Midwife

Report on Opinion - Case 98HDC13531

Complaint

The Commissioner received a complaint from the complainants on behalf of their daughter, the consumer, concerning a midwife. The complaint is that in early March 1998 the midwife:

- *Did not take reasonable action to diagnose that the consumer's baby was lying in a breech position.*
- *Did not adequately monitor the labour of the consumer.*

Investigation Process

The complaint was received on 30 March 1998 through an Advocacy Trust and an investigation was commenced on 28 April 1998. Information was obtained from:

The Complainant/Mother of the Consumer
The Complainant /Father of the Consumer
The Consumer/Complainant
The Provider /Midwife
A Second Midwife
A Third Midwife
A Fourth Midwife
The General Manager of a Crown Health Enterprise ("CHE")

The consumer's medical records were obtained and reviewed. The Commissioner received advice from an independent midwife

Information Gathered During Investigation

In mid August 1997 the consumer registered the midwife as her lead maternity carer, the person who provides most of the consumer's care while the consumer is pregnant, during birth and after the birth ("LMC"). The consumer was twelve to fourteen weeks pregnant with her estimated date of delivery in early March. Initially the consumer had slightly elevated thyroid function levels. The midwife consulted with the consumer's general practitioner about the thyroid levels, but the levels soon settled to normal.

At thirty-seven weeks pregnant the consumer had a major crisis when her brother drowned. The consumer's blood pressure became elevated but after two weeks was once more within the normal range.

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Information Gathered During Investigation *continued*

The midwife stated to the Commissioner that when examining the consumer throughout her pregnancy none of the classic indicators of breech presentation were present on palpation. Breech presentation is when the baby presents with the head up instead of the usual downward position. This can sometimes lead to complications in a vaginal delivery requiring a caesarian section. The midwife stated that from thirty-seven weeks onwards she palpated the baby's head as presenting in the latero-posterior (downwards) position.

In early March 1998 at 3.00pm the consumer telephoned the midwife to advise that she had been having contractions at fifteen minute intervals.

The midwife stated she advised the consumer to get some rest because she would probably go into labour. The midwife had another client, a friend of the consumer's, who was in labour and had gone into hospital at 1.30pm that day. The midwife stated it seemed likely her two clients would be in labour at the same time so she tried to arrange back-up. The midwife's usual back-up midwife was about to attend a home birth and had contacted another midwife to assist her.

The midwife rang another midwife, the second midwife, who was about to fly to the city. The second midwife stated to the midwife that she would be available for backup after 7.30pm and could be paged at a meeting she planned to attend later that evening. The second midwife stated to the Commissioner:

> *"After arriving back in* [the city] *I left from home at 7.55pm to go to my meeting, not having heard from* [the midwife] *and knowing I had both my cell phone and pager with me in my bag."*

The midwife rang the consumer back at approximately 5.00pm to check on her progress. The midwife stated the consumer was contracting irregularly, but she believed that the consumer was not in established labour. The midwife telephoned the consumer again at 6.00pm and was informed by the consumer's partner that the contractions were still irregular and that the consumer was most comfortable in the bath. There was discussion about coming to the hospital for an assessment. The midwife stated she informed the consumer and her partner (with the consumer's friend's permission) that the consumer's friend's baby was close to being born and that the midwife might be occupied when they first arrived.

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Information Gathered During Investigation *continued*

The consumer and her partner arrived at the birthing centre at approximately 7.00pm. The midwife stated that she assessed the consumer, briefly palpating the baby and that she thought that the lie of the baby was occipito-posterior (head down in a normal position). The midwife said she had trouble hearing the foetal heartbeat with the hospital sonicaid because the batteries were flat and therefore she obtained her own instrument. The midwife stated the heart could be heard just above the symphysis pubes where it was heard the last time she listened. The rate was 135 to 145 beats per minutes ("bpm") and movements were felt over a wide area.

