Midwife, Ms D

Midwife, Ms E

A Report by the

Health and Disability Commissioner

(Case 06HDC08238)

Parties involved

Ms A	Consumer/Complainant
Mr B	Consumer's partner / Complainant
Baby A (dec)	Consumer
Ms C	Provider/Lead Maternity Carer
Ms D	Provider/Back-up midwife
Ms E	Provider/Second back-up midwife
Ms F	Midwife
Ms G	Student midwife
Ms H	Midwife

Complaint

On 6 June 2006, the Commissioner received a complaint from Ms A and Mr B about the services provided by Ms D and Ms E. The following issues were identified for investigation:

- The adequacy and appropriateness of the care provided by Ms D to Ms A and her son, Baby A.
- The adequacy and appropriateness of the information provided by Ms D to Ms A.
- The adequacy and appropriateness of the care provided by Ms E to Ms A and her son, Baby A, during her delivery.
- The adequacy and appropriateness of the information provided by Ms E to Ms A during her delivery.

An investigation was commenced on 9 August 2006.

Information reviewed

Information from:

- Ms A
- Mr B
- Ms C
- Ms D
- Ms E

- ACC
- St John's Ambulance
- Coroner

Also reviewed were Ms A's maternity records and her medical records from the District Health Board.

The following responses to my provisional opinion were received:

- Ms A and Mr B, on 23 May 2007
- Ms E, on 12 June 2007.

Ms D did not respond despite being granted an extension of time to do so.

Independent expert advice was obtained from Ms Elizabeth Jull, a registered midwife with experience in rural Lead Maternity Carer[1] midwifery care.

Information gathered during investigation

Chronology

Antenatal period
In October 2004, Ms A, aged 40, became pregnant with her second child.[2] She and her partner, Mr B, chose independent midwife Ms C as the Lead Maternity Carer (LMC). Ms C was interested in natural health and alternative therapies, and her practice and philosophy fitted the way Ms A wanted her maternity care to be provided. During the first visit on 14 December 2004 (when Ms A was 10 weeks into her pregnancy), Ms C recorded that Ms A "wants [midwife] care". Ms C worked with several independent midwives in the town, and her immediate back-up midwife was Ms F. Ms C also trained and supervised midwifery students.

The antenatal period was straightforward and, on 30 April 2005, Ms A and Mr B advised Ms C that they "definitely would like a homebirth".[3] Ms A stated:

[1] The practitioner responsible for providing and co-ordinating a woman's maternity care during her pregnancy, attending the labour and birth, and providing postnatal care four to six weeks after birth. A lead maternity carer can be a midwife (independent or hospital based), general practitioner, an obstetrician or a hospital team.

[2] Ms A terminated her first pregnancy in 2001.

[3] As documented in Ms A's midwifery notes. In response to my provisional opinion, Ms A clarified that "at that stage [she and Mr B] were still considering [their] options of home birth and hospital birth" but were more inclined towards having a home birth.

> "I'd chosen a homebirth, but I chose it on the thought that I knew the hospital was close, and that I was given two midwives."

As part of Ms A's antenatal care, she attended homebirth classes facilitated by independent midwife Ms E. Student midwife Ms G was present at most of Ms A's antenatal visits from the time she was 32 weeks pregnant. (During an earlier antenatal visit Ms A had consented verbally to Ms G's involvement in her care. In response to my provisional opinion, Ms A clarified that her consent was limited to Ms G taking a background role of recording notes about her care.)

Ms C discussed alternative back-up midwifery support with Ms A as part of the birth arrangements, because Ms F was unavailable on Ms A's expected due date. According to Ms A, Ms C did not inform her of Ms F's unavailability, and Ms A had expected Ms F to attend as the second back-up midwife if Ms C was unavailable. Ms C recommended Ms D, a first-year midwifery graduate with whom Ms C had worked. As Ms E had assisted Ms C with several home births, Ms C also suggested Ms E as another back-up midwife. Ms A was agreeable to Ms D being the back-up midwife, but did not want Ms E. Ms C said that she misunderstood Ms A's decision not to involve Ms E in her delivery, and did not document this in her notes. Ms C added:

> "I don't remember discussing with [Ms D] who to call specifically as the 2nd midwife; I probably assumed she would call [Ms E] as she had been working mostly with her. … I misinterpreted [Ms A's] reply that she would rather have [Ms D] than [Ms E] given the choice; and did not remember it as a clear request to not have [Ms E] at the birth at all."

On 22 June 2005, Ms D visited Ms A in her home, at which time Ms D reviewed the birth care plans with Ms A. In contrast, Ms A recalls Ms D carrying out routine checks, but disagrees that Ms D reviewed her birth care plans with her. Apart from documenting that Ms A was "well" and that she would substitute iron supplements with another medication, Ms D did not record any other aspects of her discussion with Ms A in the birth care plan.

Ms C was scheduled for a weekend off near Ms A's due date. She informed Ms A of this a few days prior, and advised her to contact Ms D if she went into labour that weekend. Ms C also made other arrangements with her colleagues regarding Ms A's delivery: Ms C advised Ms D to adopt a low threshold for transferring Ms A to hospital, and to call Ms H (another independent midwife) for back-up support if necessary. As Ms C had misunderstood Ms A's decision regarding Ms E's involvement, Ms C did not inform Ms D that she was not to contact Ms E for back-up support. Ms E was therefore unaware of Ms A's wishes in this regard.

Sunday/Monday

Ms A's contractions began around 5pm on Sunday, and the contractions were regular and three minutes apart at approximately 9pm. (Mr B and Ms A's friend were present throughout the labour and delivery.)

Ms D was contacted and arrived at approximately 10.35pm. Ms G arrived prior to Ms D and assisted by listening to the fetal heart rate (FHR). The first FHR recorded by Ms G was 140bpm (beats per minute) at 10.30pm.

Over the next few hours, Ms A's labour continued, and the FHR was monitored immediately after each contraction. Ms D performed a vaginal examination at 1.50am on Monday. Although Ms A's cervix appeared fully dilated,[4] Ms D stated that the baby was at station[5] –3 (this reading is not documented in the notes). The FHR was recorded as "130 + regular".

At 3am, Ms A began pushing through most of her contractions, and the FHR was recorded as 120bpm. At 3.30am, Ms D telephoned Ms E requesting her to attend as a back-up midwife. Ms D informed Ms E that the baby's head was still high. The FHR was recorded as 135 and regular. At 3.44am, the FHR decelerated to 110bpm, but recovered to 120bpm.

