Midwife, Ms B

Midwife, Ms C

Midwife, Ms D

A Midwifery Service

A Report by the

Health and Disability Commissioner

(Case 05HDC13928)

Parties involved

Ms A	Consumer/Complainant
Ms B	Provider/Midwife
Ms C	Provider/Midwife
Ms D	Provider/Midwife
A Midwifery Service	Provider/Midwifery service
Ms E	Midwife, a public hospital
Dr F	General practitioner
Dr G	Gynaecology consultant
Dr H	Colorectal surgeon
Dr I	Colorectal surgeon

Complaint

On 26 September 2005, the Commissioner received a complaint from Ms A about the services provided during her labour and postnatal care by midwife Ms D. The following issues were identified for investigation:

Ms D

- *The appropriateness and adequacy of the care provided by midwife Ms D to Ms A at a public hospital on 12 December 2004, including:*

  — *management of the second stage of her labour;*
  — *assessment and suturing of her perineal tear; and*
  — *postnatal care.*

An investigation was commenced on 19 October 2005.

On 15 May 2006, the investigation was extended to include midwives Ms B and Ms C and the following issues:

Ms B

- *The appropriateness and adequacy of the postnatal care provided by midwife Ms B to Ms A in December 2004 and January 2005, including assessment of her perineum.*

Ms C

- *The appropriateness and adequacy of the postnatal care provided by midwife Ms C to Ms A in January 2005, including assessment of her perineum.*

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Information reviewed

Information from:

- Ms D
- Ms C
- Ms B
- Ms E
- Ms A's antenatal, delivery and postnatal records
- ACC report, including expert advice from midwives Rhonda Jackson and Terryll Muir.

Independent expert advice was obtained from midwife Terryll Muir.

Information gathered during investigation

Overview
On 12 December 2004, Ms A (aged 25 years) gave birth to her first baby, delivered by independent midwife Ms D at a public hospital. Ms D recorded that Ms A suffered a first degree laceration, which Ms D sutured. Ms A seemed to have an uneventful recovery, except for some difficulty breastfeeding. On 15 December Ms A and her baby were discharged home.

Between 16 December 2004 and 12 January 2005, when Ms A had been discharged from a midwifery service, she received postnatal visits from two other midwives, Ms B and Ms C, only one of whom examined Ms A's perineum to assess healing.

On 14 March 2005, Ms A was found to have a complete absence of tissue between the vagina and anus, with disruption of the anal sphincter.

On 8 June 2005, Ms A had an anal sphincter repair and levatoplasty at a public hospital. She was discharged on 11 June 2005. Since then she has required ongoing surgery for colorectal fistula.

The midwifery service
Ms D is an independent midwife who works with a group of independent midwives calling themselves "[a midwifery service]". It is not a formal legal entity. Each member retains responsibility for her clients and operates her own accounts. The midwives offer support for each other and provide locum cover for annual, sickness and continuing education leave, and back-up to meet the requirements of section 88 maternity notices.

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Ms D

Midwife Ms C was Ms A's lead maternity carer (LMC), but was on leave when Ms A went into labour. Ms D was acting as her "back-up".

On 12 December 2004, Ms D delivered Ms A's baby at the public hospital. It appears that the labour and delivery were uneventful; Ms A was fully dilated at 7.25pm, the baby was delivered at 7.48pm, and the placenta delivered at 7.51pm. The baby had APGAR scores of 9 and 10 at 1 and 5 minutes respectively, and weighed 4215 grams. These figures are within normal limits.

Ms A suffered a tear to the perineum. Ms D said that she had no particular concerns about the tear, which she assessed as first degree. She sutured the tear according to her normal practice:

"1. Using an aseptic technique, swabbed with chlorhexidine, and examined the perineum using sterile gloves to evaluate any lacerations and tears.

2. [Ms D] noted a first degree tear and accordingly identified the apex of the tear.

3. Infiltrated the perineum with local antiseptic (lignocaine 1%) and ensured [Ms A] was comfortable.

4. Continuous suturing of vaginal walls starting above apex with an anchoring stitch matching up hymenal ring using vicryl rapide 2.0.

5. Interrupted sutures in the muscle layer.

6. Continuous sutures to the perineum, tying off at the introitus.

7. Rectal check for any sutures, ensuring no abnormalities detected and sphincter control.

8. Reassess to ensure there is a good cosmetic result and offered pain relief.

9. Advised that it may sting initially on passing urine but not to hold off going.

10. Advised to drink plenty of fluid to dilute the strength of the urine.

11. Advised to ensure good personal hygiene and change the pads frequently and to let us know of any problems or concerns."

The public hospital midwife, Ms E, was present at the delivery. Ms E explained that she did not examine Ms A because, as the second midwife, it was her responsibility to ensure that the baby was safe and then assist the first midwife if required. Ms E could not recall Ms D requesting any assistance, nor any concerns expressed by her or Ms A. In Ms E's view there was nothing remarkable or significant in the delivery.

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Classification of perineal tears
In her report to ACC, midwifery advisor Rhonda Jackson provided the following information. Perineal tears are graded on severity. A first degree perineal tear is defined as involving the vaginal mucosa and the skin of the perineum. A second degree tear involves the deeper layers of the perineal muscle. A third degree tear is one in which the anal margin has been involved. A fourth degree tear involves the anal sphincter and mucosa.