The contractions were one every seven to ten minutes and were palpated as moderately strong. The midwife said to the Commissioner that she then suggested the consumer have a bath because this was where the consumer felt most comfortable. At 8.00pm the consumer's partner came to the midwife, who was with her other client, saying he thought his wife's membranes had ruptured because, "*there was shit floating in the bath*". The midwife stated she immediately expected meconium (the first stools of a new born baby which can indicate fetal distress) and went straight to see what was happening:

> *"I was relieved to see there was no meconium but there was white vernix* [the layer of greasy material covering a new born baby]. *I explained this to* [the consumer and her partner] *and checked the foetal heart rate. I suggested a vaginal examination to assess progress but* [the consumer] *indicated that she was not keen at this stage. Once I was assured that* [the consumer] *and baby were well I returned to* [my other client]*."*

The consumer stated to the Commissioner:

> "[The midwife] *did offer to do an internal, but said she'd have to go and get long gloves & that the other woman's delivery was critical. This would have been about 9pm. I felt like it would be a hassle for her and said if she was needed elsewhere she had better go."*

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Information Gathered During Investigation *continued*

The midwife reported that the other woman who was in labour had complications and required specialist assistance. At 8.30pm the consumer's partner advised the midwife that the consumer was becoming sore. The midwife checked the consumer and found that contractions were still not completely regular but were generally coming once every five minutes. The heart rate was checked at regular intervals and was about 135 bpm, which is within the normal range.

The midwife told the consumer that she was still not available and that she would call her back-up midwife, the second midwife, to come in. The second midwife was phoned at home and her husband told the midwife that she was at a lecture. The midwife stated she paged the second midwife three times over the next half-hour and the phone indicated that it was either switched off or outside the coverage area. The second midwife reported:

> *"I returned home at 12.30am and heard my tracer buzzing in my bag. I had thought it was on 'audible' rather than 'vibrate' and discovered that* [the midwife] *had traced me at 10.30pm, 2 hours previously.*
>
> *While my cellphone had been turned on during the meeting, the battery at some stage had expired."*

The midwife attempted to contact another midwife but she was also unavailable. At this time the midwife was called urgently into her other client's room to assist. Later the midwife returned to the consumer to check that all was well and found that the consumer was still in the bath. The midwife explained that the other client was to go to the post-natal ward and that she would be back as soon as possible. The midwife then brought in the other client's baby and showed it to the consumer. The midwife was unaware that the consumer had stated to her partner that she did not wish to see her friend's baby.

The consumer said that she later found out her friend, who was delivered of her baby at around 9.00pm, had a specialist present during the labour and three different types of pain relief including an epidural:

> "*Lots of attention from lots of people (including* [the midwife], *but* [the midwife] *hadn't actually assisted much with the delivery (performed by a specialist)."*

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Information Gathered During Investigation *continued*

The consumer stated that the midwife returned at between 9.50pm and 10.00pm and performed an internal. By this time the consumer described her contractions as intensely strong and evenly spaced at three-minute intervals. The consumer said the internal revealed that she was ten centimetres dilated with a foot coming down.

The midwife reported that at 11.00pm, when the consumer was complaining of increasing pressure, a vaginal examination was performed showing a breech presentation. Eleven pm was also the time which the midwife recorded in the labour summary that the assessment was undertaken. The midwife informed the consumer and her partner and called the hospital midwife for assistance. The midwife asked that an obstetrician be called as none were in the unit. The hospital staff set up for a breech delivery while the midwife listened to the heart rate. The midwife stated the heart rate was reactive but started having marked decelerations during contractions with good recovery.

The obstetrician, arrived after about twenty minutes. The medical notes indicate that the obstetrician assessed the consumer to be fully dilated and said that the baby would deliver vaginally. The consumer was placed in the lithotomy position and began to push. As the feet were delivered, the midwife reported that she lost contact with the heartbeat and informed the obstetrician of this. The next contraction delivered the legs. There was a delay at the shoulders because the contractions "*died off*" and the obstetrician checked to see that he had not missed some "*undilated cervix*". The obstetrician asked the consumer to push without the contractions and he placed his hand in the vagina to assist flexion. The midwife reported these last pushes were very painful for the consumer and she cried out and that this was difficult for the consumer's partner to watch. However, he remained and supported the consumer throughout.