At 3.50am, the FHR decelerated to 100bpm. Ms G performed a vaginal examination at Ms D's request. The clinical record states that at 3.55am:

> "[Ms G] did a quick check, baby's head is still high. [Ms E] arrived."

Shortly afterwards, Ms D and Ms E discussed transferring Ms A to hospital in light of Ms D's concerns about the slow progress of the labour and the FHR decelerations over the previous hour. Ms E suggested that the FHR decelerations could be related to the baby's head being compressed as it passed through the birth canal, and recommended monitoring the FHR following the next contraction. Ms E stated:

> "[Ms G] listened through the contraction and a good long minute after. The listening device was a hand held Doppler which emits an audible heart beat to those in the vicinity/room. The baby's heart rate was variable at the baseline through that minute of listening following the contraction, with no deceleration. I gave information to [Ms A and Mr B] stating that their baby sounded happy with a variable strong heart beat. Both [Ms A and Mr B] appeared reassured. At that time there was no further discussion about transfer."

Ms D did not revisit her discussion with Ms E about transferring Ms A to hospital. At 4am, the FHR recovered to 120bpm and at 4.10am, it was between 120–130bpm.

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[4] During the investigation, Ms D clarified that she had informed Ms A that Ms A was "nearly there" with another $^1/_2$cm to dilate but had recorded in her notes that Ms A was "fully dilated" at 1.50am on [Monday].

[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 a 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 of the fetus is at the perineum (synonymous with crowning).

At the peak of contractions at 4.57am, the baby's head was seen by Ms D. At 5.01am, more of the baby's head could be seen with each push. At 5.05am, the FHR was 120bpm.

Ms D stated:

> "I recall looking at the time at 5.05am and thinking that [Ms A] had been pushing just over 2 hours from 3am when effective pushing was noted.
>
> I was confident that the baby would be born soon as [Ms G] had seen a 'peep' of the baby's head at 4.46am, so I had no concern[s] about time. Also, good progress was being seen and recorded.
>
> [Ms A] continued changing positions frequently until the head remained visible from 5.12am …
>
> …
>
> I noted that the head was staying visible at this time. At this point [Ms E] attempted to find the heartbeat but was unsuccessful.
>
> After the next 2 contractions, [Ms G] and I tried separately to locate the heart beat, but could not.
>
> We were reassured that the [baby's] heart had likely passed behind the pubic bone and we could visualise that the head was a healthy purple colour.
>
> [Ms E] verbalised to the family that the heart rate was difficult to locate as is common at this stage of labour because the baby's heart passes behind the pubic bone. From this point [Ms A] was strongly encouraged to increase her pushing efforts."
>
> The baby's head was born at 5.37am, but the FHR could not be located. His birth was complicated by a shoulder dystocia.[6] In response to my provisional opinion, [Ms E] stated that she "applied manoeuvre and traction".[7] At 5.45am, [Baby A] was delivered weighing 3.93kg.

Ms D stated:

> "At birth it was noted that [Baby A] had no tone, no refle[x], made no effort to breathe, was blue[8] and had a heart rate of 60bpm.[9] …

[6] Shoulder dystocia is a delivery problem occurring at the second stage of labour when the fetal head is born, but the shoulders are too broad to enter and be delivered through the pelvic outlet.

[7] The exertion of a pulling force to assist in the delivery of an infant.

[8] According to Mr B, Baby A had dark coloured hair, and was pale cream in tone following his birth.

> [Ms G] was unable to detect a pulse in the cord[10] and so listened with the stethoscope.[11] [Baby A] was immediately stimulated and I attempted to inflate his lungs with oxygen bag and mask, but was unable.
>
> [Ms E] then suctioned a significant amount of mucous from [Baby A's] mouth and nose[12] and successfully started artificial respiration. At this time the heart [rate] was low and I began chest compressions. [Ms E] and I continued CPR.
>
> I reassessed [Baby A's] heart rate and stopped chest compressions because it was 120–140. [Ms E] continued bagging because he had made no effort to breathe on his own."

At around this time (recorded by the Ambulance Service as 5.49am), Ms E directed Ms G to call an ambulance. Ms D recalls:

> "Colour had improved at this point but he still made no movement.
>
> During this time everyone present, especially the parents were speaking to him, asking him to breathe and the parents were asked to keep their hands on him.
>
> I continued to listen to his heart and heard it very rapidly drop and once again started chest compressions.
>
> Again his heart rate picked up over 120 and I stopped briefly until his heart slowed a third time as I listened and then resumed chest compressions.
>
> During these actions I was unaware of the time but now know that it was under 2 minutes, as the ambulance had recorded the time of the call at 5.47am."

At 6am, the ambulance arrived while Ms E and Ms D continued their attempts to resuscitate Baby A. At 6.10am, the cord was clamped and cut, and there was no pulse in the cord. Baby A's FHR fluctuated between 80–140bpm, and he was toneless. At 6.15am, it was noted that Baby A was becoming cold, and attempts were made to warm him with hot towels, hot water bottles, and skin-to-skin contact with Mr B. No FHR was detected at 6.20am. At 6.23am, the ambulance departed from Ms A and Mr B's home. Ms D and Ms G accompanied Ms A, Mr B and Baby A in the ambulance while Ms E travelled separately in her car. Shortly afterwards, at 6.28am, the ambulance arrived at hospital.

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[9] A normal fetal heart rate is between 105 and 155bpm.

[10] The umbilical cord pulsates for a moment after the baby is born as a last flow of blood passes from the placenta into the baby. The absence of a pulse indicates cessation of blood flow from the placental supply to the baby.

[11] Ms G conducted these checks based on Ms E's suggestion.

[12] To prevent aspiration of the secretion.

On admission to the hospital's Emergency Room, Baby A was intubated and manually ventilated, and Ms A delivered the placenta with the ward nurses' assistance. He was then transferred to the neonatal unit for review. The paediatric team advised Ms A and Mr B in the presence of Ms D, Ms E and Ms G that Baby A's prognosis was poor, and a decision was made to withdraw active treatment. The ventilator was disconnected and, after several intermittent gasps, Baby A died in Ms A's arms at 10.40am.