Postnatal care
Ms D said that if she has any concerns about the perineum at her initial examination, or at follow-up postnatal visits, she calls the registrar or consultant. She cannot recall the position of the apex of the tear nor where it terminated. She has no recollection of any problems with Ms A, and recorded so in her postnatal notes.

At 10.45pm on 12 December, Ms A was examined by an associate midwife, given Panadol for perineal pain, and transferred to a maternity unit (the unit).

Ms A said that while she was in the unit, she remembers telling one of the staff that she thought the blood she was passing looked very brown. She now believes it could have been faecal matter. She said that her perineum was not examined once while she was in the unit. According to her records, Ms A had no bowel or urine problems. She had problems with breastfeeding only. On 15 December 2004, Ms A and her baby were discharged from the unit.

On 17 December 2004, Ms B, another member of "[the midwifery service]", visited Ms A for her first postnatal visit. Ms A told Ms B about her painful perineum. Ms B examined Ms A and recorded: "Checked, fine, tender." Ms B said that when she examined Ms A's perineum it was "fine" and "healing well". She recalls that the lighting was not good, but what she could see appeared normal. Ms B visited Ms A again on 18 December and 6 January 2005. On each subsequent visit she asked Ms A about excessive pain, incontinence, offensive discharge or bowel and urinary problems, but there is no documentation of these discussions. Ms B said that if Ms A had reported any of these symptoms, the significance would have been explained. Ms B did not examine the wound again, as there was nothing to indicate an examination was necessary.

On 23 December, Ms A had a breast infection, and her general practitioner prescribed antibiotics.

Telephone calls
Ms A said that she telephoned "[the midwifery service]" because of the appearance of her perineum, and the fact that she was having trouble "holding everything in". She wanted to speak to "my midwife" and was put through to one of four midwives. She felt "fobbed off", and rang three times in total. On each occasion they spoke to her as though she was "stupid". One of the midwives came to her home to look at the

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stitches. Ms A cannot recall her name but was told that everything looked normal and that it takes a while to heal completely. There is no signature on the 20 December entry, and the signature on the 28 December entry is illegible.

On 12 January 2005 Ms C attended Ms A for her final postnatal visit. It was Ms C's only postnatal visit. She asked Ms A whether she or the baby were having any problems. The only matter raised was the baby's heat rash. Ms C examined the baby and advised Ms A on the appropriate treatment. Ms C said that as a matter of "good practice" she would not examine any woman's perineum without specific consent. She did not anticipate any problems with a first degree tear and, as Ms A did not say anything about incontinence or bowel problems, and as everything seemed to be progressing well, Ms A was discharged. Ms C recorded: "All well, D/C [discharge] today."

Ms A said that weeks later she thought she still did not look "quite right" in the perineal region, and had problems passing flatus. She telephoned "[the midwifery service]" for advice on whether it was possible that her stitches had fallen out, because she began to doubt whether she had ever been sewn up. Whoever she spoke to on the telephone said that she would contact Ms D. Ms A said that she received a message from Ms D telling her that there was no way her stitches could have fallen out. Ms A believed the midwives when they told her that everything was normal. The only advice she received was to continue the pelvic floor exercises. Ms A said that as a first-time mother she did not know what to expect, and "put up with my problems for 3 MONTHS".

On 14 March 2005, Ms A attended her general practitioner Dr F, for a cervical smear and examination. Dr F recorded:

> "Perineal tissue posterior fornix and anus absent. Anal sphincter deficient anteriorly."

Dr F referred Ms A to the Gynaecology Clinic at the public hospital.

On 23 March 2005, Ms A was seen by gynaecology consultant Dr G. She advised that initially Ms A was passing urine, and her bowel movement was "OK". Dr G told Dr F:

> "However since then she has noticed increasing problems with passing flatus through her vaginal and faecal incontinence. She has diminished sensation of the urge to pass bowel motion and has found she has already passed bowel motions without warning. She is also incontinent of flatus.
>
> With regard to her bladder, she is experiencing urgency and minor stress incontinence and does not need to wear a pad for this. She is attempting to do pelvic floor exercises. … On examination today she has a complete disruption of her anal sphincter. She has no perineal body and no sphincter anteriorly, there is just mucosa between the anus and the vagina. She has poor pelvic floor tone. … I

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> am referring her to [Dr H], colorectal surgeon, for consideration of repair of her sphincter and perineum. I have said to her that if this is done she will need to have her other remaining children by Caesarean section. She understands this. The other option is not to repair it until her child bearing is complete but I think her symptoms are too bad to warrant this and she agrees with this. I am organising an MRI of her anal sphincter and hopefully she will be seeing [Dr H] on 1 April."

Ms A was placed on the priority 1 surgical waiting list for repair of her perineum. Essentially Ms A had a "common opening between the anus and the vagina". On 1 April 2005, Ms A saw colorectal surgeon Dr H. He agreed with Dr G's assessment and reported his findings to her:

> "Perineal examination revealed almost a cloacal deformity of the perineum. There is only mucosa lying between her vagina and anus. She has an obvious sphincter defect arterially and has minimal ability to produce a squeeze. I am impressed that she is managing to maintain such a degree of continence despite these injuries. She is somewhat tender and I therefore did not proceed with any other further examination.
>
> [Ms A] obviously has a major sphincter injury. One is a little bit concerned with her history of passing flatus vaginally and I suppose there is a risk of a fistula there as well. She does deny passing of any bowel motion transvaginally however."

