Midwives, Ms B / Ms C / Ms D

Opinion - Case 97HDC9767

Complaint

The Health and Disability Commissioner received a complaint from the consumer, Ms A, about the services provided to her by Ms B, Ms C and Ms D, all midwives at the Midwifery Service. The complaint was that:

Midwife, Ms B

- *On 6 May 1997 Ms A advised Ms B that her baby had stopped moving on 3 May. Ms B took no action to assess the health of the baby but told Ms A that she should not worry because babies sleep a lot.*
- *Ms B did not fully inform Ms A about her scan results, including the size of the baby.*
- *Ms B did not take appropriate and timely action in response to the scan results.*
- *On 17 June 1997 Ms B questioned Ms A about why the shared care midwife had arranged for Ms A to have an urgent scan.*

Midwife, Ms C

- *In June 1997 Ms C advised Ms A to make an urgent scan appointment but did not inform Ms B.*
- *When Ms A reported to Ms C that she was having contractions during her pregnancy, Ms C advised Ms A that these were caused by the uterus getting ready for birth.*

Midwife, Ms D

- *On 22 June 1997 when Ms A informed Ms D by telephone that her baby had stopped moving and she was coming to hospital Ms D advised Ms A that she was not to come in for an hour because Ms D was having her lunch.*

Midwives, Ms B / Ms C / Ms D

Opinion – Case 97HDC9767

Investigation

The Commissioner received the complaint on 7 November 1997. An investigation was undertaken and information was obtained from:

Ms A	Consumer
Ms B	Provider / Midwife, Lead Maternity Carer
Ms C	Provider / Midwife
Ms D	Provider / Midwife

Ms A's antenatal records, the postmortem report, ACC records, medical records from Crown Health Enterprises and the medical centre, and blood test results were obtained and reviewed.

The Commissioner also received expert advice from two independent midwives.

Outcome of Investigation

The consumer, Ms A, first came under the care of the Midwifery Service when she was 20 weeks pregnant. Ms A was 39 years old and this was her third pregnancy. In 1975 she had had a normal pregnancy, labour and birth and in 1981 she had delivered twins with an induced labour and normal birth.

Ms A's antenatal care was shared between two midwives - Ms B, her lead maternity carer (LMC), and Ms C. The midwives visited Ms A at her home on various occasions during her pregnancy.

Ms A stated that the midwives did not warn her of the risks of having a baby at an older age. She also stated, in a letter to the ACC dated 30 March 1998:

> "*I was never made aware of the problems that a small baby could find itself in or that a baby in distress could be a life or death matter.*"

Continued on next page

Midwives, Ms B / Ms C / Ms D

Opinion – Case 97HDC9767

Outcome of Investigation

Both midwives state that the most significant risk factor Ms A faced as an older women having a baby is the possibility of foetal chromosomal abnormalities. An amniocentesis is the usual way of ruling this out and this is offered to all women in her age group at around the 14th week of pregnancy. Because Ms A did not come under midwifery care until her 20th week of pregnancy, discussion on the issues of risks associated with an amniocentesis and of having a pregnancy later in life would therefore have been the responsibility of her general practitioner. Ms A had earlier declined to have this test and discussed the reasons for this choice with the midwives.

On 6 May 1997 Ms A advised Ms B that her baby had stopped moving for several hours on 3 May. Ms B stated:

> "*... we discussed the patterns of baby's movements, i.e. that they have active and sleepy periods, and that it is important for a mother to be aware of the baby's movements throughout the day, and many baby's develop quite a clear individual pattern of waking and sleeping.*"

An independent midwife advised the Commissioner, relying on Enkin, "*A Guide to Effective Care in Pregnancy and Childbirth*", that women may experience wide variations of movements within a single pregnancy. Mothers also differ widely in the ability to perceive movements with some feeling nearly all movements, some only a proportion and some none at all. In addition, a mother's perception of her baby's movements show wide day to day variations due to distractions, although the majority of women are consistent in the proportion of movement they feel. She advised:

> "*However, a reduction or cessation of fundal movements may precede foetal death by a day or more. Recognition of this reduction, followed by appropriate action is a basis of using counts of foetal movements. Monitoring of foetal movements should be used as a screening test, the results of which should prompt other diagnostic tests.*"

Continued on next page

Midwives, Ms B / Ms C / Ms D

Opinion - Case 97HDC9767, continued

Outcome of Investigation *continued*

Ms B responded with the following statements:

> "*I saw* [Ms A] *on 6 May 1997 and questioned her about movements as part of my usual midwifery assessment.* [Ms A] *had said that her baby had not moved for a couple of hours, 3 days before on 3 May but it had been moving otherwise normally. I explained that a quiet period of a few hours is not unusual as babies have sleeping and waking times. There was nothing at that visit to support the* [view] *that* [Ms A's] *baby had had reduced movements. There was also no reason to consider starting a kick chart, or organising a scan or referral as* [Ms A] *said that the baby was moving normally. … A single occasion of a couple of hours of little or no movement is by no means unusual. It is well documented in the medical and midwifery literature that this occurs and none of the research or literature would accept that little or even absent movement over 2 hours would therefore be considered as reduced.*"

Ms A told both Ms B and Ms C that she was having contractions during pregnancy. Both midwives advised her that these were caused by the uterus getting ready for the birth. Known as Braxton Hicks contractions, it is normal for a woman to feel such contractions during the later part of her pregnancy.

Ms A had an antenatal check by Ms B on 20 May 1997. The notes of that examination state "*foetal movements felt*". My independent midwife stated:

> "*Given that* [Ms B] *at no time suspected that* [Ms A's] *baby was significantly growth retarded, as evidenced by assessment entries in the clinical record in which clinical gestation is always equal to or greater than the calculated gestation … a single episode of decreased fetal movements would not in itself cause any concern.*"

Continued on next page

Midwives, Ms B / Ms C / Ms D

Opinion - Case 97HDC9767, continued

Outcome of Investigation *continued*

On 5 June 1997 Ms A was seen by Ms C. The antenatal notes record that foetal movements were satisfactory. Ms C stated to the Commissioner that when asked about foetal movements, Ms A appeared not to be taking much notice. Ms C stated:

> "*There was no question of less movements at those visits ..., but there was a lessened concentration or awareness of foetal movements because* [Ms A] *had so much on her plate .... In each of these assessments I satisfied myself that there was not a decreased movement situation and ticked the ante-natal record charts that the movements were satisfactory.*"

Ms C questioned whether the baby was in a breech position and arranged to see her the following week. At this appointment on 10 June 1997 Ms C advised Ms A to make an appointment for an ultrasound scan to check the position of the baby. The ultrasound scan was performed on 11 June 1997 with the results to be sent to Ms B, as the LMC.

The report on the scan stated that the overall amount of liquor around the baby was probably slightly reduced. Dr E, radiologist, advised that the baby was small for dates with the measurement being more in keeping with 33 weeks rather than the known gestation of 36 weeks "*indicating a degree of symmetrical IUGR (Intrauterine Growth Retardation)*". He stated these results are consistent with a pregnancy where growth is not progressing satisfactorily. In the box related to amniotic fluid in the sonographer's report, accompanying the radiologist's report, the normal category was ticked. However, Dr E advised that the radiologist's report is the definitive statement on the scan.

Continued on next page

Midwives, Ms B / Ms C / Ms D

Opinion – Case 97HDC9767, continued

Outcome of Investigation *continued*

Ms B stated that the ultrasound scan report came in the mail on Saturday 14 June 1997 and she looked at it on the evening of 15 June 1997. Ms B advised in a letter to the ACC dated 30 March 1998 that she believed that the scan meant "*the growth of the baby was becoming deficient and therefore the baby could become compromised*". She stated that she discussed the report with Ms C on 16 June 1997 and they agreed that Ms A would need to consult a specialist. Ms B stated she was caught up in Delivery Suite on 16 June so did not have an opportunity to see Ms A until her scheduled appointment with her on the morning of 17 June 1997.