Accident Compensation Corporation

On 3 February 2006, ACC advised Ms A that it had accepted her claim for treatment injury in relation to "the death of [Baby A]" and the "mental injury to Ms A caused by death of Baby A". In reaching its decision, ACC obtained external clinical advice from midwife Nimisha Waller. Ms Waller stated in her report to ACC dated 31 January 2006:

> "The care for [Ms A] on [Sunday] when she contacted the midwife [Ms C] with history of SRM was appropriate. The initial care when [Ms A] rang back at [6.15pm and 9.45pm] is also reasonable. The care from [3.55am on Monday] till the baby was born is not reasonable. There was evidence of possible fetal distress and the head at the quick vaginal examination done by [Ms G] at this time showed the head to be still high which is 2 hours from the previous vaginal examination at [1.50am] when the head is documented as high though it is not quantified how high it is from the ischial spines. During this stage [Ms A] was also feeling hot and cold and there is no documentation of maternal temperature in the file sent. [Ms A] was a primagravida[13] and as the baby's head remained high after two hours of pushing it would have been beneficial if the midwife had considered consultation with secondary services. There was also possible evidence of fetal distress and a transfer would have enabled the midwives to do a CTG[14] to support or refute a possibility of fetal distress.
>
> The [Ministry of Health] Section 88 Referral guidelines (2000) stipulate that when prolonged second stage of labour is present [—] that is when a second stage is greater than two hours in a primagravida [—] then a consultation with secondary service is recommended (Code 5021). The referral guidelines also stipulate that in [the] presence of fetal heart rate abnormalities (Code 5011) consultation with secondary service is recommended. There is no evidence of any discussion of a need for consultation or transfer with [Ms A and Mr B] or with secondary services for either of those conditions documented in the file sent to me.
>
> The fetal heart rate [had] been documented every hour to an hour and fifteen minutes in [the] first stage of labour and every twenty minutes to half an hour in the

[13] A woman in her first pregnancy.

[14] A cardiotocograph 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.

second stage of labour. It is difficult to know from documentation whether fetal heart rate was auscultated[15] more frequently than what is documented as there is no partogram in the file. Evidence recommends auscultation of fetal heart rate every half an hour in first stage of labour … and every five minutes or after every contraction in second stage of labour. However, when labour is normal and occurring at home some practitioners would consider auscultation of fetal heart rate in first stage of labour every hour to be reasonable. When there is evidence of a possibility of fetal distress then more frequent auscultation needs to occur, particularly in presence of a high head and a possibility of transfer to hospital for CTG needed to be discussed with [Ms A and Mr B].

…

The treatment provided by midwives in labour, particularly [the] second stage of labour did not identify that the baby was possibly distressed and that there was poor descent [although Ms A] was pushing actively from 5 minutes before full dilatation of the cervix was confirmed. There was no consultation with secondary services regarding the possibility of fetal distress and particularly about high head and slow descent of the head in second stage of labour. The second stage of labour was well over two hours for a primagravida who was actively pushing. The treatment given by the midwives did not contribute to the shoulder dystocia.

Shoulder dystocia was probably the last straw for [a] baby that was possibly distressed. If there had been early consultation regarding possible fetal distress, high head and slow descent appropriate action may have been taken and the outcome may have been different for [Baby A]."

Coroner's inquest
The case was referred to the Coroner by the DHB. An inquest was held in 2006. At the time of the publication of this report, the Coroner had not released his findings.

Independent advice to Commissioner

The following expert midwifery advice was obtained from Ms Elizabeth Jull:

Independent advice to Commissioner on Case 06/08238. 10 March 2007.

"I have been asked to provide an opinion to the Commissioner on case number 06/08238. I have read the HDC guidelines for Independent Advisors and agree to follow them.

[15] The process of listening, usually with the aid of a stethoscope, to sounds produced by movement of gas or liquid within the body chiefly for ascertaining the condition of the heart, lungs, pleura, abdomen and other organs.

I am a registered Midwife with over fourteen years experience in rural Lead Maternity Carer (LMC) midwifery care.

I have discussed aspects of this case with a Midwifery colleague who is also an HDC advisor."

Information supplied by HDC
Copy of advice on the midwifery care given by [Ms D] and [Ms E] to [Ms A] [in the last months of the pregnancy]. HDC 06/08238.

Expert Advice Required

To advise the Commissioner whether, in your professional opinion, the care provided by midwives, [Ms E] and [Ms D] to [Ms A] were of an appropriate standard. Please include references to professional standards that apply to this case, and advise whether these standards were satisfactorily applied by [Ms D] and [Ms E].

[At this point Ms Jull lists the questions asked of her, which she repeats in her advice. She also lists the documents provided to her and a précis of the background of the case. These have been omitted for the purpose of brevity.]

Independent adviser comments on specific areas

"Care provided by [Ms D]

Comment on the adequacy of the antenatal visit [Ms D] conducted on the 22nd June 2005 including whether adequate information was provided to [Ms A] about birthing at home. If relevant, please outline any additional investigations/actions [Ms D] should have undertaken or information she should have provided during this visit.

[Ms D] first met [Ms A] on 22nd June 2005, as is usual for a back up Midwife. [Ms D] indicated that she was [Ms C's] back up Midwife when [Ms C] had time off. Adequate information was given to [Ms A] at this visit regarding [Ms D's] role as back up Midwife. [Ms D] did a full antenatal check up which is usual practice for the back up Midwife to do. [Ms D] discussed with [Ms A] her philosophy of practice, which was that, 'birth is a natural process' and that she encouraged families to be responsible for the decisions they make. [Ms D] reported that she reviewed [Ms A's] medical history and gave [Ms A] the opportunity to ask any questions about her planned home-birth.

[Ms A] asked no further questions about the homebirth.

[Ms D] gave adequate information regarding birthing at home at this visit.

There were no further investigations that [Ms D] needed to provide at this visit.

It would have been appropriate for [Ms D] to have documented on the birth plan who she would call as a second Midwife to attend the birth. It would also have been appropriate for [Ms D] to have discussed the role of a student Midwife and to have confirmed that [Ms A] was happy to have a student Midwife present. The care plan did not indicate what role the student Midwife would play in the labour. However this was discussed with the primary LMC Midwife, [Ms C].

It would also have been appropriate for [Ms D] to have documented in the notes that she had discussed the care plan with [Ms A].

Not documenting these issues is a minor departure from appropriate care.

Comment on the adequacy of [Ms D's] care and monitoring during [Ms A's] labour and delivery on [Sunday/Monday]. If relevant, please explain what additional examination/review [Ms D] should have undertaken.

[Ms D] was paged by [Ms A] at 11am on [Sunday] to say that her 'waters had broken', [Ms D] asked about the colour of the fluid draining and whether there were contractions, [Ms A] was advised to eat and drink well and rest. [Ms D] also advised [Ms A] 'not to bath or put anything into her vagina'.

It would have been appropriate to make sure that [Ms A] checked her temperature four hourly and for [Ms D] to advise what a normal temperature would be, as pre-labour rupture of the membranes can be an early sign of infection. It would also have been appropriate for [Ms D] to have asked [Ms A] if the baby movements were active, this is a sign of a well baby.