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Information Gathered During Investigation *continued*

The obstetrician wrote in the labour summary:

> *"Called to undiagnosed breech.*
> [11.15pm] *Small baby. Feet in vagina with rapid descent occurring. Decision to continue with vaginal breech delivery.*
>
> *Assisted vaginal breech delivery. Rapid descent during contractions. Good maternal effort. Legs and trunk delivered spontaneously. Arms brought down in Maurice-Smellie-Viet manoeuvre to deliver head. Live male infant* […] *delivered in fairly good condition and handed to* [paediatrician]*.…"*

The baby was delivered at 11.45pm. The midwife reported:

> "[T]*here was some meconium present which is not unusual with breech babies. He was pale and floppy and placed on* [the consumer's] *abdomen while the cord was cut and then he was given to the paediatrician. I explained to* [the consumer] *that he needed his airways cleared and would probably be intubated and given some oxygen. The* [paediatrician] *commented on his good heartbeat.* [The baby] *rallied well and at 10 minutes was breathing on his own and had good muscle tone. He was transferred to the* [neonatal intensive care unit] *because of the delay in the delivery of the head and small birth weight, but he did not develop respiratory distress. The baby was fully breast feeding on discharge and was gaining weight and appeared to be doing well."*

The midwife reported that the consumer told her that she was very upset that the midwife was not with her more during her labour and that the midwife apologised for this. The midwife stated:

> "*It is very unusual for an independent midwife to have two women labouring at the same time although it can be quite common for hospital midwives."*

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Information Gathered During Investigation *continued*

The midwife said, *"it is never an ideal situation looking after two woman at one time"* and regrets that the consumer has felt let down about this.

The midwife stated that medical and midwifery texts give the incidence of breech positions as occurring in three to four percent of babies at term, and of these ten to fifteen percent will be undiagnosed in labour.

Independent Advice to Commissioner

The Commissioner obtained advice from an independent midwife as follows:

Vaginal Examination
My midwife advisor stated:

> "[T]*he intensity of the labour and the breech presentation would have been apparent at an earlier point had* [the midwife] *done a vaginal assessment either at admission to the* [birthing centre] … *or at the spontaneous rupture of membranes at* [8.00pm]. *Details from this assessment would have greatly informed the development of an appropriate care plan inclusive of Obstetrician involvement and transfer to secondary care."*

Late Diagnosis of Breech Position
When questioned as to whether the late diagnosis of breech contributed to the baby's asphyxia, my midwife advisor stated:

> *"Almost certainly. By the time the breech presentation had been diagnosed* [the consumer] *was already fully dilated with the presenting part at station +1. As there was no Obstetrician immediately available, he (*[the obstetrician]*) had to come from home twenty minutes away. In his assessment at* [11.15pm the obstetrician] *states that there were "feet in the vagina with rapid descent occurring. Decision to continue with vaginal breech delivery." It was now too late to organise emergency caesarean section.*

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Independent Advice to Commissioner *continued*

As the breech birth proceeded there was a reduction in the number of contractions necessitating [the obstetrician] *to ask the consumer to push without a contraction to affect delivery of the babes head using the Maurice-Smellie-Viet manoeuvre to enhance flexion. The babes apgar score* [a method of rapidly assessing the general state of a baby immediately after birth] *reflects graphically the difficulty of the birth for the baby, 0 at 1 minutes, 3 at 5 minutes, 9 at 10 minutes. Active resuscitation was required and the babe did not breathe spontaneously for 6-7 minutes."*

Detection of Breech Presentation

My midwife advisor, using data from Backe and Nakling in their population-based study: *Effectiveness of Antenatal Care* (1993 Brit J Obstetrics & Gynaecology 100:727-732), commented:

> *"The detection rate for small for gestational age was remarkably low (14%) and breech presentation only (69%). Unfortunately this sort of omission appears very common.*
>
> *… Given that antenatal diagnosis of breech presentation and intra uterine growth retardation are frequently missed, it would seem at least judicious to conduct a vaginal examination once labour has been determined to be established. In this situation it would have allowed for a more controlled birth experience for* [the consumer] *and baby* […]*."*

Code of Health and Disability Services Consumers' Rights

RIGHT 4
Right to Services of an Appropriate Standard

…

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

3) Every consumer has the right to have services provided in a manner consistent with his or her needs.

…

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

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Other Relevant Standards

New Zealand College of Midwives Standards for Midwifery Practice

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 a basis for on-going Midwifery.*

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

CRITERIA

The Midwife …

- *plans midwifery action on the basis of current and reliable knowledge and in accordance with Acts, Regulations and relevant policies;*
- *ensures assessment is on-going and modifies the Midwifery plan accordingly;*

…

The Second Decision Point in Labour

From Examination

- *assess woman's well-being, including her emotional and behavioural responses;*
- *check blood pressure and pulse;*
- *discuss need for vaginal examination;*
- *assess contractions, lie presentation and descent of baby;*
- *assess baby's well-being, including heart rate;*
- *if membranes have ruptured, check liquor.*

Midwife

Report on Opinion – Case 98HDC13531, continued

Opinion: Breach

In my opinion the midwife breached Rights 4(2), 4(3) and 4(5) of the Code of Health and Disability Services Consumers' Rights as follows:

Right 4(2)
The midwife did not reach acceptable professional standards in caring for the consumer during her labour. Her actions were contrary to the New Zealand College of Midwives Standard 6 and the Scope of Practice which states that midwifery actions are prioritised and implemented appropriately with no action or omission placing the woman at risk.

In particular, the midwife did not undertake a vaginal examination to ascertain the progress of labour until labour was well established. I accept my advisor's comment that a vaginal examination should have been performed at admission or at 8.00pm, especially when the midwife was only able to be present intermittently during the consumer's labour.

The midwife not only failed to detect the breech presentation but also did not pick up that the baby was smaller in size than usual. I accept that the statistics demonstrate this occurs frequently. However, if an appropriate standard of care had been given during the consumer's labour her baby may not have faced unnecessary trauma and asphyxiation at birth.

Right 4(3)
In my view the midwife did not respond adequately to the needs of the consumer and her partner. The consumer was in labour for the first time and needed more support than the midwife gave. The delays in monitoring were unacceptable. The midwife demonstrated she was not attending fully to the consumer's needs when she showed the consumer her friend's new born baby. If she had taken time to recognise what was happening for the consumer, this insensitive action would not have occurred.

Further it was not acceptable to rely on the consumer and the consumer's partner to signal that they required more assistance. As first time expectant parents, they should not in any way be responsible for monitoring the progress of labour and detecting possible deviations from the norm. This is the task of the midwife.

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Opinion: Breach *continued*

Right 4(5)

The midwife did not ensure that the consumer had continuous midwifery services. While I accept that the midwife made attempts to contact another midwife for back-up purposes, these attempts were unsuccessful and were therefore insufficient. When the second midwife did not respond to the midwife's calls, the midwife should have reviewed the situation and made attempts to find another available midwife. It was unacceptable that the consumer and her partner were not supported by a midwife during labour, particularly when this was a first pregnancy.

Actions

I recommend the midwife takes the following actions:

- Sends a written apology to the consumer and her partner for breaching the Code of Rights. This apology should be sent to the Commissioner who will forward it to the consumer and her partner.
- Ensures that all routine observations are undertaken and documented during labour, including assessing the need for vaginal examinations.
- Works under the supervision of a senior midwife for a six-month period including a review of her record-keeping.
- Examines her backup midwifery system so that in the event of some midwives being unavailable, cover can always be found when necessary.

Other Actions

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