lasting sixty seconds. The baby's heart rate is documented as 120–145bpm. [Ms B] did an admission CTG (though it has not been located). However there is no evidence to support an admission CTG when the pregnancy is low risk though some maternity units do continue to recommend admission CTG for all women. The care provided to [Ms A] by [Ms B] is of a reasonable standard at admission.

[Ms A's] contractions were coming close together at 0300hrs and she requested pain relief. A vaginal examination was done prior to Entonox (nitrous oxide and oxygen) being commenced. This is reasonable practice. The cervix was noted to be 4cm dilated with bulging membranes. Baby's heart rate is documented as 125–130bpm. Between 0300hrs and 0630hrs the baby's heart rate has been auscultated every 20 minutes to half an hour and ranged between 126–140bpm which is within normal limits. [Ms A] used the pool for pain relief during this time. This is reasonable action.

At 0645hrs [Ms A]'s membranes ruptured and clear, pinkish liquor was noted. The baby's heart rate is documented as 126–130bpm. Between 0645hrs to 0730hrs baby's heart rate was auscultated intermittently every fifteen minutes and was within normal range. [Ms A] started pushing with contractions from about

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0715hrs. At 0730hrs a peep of the baby's head was seen and baby's heart rate is documented as 126–130bpm. From retrospective documentation it appears that [Ms A] was sitting on the toilet and pushing involuntarily around this time. Baby's heart rate for 0740hrs is documented as 120–130bpm. A vaginal examination was done at 0750hrs and the cervix was found to be fully dilated. The baby's heart rate at this time is charted as 110bpm. Between 0800hrs and 0805hrs there was difficulty in hearing the baby's heart rate when [Ms A] went to the toilet and returned. [Ms C] the core midwife was called at 0810hrs to listen to the baby's heart rate as [Ms B] was uncertain that she had heard the heart rate and needed reassurance. Between 0810 to 0820hrs attempts were made by [Ms B], [Ms C] and [Ms D] to auscultate the baby's heart rate but due to uncertainty [Ms D] suggested a fetal scalp electrode to be applied. The baby's heart rate was noted to be 60–90bpm following the application of the fetal scalp electrode. [Ms A] was pushing effectively and from the documentation it appears that there was descent of the baby head with the pushes. When there was uncertainty regarding auscultation of the fetal heart rate a suggestion was made to call an obstetrician. Calling the core midwives for assistance by [Ms B] was an appropriate action. It appears that the obstetrician and the paediatrician were contacted urgently once the fetal bradycardia was confirmed rather than at the initial suggestion. [Ms B] has given a rationale for not doing this in her response to the Commissioner (page 00147, point 7 and 8). She states that she wanted to be really sure that it was not just the maternal position that was affecting the auscultation. Though this is a reasonable rationale it is also helpful to call the relevant practitioners so that they can be of assistance if the situation deteriorates. Not calling the obstetrician at the initial suggestion by the core midwife can be viewed by some practitioners with mild to moderate disapproval. Calling the relevant practitioners does not always mean that they would be there immediately as it depends on what they were doing at the time and in this instance it is debatable whether an arrival of an obstetrician or a paediatrician earlier would have changed the outcome for [Baby A].

It was suggested to [Ms B] to do an episiotomy. [Ms B] hesitated and the baby was born within three pushes. From the documentation it is not clear what the time interval was from suggestion of the episiotomy to birth of [Baby A][1] but one can assume it to be about eight minutes or less as [Ms B] states that she left the room to fast page the obstetrician and the paediatrician when baby's heart rate was noted to be 60–90bpm at 0825hrs. [Baby A] was born pale and unresponsive and the midwives commenced resuscitation. It appears that [Baby A] was born at 0836hrs and the obstetrician arrived at 0837hrs followed by the paediatrician between 0842–0844hrs. [Baby A] needed active resuscitation and was slow to spontaneously breathe though the heart rate was apparently present at birth. He

[1] Commissioner's note: In response to the provisional opinion, Ms B advised that the interval between the suggestion that an episiotomy be performed and the birth of the baby was one and a half to two minutes.