The advice given at this stage was of a reasonable standard.

Ms D attended Ms A (2230 hrs [Sunday]) when requested to by Ms A's [support person and friend]. This was the first point of assessment of the progress of labour.

The Midwife is guided by the labouring woman as to when she requires support.

[Ms D] had rung the student Midwife and as sometimes happens, the student may arrive first depending on the distance of travel.

[Ms D] was sensitive to [Ms A's] wishes for privacy and no intervention so tried to stay in the background as much as possible.

[Ms A] was making excellent progress up to 2345hrs and it is documented in the notes that she felt 'pressure' in her bottom at 2345hrs, [Sunday].

Vaginal examinations are kept to a minimum, especially when the 'waters have broken'. Some Midwives do vaginal examinations more than others to assess the progress of labour, it is just one tool that we have available to assess progress.

At 0015, [Ms A] was feeling more bowel pressure and [Ms D] discussed with [Ms A] about doing a vaginal examination at 0100 but the decision was not made to do the vaginal examination until 0150 when [Ms A] asked again for an examination. [Ms A] had been 'bearing down' since approximately 0032hrs.

This delay in examination was in keeping with low intervention but may have given useful information regarding actual progress. It is noted that, 'The urge to push may develop prior to complete dilation or several hours afterward.' (A Comprehensive Textbook for Midwives in Homebirth Practice 2004, Anne Frye.)

The vaginal examination done at 0150hrs is not documented clearly in the notes, it says that the head was high, but it is not clear as to how high. [Ms D] says in her letter to the lawyer that the head was at station –3 and that she found the examination difficult as she was unsure what she was feeling.

Vaginal examinations can be difficult to assess especially if women are in an awkward position. [Ms A] was on her rocker at the time.

It would have been appropriate to have done a more thorough vaginal examination with [Ms A] lying down if possible as it is important to have correct information on which to make decisions. It would also have been appropriate to have done a vaginal examination earlier, [Ms A] asked for one at 2345hrs [on Sunday]. It is important to have a baseline to work from so that progress can be assessed more accurately.

At 0355, the second vaginal examination was done by the student Midwife and [Ms D] said to [Ms A] that because the baby's heart rate was dipping down and not recovering that she should consider going to the hospital. It is difficult to assess progress accurately when different practitioners examine women, however it was appropriate that [Ms G] examine [Ms A], under [Ms D's] supervision. This vaginal examination was poorly documented in the notes, '[Ms G] did a quick check, baby's head is still high'.

It would have been appropriate for [Ms D] to have checked this vaginal examination, it was an important decision point as there had been decelerations of the fetal heart rate and progress in the second stage, when pushing was slow. After discussion with [Ms D] and [Ms G] it was established that progress was happening, that is the baby's head was descending lower into the pelvis.

[Ms D] did not tell [Ms A] that the baby's head was still high and that the birth was not imminent. [Ms A] and her partner did not seem to be part of the decision making process.

The student continued to listen to the foetal heart rate at frequent intervals and it appeared to be more regular with no decelerations. At this stage [Ms A] appeared to be pushing more effectively and [Ms A] felt a big movement of the baby at 0423hrs.

[Ms D] was reassured by the progress of the labour and so did not go with her initial instinct to transfer, because of poor progress.

After two hours of active pushing, progress was happening, the baby's head was descending in the pelvis.

Because progress was happening and the baby's heart rate was reassuring (within normal limits), it appeared that the birth was imminent and that transfer to Hospital was not necessary.

This was reasonable practice, however given the factors of a high head, slow progress and foetal heart variation suggests that a more thorough review of the progress of the labour progress was warranted.

Explain whether [Ms D] should have checked the fetal heart rate more regularly than was recorded in the midwifery notes. Should a CTG have been performed?

[Ms D] documented in her letter that [Ms A] began active pushing at 0300hrs.

In a homebirth, the foetal heart rate is listened to with a fetoscope or a hand held Doppler and once in established labour, it would be reasonable to listen to the heart rate half hourly moving to every five minutes in the second stage of labour. This is based on expert opinion, it is not research based, it is part of best practice.

Factors to be considered for frequency of listening to the foetal (baby) heart rate are:

- The mother's ability to cope with her labour
- The length of the labour
- The progress of the labour assessed by:
  - Frequency, length strength and character of the contractions.
  - Position of the baby and descent of the presenting part (in this case the baby's head) assessed by abdominal palpation.
  - Character, effacement, dilatation and application of the cervix assessed by vaginal examination.
- Whether the membranes are intact, in this case, they were broken.
- The baby's ability to cope with the labour.
- The geographical and time distance from assistance.

Prior to any form of foetal monitoring, the maternal pulse should be palpated simultaneously with the foetal heart rate in order to differentiate between maternal and foetal heart rates. (New Zealand College of Midwives, consensus statement July 2002.)

The foetal heart rate is one of the best indicators of foetal wellbeing.

There were a number of recordings made of the foetal heart rate during labour, decelerations of the foetal heart rate were recorded at 03.55, with 'quick recovery.'

The monitoring of the foetal heart rate appeared to be appropriate up until 0505am, when the last foetal heart reading was recorded in the notes as 120bpm, (regular at the baseline). The frequency of the foetal monitoring can range depending on the above factors. The foetal heart rate is considered normal within the range 110–170bpm.

The fetal heart rate recorded fell within this range and was reasonably consistent during the labour. This indicator was viewed positively and influenced the decision to proceed with the labour at home as planned.

There was no indication for CTG monitoring as the heart rate had responded quickly to the few decelerations noted. It is recorded in the notes that the heart rate was 120[bpm] after a contraction.

There was an unsuccessful attempt to hear the heart rate at 05.37hrs, after the head was born.

The length of time between listening to the foetal heart 0505–0537 hrs is at variance with the earlier monitoring and best practice. To not hear a foetal heart beat and with slow progress would be outside normal practice. [Ms D] did note that they tried to locate the foetal heart 'over the next few contractions' but could not, they were reassured that the heart had likely passed behind the pubic bone and 'we could visualize that the head was a healthy purple colour.'

It is usual to attempt to hear the heart rate every 5 minutes or after every second contraction in second stage.

It can be difficult to hear the foetal heart rate if the woman is moving around in labour, but it depends how long the second stage is as to how important this is.

This care would be seen as a moderate to major departure from a reasonable standard of care.

(From the letter written by [Ms D]). 'I was confident that the baby would be born soon as [Ms G], the student had first seen a peep of the baby's head at 0446hrs, so I had no concern about time.' Also good progress was being seen and recorded. ([Ms G])

If the second stage is prolonged, as in this case, (2 hours of pushing) it is very important to monitor the foetal heart rate regularly. In a quick second stage of labour (5–6 minutes) when the birth is imminent it is not always possible to have time to listen in as the birth process is happening.