On 17 June 1997 Ms B discussed the results of the scan with Ms A at the antenatal visit. She stated:

> "*It is my practice to always read the scan through with my clients and discuss these results with her. Therefore I have no doubt that I would have talked with* [Ms A] *about the size of her baby, she appeared to understand this as we discussed about the need to see a specialist obstetrician soon, aiming to see him in that week.*"

Ms A stated that during the visit on 17 June 1997 Ms B questioned her about why Ms C had arranged for her to have an urgent scan. Ms B stated that this was incorrect and that she knew the reason Ms C had arranged the scan because the two midwives had discussed the matter earlier. She understood the purpose of the scan was to check the baby's position.

Ms B informed Ms A that she would make an appointment for her to see a specialist about the baby's growth. Ms B rang Ms A on 18 June 1997 and told her she could not get a specialist appointment until 24 June 1997. Ms A stated that Ms B made the appointment with the receptionist and did not speak directly with the specialist.

Continued on next page

Midwives, Ms B / Ms C / Ms D

Opinion – Case 97HDC9767, continued

Outcome of Investigation *continued*

In response Ms B stated:

> "*I made an appointment for* [Ms A] *and his receptionist told me the first available was for the following week. I rang again on the Thursday to speak to him and try to get an earlier appointment and was told he was very busy and not available. I explained that I felt* [Ms A] *needed an earlier appointment and the appointment was brought forward two days.*"

Ms A stated that when Ms B rang she told her she was in bed, was bitterly cold and had pains in her lower back but Ms B was not concerned about this. Ms B stated Ms A did not say she was bitterly cold and had pains in her back.

Ms A further stated that Ms B advised her that "*if the baby stops kicking by the weekend ring the hospital*". In response Ms B denied making this statement and commented that Ms A did not mention any concerns about movements during this conversation. The midwife also stated that she would not have advised Ms A to ring the hospital if she had any concerns because she, as lead maternity carer, would have wanted and expected to be rung first. Ms B stated, "*If a baby stopped kicking for more than a few hours, then the LMC would want to know and would visit and assess the woman and baby. I was the LMC not the hospital and I would not say this. We are available 24 hours a day and* [Ms A] *knew to phone us straight away if she needed us.*"

Ms B stated to the Commissioner that she "*spoke with* [Ms A] *about being more alert to the baby's movements because of the possibility this baby could become compromised, and a reduction in foetal movement is a concern and that* [Ms A] *should phone at any time should that happen.*"

Furthermore the midwife stated that after discussing the scan, they agreed that "*if* [Ms A] *felt that the baby was quiet or had not felt the baby move then she would ring me and come into delivery suite for an assessment, monitoring and referral to the Obstetrician on call if needed. This may be why* [Ms A] *thought that she was to ring the hospital.*"

Continued on next page

Midwives, Ms B / Ms C / Ms D

Opinion – Case 97HDC9767, continued

Outcome of Investigation *continued*

Ms B stated that it was only after receiving the scan results that she advised Ms A to be vigilant about the movements. "*If they had in fact been reduced I would have arranged for her to have been seen sooner ....* [T]*he presenting picture was not one of reduced movements.*"

The midwife advisor stated:

> "*In my view the care of* [Ms A] *was compromised by ... [t]he failure of the midwives to recognise the significance of the problem, having been gifted the information that this baby was significantly growth retarded at a scan to confirm presentation. ... The scan measurements when plotted show an alarming fall off in growth with all of the measurements being below the tenth centile with the exception of the femur length which is on the tenth centile. Alarm bells do not appear to have gone off. ... The eight day wait for an appointment for an acute problem is unacceptable. Midwives need ready access for problems such as these.*"

Ms A stated that as she did not know what concerns Ms B wanted her to look out for she understood Ms B to mean wait a few days and notify her of the results. She stated that at that time she had not known that her baby could die in the womb and that Ms B did not explain the consequences of a reduction in movement by a baby. She also questioned how easy it was for a woman to detect a baby's movements.