On 15 April 2005, after an MRI, Ms A was seen at a Clinic by colorectal surgeon Dr I, who recorded:

> "She essentially has a common opening between the anus and the vagina. The MRI you arranged has been extremely helpful. This shows the sphincter completely disrupted between the 1 o'clock and 12 o'clock positions. There is really only a thin strip of mucosa separating the anal canal anteriorly from the vagina. Clearly this is interfering with her life dramatically. There is no evidence on MRI of an actual fistula but I do share your concerns that her history suggests she may have one. Having said there is no definite evidence of a fistula, there is a tiny amount of gas in the soft tissues around the area so it may well be there is a subtle fistula present but I could [not] detect it on clinical examination today. Her sphincter is pretty good other than the defect and I think she is going to require full reconstruction of the perineal body, including putting her sphincters back together and performing levatoplasty."

On 20 May 2005, Ms A attended the pre-admission clinic at the public hospital for assessment. On 8 June 2005 Ms A had an anal sphincter repair and levatoplasty performed by Dr H and Dr I.

On 24 June 2005, Ms A saw Dr H at the Clinic. Ms A's postoperative tenderness prevented Dr I from completely assessing the success of the operation, and he arranged another appointment at the clinic in two months' time. When Ms A saw Dr I

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again she had developed a colorectal fistula, which was continuing to discharge. On 19 September Dr I performed further surgery to open the fistula to hasten healing and, hopefully, prevent ongoing problems. Ms A obtained a second opinion from colorectal surgeon Dr J. Dr J confirmed Dr I's findings that there was nothing more to be done at this stage and he would see her again in six months' time.

ACC findings

Ms A made a claim for medical misadventure to ACC. ACC obtained advice from two midwives, Rhonda Jackson and Terryll Muir, who found that Ms A had suffered an injury as a result of failure to provide appropriate maternity care and timely intervention. ACC reported:

> "… [H]ad a referral been made to an Obstetrician at the time of delivery to assist in repair of the perineum then the fourth degree tear would have been resolved with minimal risk of adverse sequelae. Lack of sufficient follow up of the injury also meant that timely intervention could not be provided and restoration of tissue function was delayed."

ACC accepted that a personal injury had occurred, which was causally linked to the treatment Ms A received (supported by MRI evidence), resulting in a finding of medical error.

Independent advice to Commissioner

The following independent expert advice was obtained from Ms Terryll Muir, midwife:

> "My name is Terryll Muir, I am a registered midwife and have been working as a midwife for 22 years. For 16 years I worked as a self employed case loading midwife caring for women in a variety of settings: Home births, primary facilities and at the secondary base hospital. Following that I spent two years employed as a hospital midwife at the base hospital, then two years as a midwifery lecturer and for the past eighteen months I have been employed as the clinical midwife leader at our secondary base hospital. This position is a combined management and clinical role.
>
> I have been asked to give advice to the Health and Disability Commissioner on the care given to [Ms A] during her labour and birth at [the public hospital] on the 12th December 2004 and during her postnatal care up until the 12th January 2005. This advice is regarding the appropriateness and adequacy of the care provided by midwife [Ms D] to [Ms A] at [the public hospital] on 12 December 2004, including the management of the second stage of her labour; assessment and suturing of her perineal tear; and postnatal care.

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I acknowledge that I have read the following documents that were sent to me:

- E-mail dated 27 September 2005 and enclosures from [Ms A], marked 'A' (numbered 1–35).
- E-mail dated 2 November 2005 from [Ms A], marked 'B' (numbered 36–37).
- Letter dated 7 November 2005 and enclosures from ACC, marked 'C' (numbered 38–51).
- Note and enclosures received from [Ms A] on 11 November 2005, marked 'D' (numbered 52–61).
- Letter of notification dated 19 October 2006 to [Ms D], marked 'E' (numbered 62–64).
- Letter dated 17 November 2005 and medical records from [the District Health Board], marked 'F' (numbered 65–88).
- Letter dated 2 December 2005 and enclosures from [Ms B, Ms C and Ms D's solicitors], marked 'G' (numbered 89–91).
- Letter dated 16 December 2005 and enclosures from [Ms B, Ms C and Ms D's solicitors], marked 'H' (numbered 92–134).
- Letter dated 13 February 2006 from [Ms E], marked 'I' (numbered 135).
- Letter dated 16 February 2006 and enclosure from [Ms C], marked 'J' (numbered 136–138).
- Letter dated 16 February 2006 and enclosures from [Ms B], marked 'K' (numbered 139–142).

File Number: 05/13928/WS

[Ms A]
25 years
G1P1
EDD 20/09/02
Baby: Female, weight 4125g
First stage: 5 hours 25 minutes
Second Stage: 23 minutes
Third stage: 3 minutes

[Ms C] — LMC midwife who provided the final postnatal visit.
[Ms D —'[a midwifery service]' midwife who provided labour care.
[Ms B] — '[a midwifery service]' midwife who provided postnatal care.
[Ms E] — midwife who assisted at the birth.