When the foetal heart rate could not be heard, [Ms D] encouraged [Ms A] to push with more effort, as the Midwives believed the birth to be imminent.

The foetal heart was heard at 0505 and the baby's head was staying visible so the expectation was that the birth would happen soon.

Constant reassessment is important at this stage of labour and being prepared to change a previous decision or to call for extra assistance, is part of good practice.

All of the decisions seemed to have been based around the expectation of an imminent birth. The possible outcome of delayed birth and possible complications did not seem to be actively considered.

There was an expectation that the baby would be born 'any moment'.

The fact that the foetal heart rate could not be heard between 0505 and 0537 and no help was summoned is a major departure from reasonable care.

Advise whether [Ms D] provided adequate direction/supervision to [Ms G] during [Ms A's] labour and delivery. Please comment on whether it was appropriate for [Ms G] to provide the assistance she did during [Ms A's] labour and delivery.

[Ms D] provided adequate direction to [Ms G], the student Midwife, it was appropriate that [Ms G] monitor [Ms A's] labour and have as much hands on as possible as that is how the student learns. [Ms G] was mentored by [Ms D] for [Ms A's] labour and worked alongside her.

It would be appropriate for the student Midwife to have hands-on at deliveries. [Ms D] knew [Ms G] as a student would need direction at this delivery. It would be appropriate for the student to assist in any way possible, always under the direction of the registered Midwives, which happened in this case.

This was an appropriate standard of care.

Standard Ten. Midwives Handbook for practice.

The Midwife gives special recognition to student midwives and shares her expertise with them in a supportive manner.

Advise whether there were any indications that [Ms D] should have contacted a back up midwife sooner.

There was no major indicator recorded suggesting that [Ms D] should have contacted a back up Midwife sooner, progress was happening and the student midwife was there to help. The foetal heart rate, while showing slight variation appeared to be within normal limits.

There are various reasons for ringing a second Midwife to attend at a homebirth.

For instance, if the primary Midwife is tired and wants relief, [Ms D] mentioned that she was thinking of asking [Ms E] to relieve her for the postnatal care, directly after the birth as she was anticipating that she would be tired by then.

The second Midwife is usually called when the birth is imminent or sooner if the primary midwife feels that she needs extra support. Timing depends on how far the Midwife has to travel and what time of the day or night the call is made and how fast the progress of labour is, which is often difficult to predict.

This care was appropriate.

Advise whether there were any indications that [Ms D] should have transferred [Ms A] and [Baby A] to hospital sooner.

Shoulder dystocia is unpredictable, unanticipated and very infrequent and may happen only two or three times in a Midwife's life time, however there are signs in labour that it may occur. 'Shoulder Dystocia — a midwifery wheel', Carol Soutter RM. 2002.

NZCOM, Midwives Handbook for Practice, the fourth decision point in labour:

'If the woman or the midwife feels that progress is not being made, mother and baby should be reassessed regularly for factors that may indicate that additional care should be considered.'

The care delivered was within the expected range, given that there were no major adverse indicators of foetal distress up to when the foetal heart could not be heard.

Documentation is very scarce between 0505 and 0537 hrs, there are no recordings or recordings of attempts to listen to the foetal heart rate from 0505, until 0537 when the baby's head was born, 'after a slow descent'.

It appears that the public hospital is about 10 minutes distance from [Ms A's] home however at this stage of labour, it is difficult to move women who are actively pushing in labour.

It would have been appropriate to have called for extra assistance when no foetal heart beat was heard from 505am onwards.

This would have allowed for more immediate care and transfer to hospital.

This is a moderate to severe departure from a reasonable standard of care.

[Ms D] notes in her letter 'At this point I was prepared to act to help the baby to be born more quickly, expecting dystocia.'

Actions taken do not appear to match this statement.

'How much time do you have?' (Anne Frye CPM., A comprehensive textbook for Midwives in Homebirth Practice.)

'About five to seven minutes can elapse before the baby will be in distress, once the head is born.' (Benedetti, 1995 O'Leary, 1992). 'This presumes that the baby was in good shape prior to the birth of the head.' Time is of the essence when dealing with shoulder dystocia.

[Ms D] and [Ms E] assisted with the birth of [Baby A] and used the manoeuvres appropriate to deliver the baby who was described as having no tone, and made no effort to breathe. The heart rate was recorded in the notes as being 60–80 beats per minute and cardio-pulmonary resuscitation was commenced by [Ms E] and [Ms D].

The delivery was obviously difficult and the emergency appeared to be handled with the appropriate skills necessary to deliver the baby.

[Ms D] and [Ms G] were assisted by [Ms E] as there was difficulty delivering the shoulders.

It would have been appropriate for [Ms D] to have called for assistance as soon as the difficulties were encountered. This would have ensured that emergency services were on hand as soon as [Baby A] was born.

Comment on the adequacy of [Ms D's] resuscitation care to [Baby A].

Baby Resuscitation is a skill that Midwives are required to update on yearly, however it is often a 'panic situation,' especially at home.

[Ms D] had the necessary resuscitation equipment (including suction) on hand and with [Ms E's] assistance used the equipment to resuscitate [Baby A]. [Baby A] initially responded to the resuscitation efforts and the heart rate improved from 60bpm (beats per minute) to 120–140bpm.

[Baby A] made no efforts to breathe on his own.

The Midwives present applied the principles of resuscitation in what appeared to be a competent manner.

'We quietly discussed whether or not to stop resuscitation efforts, but I was hesitant and questioned whether that was the decision that the paramedics should make.' ([Ms D].)

It was appropriate to continue with the resuscitation attempts.

In your view, did [Ms D] hand over [Ms A's] care to [Ms E] on [Monday]?

I do not think that [Ms D] handed over [Ms A's] care to [Ms E] on [Monday]. It is common practice for back-up Midwives to assist at homebirths and if they sense that the primary Midwife is tired they will assist more. [Ms D] had not had any sleep and [Ms E] would have been aware of that so would have been more active in her assistance.

The notes do not indicate that [Ms D] handed care of [Ms A] to [Ms E] on [Monday].

[Ms E] was the more experienced Midwife and in a homebirth situation, as in any emergency, Midwives assist each other.

It would be normal practice to document the transfer of care if it did happen.

Was [Ms D's] documentation of an adequate standard?

While care should always be guided by the needs and desires of each woman, more frequent and regular assessment of the actual character of the labour including assessment of how [Ms A] was coping and the frequency and character of the contractions would have been more appropriate. These details were poorly documented.