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was transferred to NNU once stabilised. As documented in the notes [Baby A] died at three and half months of age.

2. Did [Ms B] respond appropriately to the changes in the FHR?

Once the difficulty in auscultating the baby's heart rate was noted [Ms B] acted appropriately in contacting the core midwives for help. [Ms B] felt that the inability to auscultate the heart rate was due to the maternal position. This thought is reasonable as there was no indication of [Ms A's] pregnancy being high risk or baby being at risk at any stage in labour until 0800hrs or later. The CTGs apparently done on the 16th June and on 26th June at admission were reassuring though these are not in the file and it appears that the CTG on the morning of the 26th June is unable to be located. Calling for assistance from core midwives was an appropriate action by [Ms B] once there was uncertainty that the fetal heart rate was heard.

3. Please comment on [Ms B]'s rationale for not performing an episiotomy.

[Ms B] in her response to the Commissioner (page 00148, point number 9) states that it was her lack of confidence in her ability to perform the episiotomy that made her hesitate. As a practitioner it is important to seek opportunities to develop confidence in such skills particularly as [Ms B] graduated in 1996 and has worked in areas since then such as Neonatal Intensive care and Plunket where such skills may not be fully utilised. This does not mean that one should do an episiotomy without indication to increase confidence but updates and simulation training can be helpful. One of the indications for an episiotomy is fetal distress or fetal heart rate irregularities and [Ms B] should not have hesitated as fetal heart rate was below 100bpm for sometime. Majority of practitioners would have done an episiotomy in this instance. Practitioners may view not doing the episiotomy with mild to moderate disapproval. However it is debatable whether an episiotomy would have changed the outcome for [Baby A].

4. Please comment on [Ms B]'s decisions regarding the calling of medical staff during [Ms A]'s labour.

This is covered in the first question regarding general comments about the care provided to [Ms A].

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

The documentation from 0800hrs until [Baby A] was admitted to NNU being in retrospect is reasonable as at the time [Ms B] would be more involved in providing care to [Ms A] and [Baby A]. There are aspects of documentation that could be more thorough. For example [Ms B] has documented the commencement of CTG at 0016hrs however there is no documentation when this was discontinued

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and what the interpretation of this CTG was. Documentation of this would have been useful for [Ms B] particularly as the CTG could not be located later.

There is some concern expressed by [Ms A]'s family about [Ms A] using the shower when her cervix was fully dilated. There was no indication at this stage that the baby was distressed or that [Ms A] had a strong urge to push. Often women at this stage use the pool for pain relief or go into the pool to birth their baby.

[Ms B] in her response to the Commissioner (page 00148, point 12) states that the way she perceived the events in this case were greatly influenced by her education. The midwifery education and the midwifery profession do promote pregnancy and birth as a normal life process and working in partnership with women about their care. The Scope of midwifery practice is within the normality of pregnancy, birth and postnatal. However, the graduates are also educated about the appropriateness of interventions and when to intervene when the process of pregnancy and birth are not going smoothly. This is what being a midwife is.

Summary
In this instance the care provided by [Ms B] is reasonable. There are aspects within the care that [Ms B] may want to reflect on and develop further confidence in. For example, reflecting on timing of consulting with medical practitioners, when an episiotomy is indicated, developing the confidence in doing this procedure and prioritising of documentation during intra-partum care may be helpful.

Further midwifery advice
Mrs Waller was asked to provide further advice, and comment on the midwifery advice provided to ACC:

"The following sources of information that were sent have been reviewed prior to the further advice being given:

1. ACC expert advice from Ms Ann Yates and her report
2. Letter of complaint (pages 1–4);
3. Notification of complaint (pages 5–7);
4. Clinical record (pages 8–138);
5. Information from [the DHB] (pages 139–145);
6. Information from LMC [Ms B] (pages 146–233)

I have been asked to review Ms Ann Yates' report and consider whether I need to alter the advice I had provided to the Commissioner and to give reasons for either altering my view or not altering my view.