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Background
Twenty-five year old [Ms A] gave birth to her first child at [a public hospital] on 12 December 2004 with assistance from [Ms D]. It was an uncomplicated delivery. [Ms E] was also present at the birth.

Following the birth [Ms D] recorded that [Ms A] had a first degree tear which she repaired. [Ms A] remained in hospital until 15 December, during which time the perineum was not checked.

Postnatally [Ms A] said she rang '[the midwifery service]' three times with concerns about the appearance of her perineum, and problems with flatus and bowel movements since the birth.

[Ms B], another of the '[midwifery service]'midwives, saw [Ms A] at home on 17 December. The perineum was checked at this visit but nothing was recorded apart from 'a bit tender'.

Further postnatal checks were done at home on 18, 20 and 28 December 2004, and 6 and 12 January 2005. The perineum was not checked at any of these visits.

[Ms A] attended her general practitioner, [Dr F], on 14 March 2005 for a smear, and was examined. [Dr F] recorded 'Perineal tissue between posterior fornix and anus absent. Anal sphincter deficient anteriorly'.

[Dr F] referred [Ms A] to the gynaecology clinic and [the public hospital], and she was placed on the Priority 1 surgical waiting list for repair of her perineum.

[Ms A] was diagnosed with a severe anal sphincter injury and cloacal deformity of the perineum. She required a full reconstruction of the perineal body including putting her sphincters back together, and a levatoplasty. The operation was performed on 8 June 2005.

However, [Ms A] continued to experience problems, and on review a fistula was discovered. She had a further operation on 19 September 2005 to repair this. [Ms A] said it will be unclear how successful the operations have been for a few months yet, but it is unlikely to be perfect.

[Ms A] said she has been advised to have Caesarean sections for future deliveries to avoid the high risk of permanent anal incontinence, which may occur if she gave birth vaginally again.

[Ms A] now has reduced sensation, suffers from insomnia, stays at home a lot, and has missed out on time with her daughter while recovering from the subsequent operations. She said her marriage has also been placed under considerable strain.

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I have been asked to comment on the following questions and I will answer them in order.

1. In your professional opinion, was the service [Ms D] and [the midwifery service] provided to [Ms A] appropriate?

No

2. If the care provided was not appropriate, please explain why?

[Ms D] did not provide an accurate assessment and classification of the trauma present at the time of birth. This resulted in other staff and team colleagues not checking the perineum adequately, as they were unaware of the extent of the trauma. It also resulted in a delay in [Ms A] receiving the care she needed and prolonged the severe discomfort that [Ms A] suffered. Assessment and classification of genital tract injury forms part of the routine care expected from a midwife immediately following birth. It is done to identify trauma that requires early intervention to stop bleeding, promote healing and restore tissue function (McCandlish, 2001). Limitations should be recognised and appropriate assistance sought (Johnson & Taylor, 2000).

When [Ms A] raised concerns about her perineum, [Ms B] tried to reassure her that this was normal. A more thorough examination would have been appropriate at this stage, and although this examination could not be as thorough as at the time of birth, to not have done so resulted in a significant delay in [Ms A] receiving the care she needed and prolonged the severe discomfort that [Ms A] suffered.

[Ms C] did not examine [Ms A's] perineum at the final postnatal visit, there was no documentation to show that the perineum had been fully examined at any earlier postnatal visit. A failure to do this resulted in a significant delay in [Ms A] receiving the care she needed and prolonged the severe discomfort that [Ms A] suffered. At some stage during the postnatal period, a perineum that has been traumatised should have a full examination, this is usually left until a time when healing has occurred, which is why it is recommended to be at the final check. Some midwives may do it a little earlier. The New Zealand College of Midwives Handbook for Practice states that the final postnatal visit is to include an examination of the perineal repair.

3. What standards apply in this case? Were these standards satisfactorily applied by [Ms D] and/or [the midwifery service]?

Standard Six: New Zealand College of Midwives Standards for Practice applies in this case:

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- The midwife is to identify deviations from the normal and after discussion with the woman, consult and refer as appropriate. [Ms D and Ms C] did not adequately meet this standard.

- The midwife is to ensure assessment is ongoing and modifies the midwifery plan accordingly. [Ms B] did not adequately meet this standard.

4. In your opinion was [Ms D's] care during the second stage of the delivery of [Ms A's] baby appropriate?

Yes, [Ms E] does not recall any difficulties or concerns that arose during the delivery. This is reassuring that the birth was managed appropriately.

The risk factors for severe perineal trauma are: nulliparous women (women delivering their first baby); fetal macrosomia (weight over 4500g); induction of labour; older women; second stage of labour over 60 minutes; forcep deliveries and fetal distress (Sheiner, Levy, Walfisch, Hallak & Mazor, 2004; Samuelsson, Ladfors, Lindblom & Hagberg, 2002). [Ms A] only had one definite risk factor, she had a low risk of severe perineal trauma.

The incidence of anal sphincter injury is reported as being 0.6% (Williams, 2003) –4.4% (Christianson, Bovbjerg, McDavitt & Hullfish, 2003). The risk factors for anal sphincter injury are: forceps, nulliparous women, increasing fetal weight and midline episiotomies (Christianson et al., 2003). [Ms A] had only one definite risk factor, possibly two counting the baby's weight, she had a low risk of anal sphincter injury.