Ms A felt no more kicks and rang the hospital on Sunday 22 June 1997. Ms B was away and Ms C was not in the area. Instead Ms C asked Ms A to contact her midwife colleague Ms D. Ms A then telephoned Ms D at approximately 12.00 midday. Ms A stated that Ms D told her to come to the hospital in an hour because she was having her lunch. Ms D advised that she spoke with Ms A at some length about her not feeling her baby moving.

Continued on next page

Midwives, Ms B / Ms C / Ms D

Opinion – Case 97HDC9767, continued

Outcome of Investigation *continued*

Ms D advised:

> "*Women's perceptions of foetal movements are variable at any stage of pregnancy and it is a healthy sign for a baby to move throughout the day ... it has often been noted too that foetal movements are less when a woman has not eaten ... and also she is less conscious of the movements when she is busy moving around*."

Ms D stated she asked Ms A to have a drink or something to eat to see whether any movements were felt. Ms D stated she arranged to meet Ms A at the Delivery Suite at around 1pm as that would leave a reasonable period of time for the above action to be effective. Ms D stated:

> "*I may well have said, in the course of this conversation, that I would have lunch too, but that was not the reason for the time lapse between her first point of contact with me and the sad discovery that in fact her baby had died in utero.*"

The hospital records note that Ms A said the baby had not been kicking for the last three days. When Ms A arrived at the hospital Ms D could not find the foetal heart beat. She called the specialist who informed Ms A her baby was dead. An ultrasound confirmed intra uterine foetal death.

Ms A returned to the hospital on 23 June 1997 for an induction of labour. The baby was stillborn on 24 June 1997. The postmortem report showed that the infant was anatomically normal and appeared to have been dead in utero for several days. The pathologist stated that the death had occurred "*over a period of time rather than an acute asphyxial event*". The pathologist stated that postmortem changes made critical comment difficult "*but the amnion shows amnion nodosum which is strongly suggestive of longstanding oligohydraminios*" related to poor utero-placental blood flow and IUGR.

Midwives, Ms B / Ms C / Ms D

Opinion – Case 97HDC9767, continued

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

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

…

4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.

5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

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 …

Opinion - Case 97HDC9767, continued

Professional Standards

NZ College of Midwives Scope of Practice of the Midwife

The Midwife must be able to give the necessary supervision, care and advice to women prior to, and during pregnancy, … This care includes preventative measures, detecting compilations in mother and child, accessing medical assistance when necessary and carrying out emergency measures …

New Zealand College of Midwives Standards for Midwifery Practice

Standard Six

Midwifery actions are prioritised and implemented appropriately with no Midwifery action or omission placing the woman at risk.

CRITERIA

The Midwife: …

- *ensures assessment is on-going and modifies the Midwifery plan accordingly; …*
- *identifies deviations from the normal, and after discussion with the woman, consults and refers as appropriate; …*
- *has the responsibility to refer care to the appropriate health professional when she has reached the limit of her expertise; …*

Midwives, Ms B / Ms C / Ms D

Opinion - Case 97HDC9767, continued

Opinion: Breach Midwife, Ms B

In my opinion midwife, Ms B, breached Rights 4(2), 4(5) and 6(1) of the Code of Health and Disability Services Consumers' Right as follows.

Right 4(2)

In my opinion Ms B did not take sufficient preventative measures when assessing the consumer, Ms A. These omissions put Ms A and her baby at risk and is contrary to the New Zealand College of Midwives standard 6 and the Scope of Practice.