…

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Thank you for giving me the opportunity to comment further and my response to the advice required is as follows:

Further detail to the summary is as follows:

Page 00017

07.00hrs [Ms A] was involuntarily pushing with contractions. Baby heart rate at this time is charted as 126–130bpm.

07.15hrs — first time difficulty in hearing the baby's heart rate and [Ms A] was asked to go back to bed and following this the heart rate is documented as 124–130bpm.

07.30hrs — peep of the baby's head and the heart rate is documented as 126–130bpm.

In retrospective documentation it is documented that at 07.35hrs [Ms A] was on the toilet pushing occasionally.

07.40hrs baby's heart rate is documented as 120–130bpm and that [Ms A] is pushing with the contractions.

07.50hrs a vaginal examination was done and the cervix was found to be fully dilated with the head at +1. There were some directed pushing and baby's heart rate is documented as 110bpm.

08.00hrs unable to hear the heart rate and [Ms A] was on the toilet pushing with contractions.

08.05hrs [Ms A] was back on bed and there baby's heart rate could not be heard.

08.10hrs LMC [Ms B] was unsure that baby's heart rate was heard but that it may have been 120bpm. As unsure and needing reassurance Midwife [Ms C] was called.

08.15hrs [Ms C] unable to hear the heart rate and [Ms A] put in left lateral position and oxygen given. She queried the need to call an Obstetrician.

08.20hrs Midwife [Ms D] came to help with auscultation of baby's heart rate and appeared to find the baby's heart rate at 120bpm. She suggested application of scalp electrode. [Ms D] has documented (page 00019) '? FHH. Left side. Briefly heard 120 the deceleration to 98 ? maternal pulse. [Ms A] actively pushing'.

08.25hrs Scalp electrode applied. Baby's heart rate noted to be 60–99bpm. [Ms C] has documented the baby's heart rate as 49–74 (page 00017). [Ms A] was effectively pushing and baby was descending.

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Further retrospective documentation has no time charted but states that [Ms A] was pushing effectively and that baby nearly out. A suggestion was made to do an episiotomy. [Ms B] hesitated with this and within three pushes the baby was born at 08.36hrs. Obstetrician and paediatrician were fast paged earlier. It appears that the obstetrician was present at 08.37hrs and paediatrician at 08.43hrs.

Ms Ann Yates in her report to ACC states that [Baby A] suffered a physical injury and this personal injury was caused by failure to treat. She feels that [Ms B] was assisted by two midwives over the next thirty six minutes until birth. Baby's heart rate was heard definitely via scalp electrode at 49–74bpm eleven minutes before birth and that the birth was not assisted by obstetrician or an episiotomy.

It is the time between 08.00hrs and 08.36hrs that is pertinent for this claim as prior to 08.00hrs the care provided by [Ms B] to [Ms A] is appropriate.

As I said in my initial report dated 14th October calling the midwife [Ms C] at 08.10hrs for assistance by [Ms B] was an appropriate action. At 08.15hrs [Ms C] was unable to hear the baby's heart rate and a suggestion was made to call an obstetrician. This didn't happen as [Ms B] wanted to be really sure that it was not just the maternal position that was affecting the auscultation. Though this is a reasonable rationale as until then labour had been normal and [Ms D] at 08.20hrs felt she had heard the baby's heart rate at 120bpm with a possible deceleration or a maternal pulse it is also helpful to call the relevant practitioners so that they can be of assistance if the situation deteriorates. For example, when the scalp electrode was applied and the baby's heart rate was noted to be 49–74 or 60–99bpm then a presence of an obstetrician could have meant a slightly earlier intervention such as a ventouse birth or an episiotomy depending on how low the baby's head was at that time. The difference this would have made timewise would possibly be five or at the most ten minutes. I am not sure whether this would have changed the outcome for [Baby A] however, you as a practitioner would have been seen to have acted on a situation that was now deviating from normal. [Dr E], consultant obstetrician, stated that even if an obstetrician had been called at 08.00hrs they would have taken at least 15 minutes to arrive, then a decision would have been made to perform a ventouse or a caesarean section and that it would have taken around 30 minutes from decision point to birth by caesarean section and by this time [Baby A] would have been born normally. [Dr E] also suggested that it was likely that the decision would have been made to perform a ventouse birth and if this had occurred it would be the ventouse birth that would have been in question (page 00130).