Pelvic floor damage is greater in women with a prolonged active phase of the second stage, which is when the woman is pushing. The average length of the second stage in a woman having her first baby is one to two hours. The second stage [Ms A's] labour was only 23 minutes, this is quite short for a primigravid woman and indicates a low risk of pelvic floor damage.

If [Ms D] had performed a medio-lateral episiotomy on [Ms A], during the delivery of the fetal head, the extent of the trauma may not have involved the anal sphincter. However, an episiotomy will always cause damage to the perineum and it is normal practice to avoid episiotomies if possible as women have more pain, heal slower, and have more long-term complications such as sexual dysfunction than if the perineum is allowed to tear (Bennett & Brown, 1999). For an episiotomy to have been considered there would need to be indications present, there were not.

5. Did [Ms D] take appropriate steps to safeguard the perineum during the delivery?

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Yes, [Ms E] does not recall any difficulties or concerns that arose during the delivery. This is reassuring that the birth was managed appropriately.

During the second stage of labour the soft tissues of the vagina and the pelvic floor gradually stretch and thin under the pressure of the advancing fetal head. The head will continue to descend sufficiently to exert pressure on the rectum and perineal tissues. The head will then become visible. With each contraction the fetal head descends and as it does the superficial muscles of the pelvic floor stretch. Between contractions the head recedes a little allowing these muscles to thin gradually (Bennett & Brown, 1999).

It is the skill of the midwife in ensuring the delivery of the baby is unhurried to help safeguard the perineum from trauma (Bennett & Brown, 1999). However, this is not always possible, there are some women who will always have perineal tears no matter how skilled the midwife is (Enkin et al, 1996).

6. Was [Ms D's] examination of [Ms A's] perineum appropriate?

No. Following the birth [Ms D] stated that she evaluated the perineum for any lacerations and tears, identified the apex and then sutured a first degree laceration. After this, she performed a rectal check to rule out any abnormalities and to ensure sphincter control and reassessed the perineum to ensure a good cosmetic result.

It is possible that the perineum became infected and broke down following being sutured correctly. However it is unlikely that the perineum would break down to such an extent as this. There was also never any mention of an infection. On the balance of probabilities it is unlikely that this occurred. It is also unlikely that sexual intercourse would result in tearing perfectly normal skin, it is possible that sexual intercourse could open up a laceration partly healed, if [Ms D] had been correct in her assessment then this would only result in a first degree laceration reopening. On the balance of probabilities it is unlikely that sexual intercourse would cause damage to this extent.

To accurately assess the genital tract, it is important that all the walls of the vagina are assessed from the cervix to the introitus. It is essential that good lighting be used. From the information provided, it is most likely that the damage to [Ms A's] perineum occurred at the time of birth and that [Ms D] misdiagnosed the extent of the damage. The most likely explanation for this occurring is that the assessment process was not adequate.

7. Should [Ms D] have requested that another health professional assess the severity of the tear at any stage? If so, please explain who would have been an appropriate person to refer [Ms A] to?

Yes and no. Yes, if [Ms D] was unsure of the degree of tissue involvement she needed to refer to an obstetrician for assistance. However, [Ms D] assessed the

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perineal damage to be a first degree laceration only, she was capable of suturing a tear of the extent that she assessed and in this case it was not necessary to refer to anyone.

8. Was it appropriate for [Ms D] to suture the tear in [Ms A's] perineum?

Yes, [Ms D] was capable of suturing a tear of the extent that she assessed.

9. Is [Ms D's] description of her usual practice regarding suturing appropriate?

Yes, except that to accurately assess the genital tract, it is important that all the walls of the vagina are assessed from the cervix to the introitus. I would recommend that in future [Ms D] visualise the cervix and the entire posterior vaginal wall during her assessment process.

10. Did [Ms D] check her suture repair of [Ms A] appropriately?

No. From the information provided, it is most likely that the damage to [Ms A's] perineum occurred at the birth and that [Ms D] misdiagnosed the extent of the damage. The most likely explanation for this occurring is that the assessment process was not adequate. For the extent of damage to be missed, the assessment after the repair was inadequate as well.

11. Did [Ms D] examine [Ms A] appropriately to ensure she had repaired the total injury?

No, answered in Q10.

12. Did [Ms D] ask [Ms A] appropriate questions about her postnatal status?

[Ms C] was the LMC. [Ms A] transferred to [the maternity unit] for postnatal maternity care on the 12th December, which was the day she delivered, she transferred home on the 15th December and was seen at home by [Ms B] for three of her postnatal visits, her final postnatal check was done by [Ms C]. From the information provided it does not appear that [Ms D] was responsible for any postnatal care.

13. Was the postnatal care [Ms D] provided to [Ms A] regarding her perineum appropriate? If not, please explain why not?

Answered in Q12.

14. Was the information [Ms D] recorded in [Ms A's] records appropriate?

Yes, it was appropriate, it was not thorough.

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15. In your opinion, is [Ms D's] training and ongoing education appropriate?

This is not possible for me to answer, this is a matter that would be best discussed with the Midwifery Council.