Abdominal palpation is a relevant tool to ascertain the lie, position and descent of the baby. It is an essential aspect of assessment, especially when the head is high. No abdominal examinations are recorded in the labour notes.

The two vaginal examinations done were poorly documented, there was no indication in the notes to say how high the baby's head was in relation to the pelvis, it was recorded as 'quite high'.

Maternal recordings (temperature, pulse, blood pressure and urinalysis) are not essential but they do add to the picture of what is happening for the mother, particularly as it was documented that [Ms A] 'doesn't feel well', 'alternatively feeling hot and then cold'.

There is no mention in the notes of any attempt to listen to the baby's heart between 0505 and 0537hrs. If the progress of birth had been quick this would not have been so important.

The lack of documentation could be seen as a deficiency. Notes are an important record that allows the Midwife to assess past experiences and review progress.

Some of the entries in the notes are not signed and it is not clear as to who has documented these details.

The lack of documentation would be seen as a moderate departure from a reasonable standard of care.

Care provided by [Ms E] RM

Comment on the adequacy of [Ms E's] care and monitoring during [Ms A's] labour and delivery following her arrival at [Ms A's] home at approximately 3.55am on [Monday]. If relevant, please explain any additional actions/investigation [Ms E] should have undertaken and/or information she should have provided to [Ms A].

[Ms E] was called to attend as back-up Midwife by [Ms D] at 0330am on [Monday], arriving at 0355. As [Ms E] documented in her letter to HDC, she was at the birth to support the primary midwife [Ms D] and to suggest, recommend or advise as necessary on the ongoing assessment and care to [Ms A] and her baby.

[Ms E] arrived soon after [Ms D] had recorded decelerations in the foetal heart rate.

[Ms E] advised [Ms D] and [Ms G] to listen further to the foetal heart rate following the contractions and was reassured by the recordings that were found. It was noted at 0400 that the baby's heart rate was 120 after a contraction, this was reassuring as the heart rate was recovering well after the contraction. [Ms E] was actively involved in supporting [Ms A] and was trying to assist her to make progress with her pushing.

Little is written in the labour notes about [Ms E's] involvement in the labour, but she indicates in her letter to HDC that she was assisting [Ms G], the student Midwife with [Ms A's] care and making suggestions, such as listening to the foetal heart rate and offering a drink to [Ms A].

It would have been appropriate for [Ms E] to have talked to [Ms A] about her lack of progress in the second stage of labour, however she gave encouragement to [Ms A] to push and progress was happening. The potential problems were not communicated to [Ms A] adequately or soon enough.

This was a reasonable standard of care, however the lack of clearly documented details on what was discussed with whom leaves an uncertainty as to the exact dialogue that took place.

In your view, did [Ms E] assume the role of LMC following her arrival to [Ms A's] home on [Monday]?

It was not documented in the notes that [Ms E] had assumed the role of LMC and her reported actions and statements do not support this idea. It is common in homebirth practice for the back-up Midwife to support the LMC, especially if the LMC is tired or requests more input. Midwives usually work alongside each other at homebirths and assist where necessary.

I do not think that [Ms E] assumed the role of LMC however she used her skills as a more experienced Midwife to assist her colleague.

In [Ms E's] assessment, the second stage of labour commenced at 3am when [Ms A] began pushing actively through her contractions. Please comment on the appropriateness of [Ms E's] assessment.

[Ms E] indicated that [Ms A] started the second stage of labour at 0300hrs. This assessment was based on the fact that [Ms A] was pushing more effectively than she had been over the previous couple of hours. The length of the second stage of labour is often not considered as important as the length of time the woman has been pushing. The time is considered in relation to other indicators, such as foetal heart rate combined with progress, baby's head descending into the pelvis.

[Ms E's] assessment was reasonable as she had discussed the progress of labour with [Ms D] and was making an assessment on what she saw and how [Ms A] was coping with the contractions.

It is often difficult for women to push effectively while the baby's head is 'high' and it can be appropriate to wait until the contractions bring the baby's head down further in the pelvis, as long as the foetal heart rate is stable.

[Ms E] realised that the foetal heart rate had had some decelerations and the progress was slow. [Ms E] encouraged [Ms A] to hasten the labour by pushing harder into her bottom, so bringing the baby down quicker.

This was appropriate advice to [Ms A] especially as [Ms A] was tired.

This action does suggest an awareness by [Ms E] that the labour was slow to progress.

In response to [Ms D's] concerns about [Ms A's] slow progress during labour and the deceleration in [Baby A's] fetal heart rate, [Ms E] suggested monitoring the fetal heart rate following the next contraction. Please comment on the appropriateness of [Ms E's] suggestion.

At 0410, the heart rate is recorded as 120–130bpm and at 0423 the heart rate is recorded as being 120–130 with good variability and beat to beat.

This was an appropriate suggestion of [Ms E] to monitor the baby's heart rate more regularly, especially over the next few contractions to see if there were still decelerations present.

Listening through the latter part of a contraction and listening to the change in rate as it wears off, gives an indication of the baby's ability to cope with the contractions when there is expected to be a normal drop in the amount of blood flow and oxygen getting to the baby. It is helpful to have the timing of the listening documented to establish this is the normal pattern. '0400hrs heart rate 120 after a contraction.'

This was an appropriate standard of care.

Comment on the adequacy of [Ms E's] resuscitation care to [Baby A].

[Ms E] started resuscitation as soon as [Baby A] was born and asked [Ms G] to call for an ambulance 5 minutes after the resuscitation commenced.

It is documented in the notes that [Baby A] had a heart rate of 60 but [Ms E] indicates in her letter that Baby had no heart rate at birth.

The baby was born 45 minutes after [Ms A] was directed to push.

[Ms E] assisted [Ms G] and [Ms D] with the delivery of the baby, when she realised that the baby was not going to be born without assistance.

[Ms E] used the techniques necessary to deliver a baby with shoulder dystocia and she managed to use her skills well. [Ms E] was aware of the seriousness of the condition of baby and had prepared her equipment accordingly, in anticipation that resuscitation would be required.

[Ms E] appeared to apply the appropriate resuscitation requirements to [Baby A] and asked for assistance (from the ambulance) for additional suction which was appropriate.

It would have been appropriate to have called the ambulance earlier, when no heart beat had been recorded for over 10 minutes.

Was [Ms E's] documentation of an appropriate standard?

It is difficult to know who has documented the notes, there is a change in the handwriting for some entries and some entries in the notes are not signed. It is also difficult to identify some of the signatures.