Not calling the obstetrician at the initial suggestion by [Ms C] at 08.15hrs can be viewed by some practitioners with mild to moderate disapproval. My reason for saying that it can be viewed by some practitioners with mild disapproval is that there are practitioners who would feel that it was appropriate for [Ms B] to wait until absolutely sure of baby's heart beat being bradycardia (low) before calling the obstetrician as the pregnancy and labour to this point had been normal and

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there was some thought that the baby's heart rate was satisfactory as [Ms D] felt that it was at 120bpm with possibly a deceleration or a maternal pulse to 98bpm. In light of this to suggest application of scalp electrode was appropriate.

Other practitioners would view not calling the obstetrician at the initial suggestion by [Ms C] at 08.15hrs with moderate disapproval as there was difficulty in hearing the baby's heart rate from 08.00hrs.Therefore to call an obstetrician fifteen minutes later would be considered to be appropriate so that he/she can be of assistance if the situation deteriorates. The obstetrician may have followed the same management as the midwives but would have been present to expedite the birth if required to do so. This is the view taken by Ms Ann Yates in her report to the ACC.

[Ms B] in her response to the Commissioner (page 00148, point number 9) states that it was her lack of confidence in her ability to perform the episiotomy that made her hesitate. One of the indications for an episiotomy is fetal distress or fetal heart rate irregularities and [Ms B] should not have hesitated as fetal heart rate was below 100bpm for sometime. Majority of practitioners would have done an episiotomy in this instance. Practitioners may view not doing the episiotomy with mild to moderate disapproval. My reason for stating that practitioners may view not doing the episiotomy with mild disapproval is that some of the practitioners I have spoken to have said that they would hesitate doing an episiotomy if the descent of the baby's head was good with the contraction and pushing. [Ms B] has documented that the baby was nearly out. Majority of the practitioners would have done an episiotomy to expedite the birth even though it may not have made a difference to the outcome. Ms Ann Yates has made similar comments in relation to this in her ACC report.

Summary
Though there would be difference of opinion between practitioners in relation to when to call an obstetrician when baby's heart rate is difficult to hear it is best to call at the earliest opportunity so that he/she can be of assistance if the situation deteriorates. Majority of the practitioners would have done an episiotomy when there is bradycardia of 49–74 or 60–99bpm. I am not sure that the delay in calling the obstetrician or not doing an episiotomy contributed to [Baby A]'s physical injury as [Dr E] — consultant obstetrician — says that if the ventouse birth had occurred then that would have been in question and the paediatrician [Dr F] says that though his heart rate was 60bpm at birth it quickly increased to 100bpm so oxygen was in his system but [Baby A] didn't breathe spontaneously for a while. However, as stated in my initial report there are aspects within the care that [Ms B] may want to reflect on and develop further confidence in. For example, reflecting on timing of consulting with medical practitioners, when an episiotomy is indicated, developing the confidence in doing this procedure and prioritising of documentation during intra-partum care may be helpful. …"

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Response to provisional opinion

Ms B stated that she would have performed an episiotomy under the supervision of Ms C. Ms B stated that "her lack of experience in assessing when it was appropriate to perform an episiotomy made her hesitate".

Through her lawyer, Ms B stated:

> "[Ms B] accepts the recommendations and says that apart from [clarifying her reasons for not performing an episiotomy], she considers the comments made by the experts in the report to raise valid opinions for her to reflect on and she has reflected on her practice, and will continue to do so through discussion with the obstetricians with whom she works and at her next Standards Review with the New Zealand College of Midwives to be held in Feb/March 2007. She is willing to undertake training regarding episiotomies."