16. Were the postnatal checks performed by the other midwives from [the midwifery service] appropriate?

The postnatal checks performed by the midwives were appropriate considering that the care and advice regarding [Ms A's] perineum would all have been based upon the knowledge that [Ms A] had a first degree laceration, which was sutured.

[Ms B] checked [Ms A's] perineum on her first visit to [Ms A] at home. She writes that the perineum is 'fine — a bit tender'. This documentation could have been more thorough.

When [Ms A] raised concerns about her perineum, [Ms B] tried to reassure her that this was normal. A more thorough examination would have been appropriate at this stage, and may have resulted in the problem being diagnosed and treatment being sought much earlier than what has occurred.

17. Did the midwives ask [Ms A] appropriate questions about her postnatal status?

I think [Ms A] gave them adequate information, no further questions were required, the perineum should have been checked at this stage, it was not.

18. Was the information recorded by the other midwives regarding the postnatal checks appropriate?

Yes

19. Are there any aspects of the care provided by [Ms D] and/or [the midwifery service] that you consider warrant additional comment?

No

Severity of departure from acceptable care
In my opinion the three midwives have provided care that is below expected standards, which has resulted in unacceptable suffering and pain to [Ms A].

Not having performed a thorough assessment of the perineal laceration at the time of delivery was a moderate departure from an acceptable standard of care by [Ms D].

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Not having assessed the perineum when [Ms A] raised concerns during the postnatal period was a mild departure from an acceptable standard of care by [Ms B].

Not having assessed the healing of the perineum at the final postnatal check was a moderate departure from an acceptable standard of care by [Ms C]."

Additional midwifery advice
Ms Muir provided the following additional advice:

"30 June 2006

We now have responses from [Ms B and Ms C]. Would you please review your original advice and make changes if necessary?

I have read the responses from both [Ms B and Ms C], and I have re-read the original complaint from [Ms A].

It is highly likely that the vaginal wall and perineum would have healed to form a bridge over the underlying damage, however a thorough examination would have easily revealed the damage. This examination would not have required a rectal examination.

[Ms B] checked [Ms A's] perineum on day 5. It was reasonable of her not to perform a thorough examination at this stage as she would be careful not to disturb the healing process that was taking place. A quick check of the perineum would have revealed a healing perineum on top of the damaged sphincter.

However, there is no documentation to support [Ms B's] comments that she asked about excessive pain, incontinence, offensive discharge or problems with bowel movements. These questions would have shown a reasonable response to [Ms A's] concerns. [Ms A] reports that she did raise these concerns with [Ms B]. The presence of any one of these symptoms would have been an indication for a more thorough examination to be performed. A complete visual check of the perineum and rectum would be all that was necessary to see the damage that has been reported.

I have considered the possibility that the perineum became infected and broke down following being sutured correctly. It is unlikely that a completely healed perineum would break down to such an extent as occurred in this case. A breakdown generally only involves the tissue that was originally damaged, also there was never any mention of an infection. On the balance of probabilities it is unlikely that this occurred.

In regards to the care given by [Ms B], I stand by my original opinion and wish to make no changes.

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During the postnatal care a final assessment of the perineum is necessary to ensure tissue function has been restored. The timing of this assessment varies, and often occurs at the final postnatal check, unless it has been done earlier. As there was no documentation to show that the perineum had been fully examined at any earlier postnatal visit, I stand by my original opinion, in regards to the care given by [Ms C] and wish to make no changes.

It is my opinion that the three midwives have provided care that is below expected standards, which resulted in unacceptable suffering and pain to [Ms A]."

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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 that comply with legal, professional, ethical, and other relevant standards.

...

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

Other relevant standards

The New Zealand College of Midwives *Standards of Practice* (1993) states:

"STANDARD THREE

The Midwife collates and documents comprehensive assessments of the woman and/or baby's health and well-being.

CRITERIA

The Midwife:

…

- Documents her assessments and uses them as the basis for on-going Midwifery.

…

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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;"

Opinion: Breach — Ms D

Under Right 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code) Ms A had the right to services that comply with professional standards. Under Right 4(5) she was entitled to co-operation between her providers to ensure consistency and quality of care. The standards that apply in this case are the *Standards of Practice* set by the New Zealand College of Midwives in 1993, specifically Standards Three and Six.

Delivery and postnatal care

On 12 December 2004, Ms D delivered Ms A's baby. Ms D was unconcerned about the delivery, which had proceeded quickly for a first-time mother, without problems. However, Ms A sustained a perineal injury that Ms D classified as "first degree", involving the vaginal mucosa and outer perineal skin only. Ms D described how she sutured the tear, following her normal procedure, using "interrupted sutures to the muscle layer". It would not have been necessary to suture torn muscle if Ms D had assessed the tear accurately, because a first degree tear does not involve muscle tissue. Ms D said that, after suturing, she carefully examined Ms A's perineum and anal sphincter for appearance and could see no abnormality.

Ms E recalls that Ms A's labour and delivery went well. It was Ms E's responsibility to care for the baby, and be available if Ms D needed assistance. However, Ms D simply proceeded to suture the wound and did not need any assistance.