Maternal recordings (temperature, pulse, blood pressure, urinalysis) are not essential, but they do add to the picture of what is happening for the mother, particularly as [Ms A] was feeling exhausted and unwell at times throughout her labour.

[Ms E] has not signed her documentation and the notes are very brief.

There have been no reasons given for not attempting to continue to hear the heart rate from 0505 hrs to 0537 hrs. In fact there is nothing documented in the notes between 0537 and 0545hrs.

The recorded monitoring does not appear to be adequate, given the fact that there were two midwives present and one student and given the fact that the birth was not happening quickly. It is indicated that the Midwives were working hard with [Ms A] to encourage her to push the baby out, often these records are written in retrospect.

There appears to be a less than reasonable standard of documentation by [Ms E].

Summary

It appeared that [Ms D] and [Ms E] had tried hard to provide a good standard of care to [Ms A]. The early part of the labour followed normal patterns and the level of care was appropriate.

There appears to have been a 'hopeful interpretation' of the birthing indicators as the labour progressed. This encouraged the Midwives to continue with the homebirth. Progress was happening, however the progress was slow. At [0]505 when the foetal heart rate could not be heard, the delay in seeking extra assistance was a departure from good practice."

Responses to provisional opinion

Responses to my provisional opinion were received from the following parties:

Ms A
Ms A clarified several aspects of her antenatal care, labour and delivery. The relevant aspects have been incorporated in the "information gathered" section of this report.

Ms E
Ms E clarified several aspects of Ms A's labour and delivery. She also stated:

"I agree with expert midwifery advice given by Ms Elizabeth Jull relating to the potential problems not communicated to the family in connection with slow progress.

I also agree with the point made of there being a delay in seeking additional assistance and expect that value would have being gained from involving the ambulance earlier. I have stated this in both my apology to the family and my

evidence given during the coroner's inquest. I have altered my midwifery practice in this regard.

Documentation I agree was of a poor standard. Many entries that I have written in the clinical notes were not signed and failure to note the sequence of events specifically as they occurred does not provide continuity or a clear picture of the events. My journaling of the events less than a week following the birth event became my most reliable written recollection for review and evaluation to accompany my debrief with colleagues and my Practice Review with the New Zealand College of Midwives Standards Review Committee in December 2005.

…

As expressed to the family I continue to consider the differences made by acting differently at the time, now that I see the complete experience behind me, rather than as the unknown, about to occur. I also continue to feel sorry for the grief and distress that the family have experienced through this time.

My practice as a midwife has deeply been altered by the events that took place with the family and the sequence of events following that day. I have not practiced in the community as a midwife from October 2005 and continue evaluating and reflecting on my role as a health professional within the community with assistance from a local Clinical Psychologist. At this point in time I remain uncertain regarding a return to midwifery in the future."

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 relevant standards

The Notice issued pursuant to section 88 of the New Zealand Public Health and Disability Act 2000, which sets out the terms and conditions for the provision of Maternity Services, states:

"PART C:

3.8 … The Lead Maternity Carer will exercise wise clinical judgment about the services s/he provides, taking into account the limits of her or his own competency and the Referral Guidelines. …

4.1 … The Lead Maternity Carer will …

(b) conduct a comprehensive pregnancy assessment of the woman including a physical examination, an assessment of her general health, family and obstetric history; …"

Appendix 1

GUIDELINES FOR CONSULTATION WITH OBSTERIC AND RELATED SPECIALIST MEDICAL SERVICES

…

Level 2
The Lead Maternity Carer must recommend to the woman … that a consultation with a specialist is warranted given that her pregnancy, labour, birth or puerperium[16] (or the baby) is or may be affected by the condition.

[The Appendix sets out a table that includes "foetal heart rate abnormalities" and "prolonged second stage of labour … >2 hours nullipara" as level 2 referrals.]

Standards of Practice, *New Zealand College of Midwives Handbook for Practice*, (2002):

"Standard One:
The midwife works in partnership with the woman.

…

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

Standard Four:
The midwife maintains purposeful, on-going, updated records and makes them available to the woman and other relevant persons.

…

Standard Six:
Midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk."

[16] The period up to about six weeks after childbirth, during which the uterus returns to its normal size.

Opinion: Breach — Ms D

Under Rights 4(1) and 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code), Ms A and Baby A were entitled to have services provided with reasonable care and skill by Ms D, and in compliance with legal, professional, ethical, and other relevant standards. In the context of services provided by a midwife, those standards include the Notice pursuant to Section 88 of the New Zealand Public Health and Disability Act 2000 (the section 88 Notice) and Midwifery Standards of Practice.

Standard of care

Antenatal period
I am satisfied that Ms D provided a generally acceptable standard of care during the antenatal phase of Ms A's pregnancy. Although Ms D failed to document the full details of her discussion of the birth plan on 22 June 2005, I agree with my expert, Ms Jull, that this is a minor departure from the appropriate standard of care.

Labour
Ms A's main concern relates to the care provided when she went into labour. Due to the absence of her original LMC, Ms C, it had been agreed that the midwifery care would be provided by Ms D. She was assisted on this occasion by Ms G, a student midwife, and called on Ms E for back-up support part way through Ms A's labour. Despite the attendance of Ms E, who was a more experienced midwife, it was Ms D's responsibility, standing in as LMC, to ensure that Ms A received an appropriate standard of care. (Ms E's involvement is discussed separately below.)

At 1.50am on Monday, Ms D performed a vaginal examination. Although Ms D stated in her response to the complaint that the baby's head was at station –3, she omitted to record this vital information in Ms A's notes.

I agree with Ms Jull's view that 3.55am was "an important decision point as there had been [several] decelerations of the fetal heart rate" in the past hour, and the progress of Ms A's second stage of labour had been slow. These concerns prompted Ms D to consider transferring Ms A to hospital, and she took appropriate steps to discuss this with Ms E shortly after Ms E's arrival at 3.55am. (This aspect of the care is also discussed below.) Ms E suggested that the decelerations in fetal heart rate could be related to the baby's head being compressed as it passed through the birth canal, and advised monitoring the fetal heart rate following the next contraction. Shortly afterwards, Ms A appeared to push more effectively, and the fetal heart rate returned to 120bpm at 4am. As this reassured Ms A and the midwives, the discussion regarding transfer to hospital was not revisited.

A second vaginal examination was also performed by Ms G at 3.55am. However, this examination was poorly documented: "[Ms G] did a quick check, baby's head is still high".

Although I accept that Ms G was there to learn and gain hands-on clinical experience, her involvement does not absolve Ms D, as the responsible midwife, from ensuring that Ms A was provided with an appropriate standard of care. I accept my expert's view that it would have been prudent for Ms D to have verified the findings of Ms G's examination, especially as Ms G was working under her supervision.