Code of Health and Disability Services Consumers' Rights

The following Right in the Code of Health and Disability Services Consumers' Rights is 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.

Other relevant standards

New Zealand College of Midwives 'Midwives Handbook for Practice' (2005)

> "**Performance Criteria**
>
> The midwife:
>
> …
>
> 4.4 recognises strengths and limitations in skill, knowledge and experience and shares or seeks counsel, consults with, or refers to, a relevant resource, other midwives, or other health practitioners; …"

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Opinion: Breach — Ms B

Having reviewed the available documentation, and taken account of the independent expert midwifery advice from Mrs Nimisha Waller, I am satisfied that the care Ms A received until the morning of 26 June 2005 was of an appropriate standard. However, concerns have been raised about the care provided to Ms A in the period immediately prior to her baby's birth.

For the reasons given below, in my opinion Ms B failed to provide midwifery services with reasonable care and skill, and therefore breached Right 4(1) of the Code.

Obstetrician involvement
When Ms B experienced difficulty obtaining the fetal heart rate, she did the correct thing: she asked for advice from an experienced colleague, Ms C. She, however, could not detect the heartbeat, and suggested that the obstetrician be called. Ms B chose otherwise, asking another midwife to assist, who "thought she heard the heartbeat". Although I understand Ms B's reluctance to call an obstetrician until she had some "concrete information to give him", in circumstances where not one of the three midwifes was able to hear, for certain, the fetal heart rate, and a colleague recommended on two occasions that she should call the obstetrician, I believe that she should have acted with more caution, and followed that advice.

Mrs Waller advised that although waiting for concrete information to tell the obstetrician is a "reasonable rationale, it is also helpful to call the relevant practitioners so that they can be of assistance if the situation deteriorates".

Ms Ann Yates provided expert midwifery advice to ACC. Ms Yates is an expert who is also on my panel of independent advisors. In Ms Yates' opinion, there was a delay by Ms B in obtaining obstetric assistance.

Episiotomy
Ms C suggested that an episiotomy be performed to hasten Baby A's birth, as by this stage a scalp clip had been attached and the fetal bradycardia was evident. Ms B said that she did not perform an episiotomy because of her lack of familiarity with the procedure; in fact, Ms B had never performed one, and had only seen two performed. However, in my view an episiotomy should have been performed. Ms Waller advised that although there is varying practice amongst midwives in relation to episiotomies, one should have been performed in this case. This is a view shared by Ms Yates in her advice to ACC.

In my view Ms B should also have been aware of a significant gap in her professional experience. It is a midwife's responsibility to ensure that she recognises, and acts on, any limitations in her skill base. By June 2005, Ms B had been a midwife for nine years, and a caseloading midwife at the DHB for over two and a half years. Although I am surprised by Ms B's statement that during this time she had not performed an episiotomy (nor during her training), she should have been prepared to perform one should the need arise. Mrs Waller advised that "updates and simulation training can

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be helpful". I am not satisfied that Ms B had taken appropriate steps to fill this gap in her experience.

Summary
Ms B should have contacted the obstetrician at the point when her colleague, Ms C, first recommended doing so. Ms B *may* have found that she had called for medical assistance unnecessarily, but in my view this was not a risk she should have taken. In my view Ms B should also have performed an episiotomy to hasten the birth — again, as suggested by her colleague Ms C. In these circumstances, Ms B failed to provide midwifery services to Ms A with reasonable care and skill, and breached Right 4(1) of the Code.

Recommendations

I recommend that Ms B:

- apologise to Ms A for her breach of the Code;
- obtain further training in performing episiotomies;
- review her practice in relation to involving medical staff in the care of the women for whom she is responsible.

Follow-up actions

- A copy of this report will be sent to the New Zealand Midwifery Council.
- A copy of this report with details identifying the parties removed, except the name of Ms B, will be sent to the New Zealand College of Midwives.
- A copy of this report, with details identifying the parties removed, will be sent to the Maternity Services Consumer Council, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.