My advisor noted that anal sphincter damage can occur during delivery, particularly when a woman is delivering for the first time. Ms A would have been considered "low risk" because she did not have any other factors likely to damage the perineum or

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surrounding tissues, such as an overly large baby, delayed delivery or excessive pushing on the perineum.

Ms Muir commented that a perineal tear usually occurs as the baby's head is appearing, stretching the tissues to accommodate the descending head. Ms D could have performed an episiotomy to expand the opening, but accepted practice is to avoid an episiotomy if possible because women experience more pain, are slower to heal and there is an increased risk of long-term complications.

Ms D believed that Ms A had a first degree tear and did not consider an obstetric consultation necessary. It appears that Ms D followed normal practice — she examined Ms A's perineum, evaluated the laceration, and performed a rectal check, after she had sutured the laceration. I accept that Ms D would not have hesitated to call an obstetrician if she had thought that Ms A had a fourth degree tear. Ms D wondered whether some other injury may have exacerbated the tear and delayed healing.

Ms Muir advised:

> "It is possible that the perineum became infected and broke down following being sutured correctly. However it is unlikely that the perineum would break down to such an extent as this. There was also never any mention of an infection. On the balance of probabilities it is unlikely that this occurred. It is also unlikely that sexual intercourse would result in tearing perfectly normal skin, it is possible that sexual intercourse could open up a laceration partly healed, if [Ms D] had been correct in her assessment then this would only result in a first degree laceration reopening. On the balance of probabilities it is unlikely that sexual intercourse would cause damage to this extent.
>
> To accurately assess the genital tract, it is important that all the walls of the vagina are assessed from the cervix to the introitus. It is essential that good lighting be used. From the information provided, it is most likely that the damage to [Ms A's] perineum occurred at the time of birth and that [Ms D] misdiagnosed the extent of the damage. The most likely explanation for this occurring is that the assessment process was not adequate."

Colorectal surgeons Drs I and J both concluded that the injury was a complete disruption of the anal sphincter that occurred at the time Ms A's baby was born. The findings were confirmed on MRI scan. I am satisfied that Ms D incorrectly classified Ms A's laceration.

Ms D had no further contact with Ms A, apart from one telephone call (not documented) in response to a telephone enquiry from Ms A (after the final postnatal visit on 12 January 2005) when Ms D assured her that the stitches could not have fallen out. This was another missed opportunity to assess the wound and intervene sooner.

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I am satisfied that Ms D managed Ms A's labour and delivery well and did not breach the Code. Nevertheless, she breached Standard Six of the College's *Standards of Practice*, in failing to identify the true extent of Ms A's perineal injury, discuss the situation with her, and seek an obstetric assessment as appropriate. The flow-on effects of the omission were alarming for Ms A. Ms D's colleagues were not alerted to the need of ongoing assessment and the risk of delayed healing. The consequences of Ms A's untreated injury were significant and distressing for her.

In failing to comply with professional standards, Ms D breached Right 4(2) of the Code.

Opinion: Breach — Ms B

Ms B believes that she provided an appropriate standard of care for Ms A. Ms B made three postnatal visits, the first on 17 December 2004. When Ms A said that her perineum was "tender", Ms B examined the wound. The light was not good but, as far as she could see, the wound appeared to be "healing well" and "firm". Ms A said that she had not experienced any urine or bowel problems. Ms B told her that it was normal to have some discomfort after a tear, and she did not anticipate any problems. On the two follow-up postnatal visits Ms B did not examine Ms A's perineum, relying on her to report any symptoms, such as urine and bowel problems, unpleasant discharge or ongoing pain.

Ms A remained concerned and called the midwives for help. She is vague about the times she called and which midwives she spoke to. However, it is clear that Ms A was given the impression that everything was normal and her concerns were unfounded. Ms A said that she was made to feel "stupid" and that she simply had to put up with the problems.

My advisor said that Ms B's care on her first postnatal visit to Ms A was appropriate, given Ms D's assessment and classification of the trauma. Ms B assessed Ms A's perineum five days after the baby's birth. The amount of healing that takes place in five days is limited, and Ms A needed further assessment some time later. To accurately assess the vaginal tract, it is important that all vaginal walls are assessed, under good lighting.

Ms B submitted that a thorough examination would entail a rectal examination, and that this would be inappropriate, as it would disrupt healing. My advisor commented:

> "It is highly likely that the vaginal wall and perineum would have healed to form a bridge over the underlying damage, however a thorough examination would have easily revealed the damage. This examination would not have required a rectal examination.

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> [Ms B] checked [Ms A's] perineum on day 5. It was reasonable of her not to perform a thorough examination at this stage as she would be careful not to disturb the healing process that was taking place. A quick check of the perineum would have revealed a healing perineum on top of the damaged sphincter."

It would have been wise for Ms B to have examined Ms A on subsequent visits, with good lighting, when the swelling had subsided and further healing had taken place. The brevity of Ms B's documentation does not make it possible to confirm whether her examination was adequate. Dr I said that Ms A must have been experiencing quite severe problems. Ms A said that she had been made to feel "stupid" whenever she asked about her wound, so it is not surprising that she did not continue to report her problems to "[the midwifery service]".

Although Ms B's initial postnatal care was appropriate, in my opinion her overall postnatal care was inadequate and did not comply with professional standards. Accordingly, Ms B breached Right 4(2) of the Code.