I am satisfied that the fetal heart rate was adequately monitored until 5.05am. However, from then on, the fetal heart rate could not be detected by any of the clinical staff present. Ms D assumed that this failure was because the baby's heart was behind Ms A's pubic bone, and she had observed that his head was a "healthy purple colour". Despite the fact that the heartbeat could not be located, there had been earlier concerns about the decelerations in fetal heart rate, and the second stage of labour had been prolonged, Ms D did not consult with secondary services, nor did she seek further assistance at this juncture. The Section 88 Notice states that when the second stage of labour has exceeded two hours, and there are concerns about the fetal heart rate:

> "The Lead Maternity Carer must recommend to the woman … that a consultation with a specialist is warranted given that her pregnancy, labour, birth or puerperium (for the baby) is or may be affected by the condition."

It cannot be known whether, had Ms D made such a referral, Baby A would have survived. The failure to contact a specialist when the fetal heart rate could not be located, and the second stage of labour had progressed beyond two hours, was an unacceptable omission which deprived the baby of a key opportunity for specialist intervention to save his life.

I share the view expressed by Ms Jull:

> "All of the decisions seemed to have been based around the expectation of an imminent birth. The possible outcome of delayed birth and possible complications did not seem to be actively considered."

Ms Jull referred to this failure to ask for assistance as "a major departure from reasonable care". Her views are consistent with the advice that ACC obtained from Ms Nimisha Waller, who is also on my panel of independent midwifery experts. According to Ms Waller:

> "The treatment provided by [the] midwives … did not identify that the baby was possibly distressed and that there was poor descent [although Ms A] was pushing actively from 5 minutes before full dilatation of the cervix was confirmed. There was no consultation with secondary services regarding the possibility of fetal distress and particularly about high head and slow descent of the head in second stage of labour.
>
> …

> If there had been early consultation regarding possible fetal distress, high head and slow descent appropriate action may have been taken and the outcome may have been different for [Baby A]."

Documentation

Right 4(2) of the Code states that consumers have the right to have services that comply with the relevant legal, professional, ethical, and other relevant standards. Professional standards require health professionals to fully and accurately record their observations. Proper record-keeping is an essential part of good quality care.

As discussed above, the only fetal heart rate recorded between 5.05am and 5.37am was a reading of 120bpm at 5.05am. Following that, the maternity notes contain no record of the midwives' unsuccessful attempts to locate the fetal heart rate despite indications that the birth was imminent. The next recorded fetal heart rate of 60bpm was at 5.45am when Baby A was born flat and toneless. While I accept that the management of this period of Ms A's labour was especially stressful, it was unacceptable not to maintain an accurate contemporaneous record given that there were three midwifery staff present (albeit that one was a student).

Overall, Ms Jull was also critical of Ms D's failure to maintain adequate documentation:

> "The lack of documentation could be seen as a deficiency. Notes are an important record that allows the Midwife to assess past experiences and review progress.
>
> Some of the entries in the notes are not signed and it is not clear as to who has documented these details.
>
> The lack of documentation would be seen as a moderate departure from a reasonable standard of care."

Information provided during labour

Under Right 6(1) of the Code, consumers have the right to receive full information about their care and treatment including an explanation of their condition, and the treatment options available.

Although it was appropriate for Ms D to discuss her concerns about Ms A's prolonged labour with Ms E, my expert noted that Ms A was not told that her baby's head was still high and that his birth was not imminent. I consider the lack of information suboptimal given that Ms A was delivering her first child, and was reliant on midwifery staff to guide her through the birthing process. Standard One of the New Zealand College of Midwives Handbook for Practice 2002 states that "the midwife works in partnership with the woman", and it is important that a lead maternity carer fully involve the woman in all aspects of her labour and delivery. I draw to Ms D's attention Ms Jull's comments that Ms A and Mr B "did not seem to be part of the decision making process".

Summary

Although Ms D was the less experienced midwife, she effectively assumed the role of lead maternity carer and had overall responsibility for the management decisions made when she attended Ms A's labour and delivery. In particular, Ms D should have called for specialist assistance promptly when the fetal heartbeat could not be detected between 5.05am and 5.37am. Ms D breached Rights 4(1) and 4(2) of the Code as she failed to provide Ms A and Baby A with services with reasonable care and skill, and that complied with professional standards.

In addition, Ms D also failed to adequately document the progress of Ms A's labour, including the two vaginal examinations performed at 1.50am and 3.55am on Monday. In my view, her record-keeping did not meet the standard of documentation expected of a midwife, and breached Right 4(2) of the Code.

Finally, the failure to provide vital information regarding the slow progress of Ms A's labour prevented Ms A from being involved in the important decisions regarding her care. In my opinion, Ms D breached Right 6(1) of the Code.

Opinion: Breach — Ms E

Standard of care
Guided by my expert, I am satisfied that the clinical care provided by Ms E as back-up midwife was of a generally appropriate standard, and that she did not breach the Code in this regard.

Documentation
I am concerned by the standard of Ms E's documentation. Ms E did not sign the documentation, and the comments she made were brief. In addition, my expert noted that "the lack of clearly documented details on what was discussed with whom leaves an uncertainty as to the exact dialogue that took place".

I agree with Ms Jull that Ms E provided a "less than reasonable standard of documentation". Ms E herself acknowledges that the standard of her documentation was "poor". In these circumstances, Ms E breached professional standards and Right 4(2) of the Code.

Information provided during labour
Although Ms E encouraged Ms A to push through her contractions, my expert noted that Ms E omitted to discuss with Ms A the slow progress of her labour. Ms E accepts my expert's comments that "the potential problems were not communicated to [Ms A] adequately or soon enough".

Actions taken

During the investigation, Ms E apologised formally to Ms A and Mr B for the care she had provided. The apology was forwarded to my Office before any findings were made about Ms E's care. I commend Ms E on her prompt and unreserved admission of responsibility.

Ms E advised that she has reflected on and reviewed her practice in light of this case.

Recommendations

I recommend that Ms D:

- provide a written apology to Ms A and Mr B for her breaches of the Code. The apology is to be forwarded to my Office for sending to Ms A and Mr B.
- review her practice in light of this case.

Follow-up actions

- A copy of this report will be sent to the Midwifery Council of New Zealand, with a recommendation that the Council consider whether a review of Ms D's competence is warranted, and to the District Health Board.
- A copy of this report, with details identifying the parties removed, will be sent to the New Zealand College of Midwives, the Maternity Services Consumer Council, and the Federation of Women's Health Councils, Aotearoa, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.