In particular I consider that Ms B did not show sufficient concern and promptness of action on receipt of the scan results. Ms A had a scan on 11 June 1997 to determine the position of her baby. The scan results were received by Ms B on 14 June 1997, three days after the scan, and she discussed it with Ms A on 17 June 1997, six days after the scan. An appointment was made to see the specialist on 24 June 1997, 13 days after the scan and seven days after her appointment with Ms B.

The scan showed the baby was small for dates and indicated growth was not progressing satisfactorily. I am advised that these results along with Ms A's risk factors, such as age, indicated further investigations were required promptly. Ms A's condition therefore required careful and ongoing monitoring and an urgent referral to a specialist. It was unacceptable for Ms B to merely advise Ms A to monitor her baby's movements.

In regard to Ms A's initial concern of foetal movements, I accept that one reported episode of reduced foetal movements over a period of three hours is not sufficient cause for concern, especially when subsequently normal movements were felt and no further concerns about movement were reported.

Right 4(5)

Ms B's failure to promptly organise a specialist appointment on receipt of the scan's results demonstrates a lack of co-ordination to ensure Ms A received appropriate care. If the specialist was unavailable for an urgent assessment, a referral to another specialist should have occurred.

Continued on next page

Midwives, Ms B / Ms C / Ms D

Opinion – Case 97HDC9767, continued

Opinion: Breach Midwife, Ms B ***continued***

Right 6(1)

By not fully informing Ms A of the circumstances or risks of her condition, Ms B breached the Code of Rights. For example, after receipt of the scan results showing the baby was small for dates, Ms B's advice to monitor her baby's movements and report any further concerns was insufficient. Ms B did not adequately inform Ms A about the baby's size, about what risks were present and what was significant about experiencing a lack of foetal movements.

In not having this information, Ms A was unable to make informed choices on the care for herself and her baby.

Opinion: No Breach Midwife, Ms C

In my opinion midwife, Ms C, did not breach Rights 4(5) and 6(1) of the Code of Rights.

Right 4(5)

Based on the information provided, Ms C did not request a scan urgently but did so to assess the position of the baby. Ms C effectively advised Ms B by requesting the scan results be sent to her as lead maternity carer.

Right 6(1)

Ms C correctly informed Ms A about the significance of contractions during pregnancy.

Opinion: No Breach Midwife, Ms D

Right 4(4)

In my opinion midwife, Ms D, did not breach Right 4(4) of the Code of Rights. I accept that although Ms D may have mentioned that she was going to have her lunch before she saw the consumer, Ms A, the reason for the delay was to allow Ms A to have something to eat or a drink to determine whether this enabled her to feel any movements of the baby. I accept that such an instruction was appropriate in the circumstances.

Midwives, Ms B / Ms C / Ms D

Opinion – Case 97HDC9767, continued

Actions: Midwife, Ms B

I recommend midwife, Ms B, takes the following actions:

- Sends a written apology to the consumer, Ms A, for breaching the Code of Rights. The Commissioner will forward this to Ms A.
- Ensures she fully informs consumers in future. Questions should be encouraged and any queries or concerns should be addressed openly and honestly. Any risks should be clearly outlined and symptoms of potential problems explained so the consumer understands how they are to be identified.
- Liaises with specialists to ensure her clients have easy access to an urgent assessment when needed.
- Discusses this opinion with the College of Midwives and operates under supervision until the matter is heard before the Nurses Council or a decision made not to proceed.
- Confirms that all her clients are informed of this opinion and that the matter is pending.

Other Actions

A copy of this opinion will be sent to the New Zealand College of Midwives and the Nursing Council of New Zealand.

I have decided to refer this matter to the Director of Proceedings for the purpose of deciding whether any action should be taken in accordance with section 45(f) of the Health and Disability Commissioner Act 1994 (the Act).

This referral is subject to section 53 of the Act which precludes proceedings before the Complaints Review Tribunal where the matter had been resolved between the parties. The Commissioner will call a mediation conference under section 61 of the Act for the purposes of resolving the matter if the parties so require.