Opinion: Breach — Ms C

Ms C said that she provided an appropriate standard of care for Ms A, given that she saw her only once.

On 12 January 2005, Ms C attended on Ms A for her final postnatal visit. Ms C did not examine Ms A's perineum, and documented: "12/1/05 all well D/C [discharged] today", perineum "fine", bowel/bladder "normal".

My advisor said that Ms A's wound should have been checked to ensure tissue integrity and perineal function before she was discharged from maternity care. There is no specific time for this examination but if it has not been done beforehand it should be included in the final visit. Ms A's wound was examined on one occasion (17 December 2004) after her baby's birth on 12 December 2004. Ms C's failure to examine Ms A before discharging her from maternity care was a moderate breach of Standard Six of the College of Midwifes' *Standards of Practice*. In failing to comply with professional standards, Ms C breached Right 4(2) of the Code.

Opinion: No Breach — The Midwifery Service

Vicarious liability
Section 72 of the Health and Disability Commissioner Act 1994 (the Act) provides that employing authorities are vicariously liable for the acts and omissions of

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employees, agents and members. For section 72 of the Act to apply, there must be an "employing authority", which is defined in section 72(1) as being a health care provider or a disability services provider.

Ms D, Ms B and Ms C are members of a group of four midwives called "[the midwifery service]". Each member is an independent midwife, caring for their own clients and responsible for the associated administration. In order to provide 24- hour coverage and to meet the section 88 notice requirements, each midwife provides a locum service for their group. It is a reciprocal arrangement whereby each midwife works with her colleagues to ensure care and continuity of service.

"[The midwifery service]" is not a legal entity and does not itself provide health or disability services. Accordingly, "[the midwifery service]" is not an employing authority under the Act and therefore vicarious liability cannot arise.

Opinion: Breach — Ms D, Ms B and Ms C

Although I have concluded that no vicarious liability arises on the part of "[the midwifery service]", there are some areas of common concern regarding the care provided to Ms A by Ms D, Ms B and Ms C. I consider that the documentation they used, and the systems that they had in place for seeing each other's clients, were not of an acceptable standard and did not serve to provide the necessary continuity of care.

Documentation
Ms D, Ms B and Ms C are independent midwives who provide a locum service for their colleagues. I am concerned that, in caring for Ms A, each midwife acted on very limited information.

Ms Muir has drawn my attention to the brevity of the documentation used by each midwife. I have examined the form used by "[the midwifery service]" midwives to record their postnatal findings. It records the findings of eight postnatal visits, and assessments of 15 aspects of postnatal care. There is not enough room on the form for adequate recording. In my view the standard forms used by members of "[the midwifery service]" contributed to the lack of necessary detail in their records.

Initially, Ms B and Ms C were lulled into thinking that Ms A had a first degree tear, by the fact that this was the assessment recorded by Ms D. However, Ms A subsequently questioned whether her wound was healing appropriately, and this information was not documented or relayed to her midwives. This omission did not facilitate early intervention, and delayed healing. All three midwives must accept responsibility. Standard Three of the College of Midwives' *Standards of Practice* requires that the

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midwife "documents her assessments and uses them as the basis for on-going midwifery". Clearly, this standard was not met.

During this investigation, Ms D could not recall important information, such as the position of the apex and termination of the perineal laceration. If she had recorded the information she would have been in a better position to defend her assessment.

Between them Ms B and Ms C saw Ms A four times. They were able to tell me the questions they would have asked Ms A. However, there is no substantive documentation of their findings from each postnatal visit on which to base ongoing assessments.

Ms A said that she telephoned "[the midwifery service]" for help on several occasions expressing concern about her perineum, but calls are not recorded in her notes, the midwife who took the call is not recorded, and none of the four "[midwifery service]" midwives could recall whether she received this information.

Each midwife told me that they relied on Ms A to tell them if she had any problems. Midwives must remember that first-time mothers will naturally ask questions about issues experienced for the first time, whereas the midwife may have answered the same questions many times before. The manner in which a first-time mother is addressed influences whether she has the confidence to ask again. In Ms A's case she said she felt "fobbed off" and "stupid". It is unlikely she would be willing to ask a second time. The fact that she "put up" with this situation for three months confirms that Ms A felt unable to seek further attention from "[the midwifery service]".

Ms A had the right to co-operation between her midwives to ensure quality and continuity of care. Where several different providers provide a service, appropriate and adequate documentation are critical to ensure consistency and quality of care. The fact that Ms A's concerns and phone calls were not noted anywhere meant that they were not followed up when she was seen by a different midwife.

In these circumstances, Ms D, Ms B and Ms C breached Rights 4(2) and 4(5) of the Code.

Recommendations

I recommend that Ms D, Ms B and Ms C take the following actions:

- Apologise to Ms A for breaching the Code. These apologies are to be sent to the Commissioner's Office and will be forwarded to Ms A.

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- Confirm that they have improved their systems for documentation of delivery, postnatal findings and contact with clients, and advise the Commissioner of the steps taken.

Follow-up actions

- A copy of this report will be sent to the Midwifery Council of New Zealand.
- A copy of this report, with details identifying the parties removed, except the names of Ms D, Ms B and Ms C, 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.

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