Midwife, Ms B

Midwife, Ms C

A Report by the
Health and Disability Commissioner

(Case 04HDC05503)

Parties involved

Mrs A	Consumer
Mr A	Consumer's husband
Baby A	Consumer's daughter (deceased)
Ms B	Provider/Midwife
Ms C	Provider/Midwife
Dr D	Obstetrician and gynaecologist
Dr E	Obstetric registrar
Dr F	Obstetric registrar
Ms G	Delivery Suite Coordinator
Dr H	Paediatric registrar
Dr I	Paediatric consultant
Ms J	Midwifery Director
Ms K	Group Manager, Women's, Child and Public Health
Dr L	Clinical Director, Women's Health

Overview

On 5 April 2004, the Health and Disability Commissioner (HDC) received a complaint, forwarded by the Nursing Council of New Zealand, about the services provided to Mrs A by independent midwives Ms B and Ms C. The complaint was made by the Otago District Health Board (ODHB), which also subsequently complained directly to the HDC. The ODHB was concerned that the two midwives had acted inappropriately during the vaginal breech delivery of Mrs A's baby, Baby A. The ODHB said that the midwives' inappropriate actions had contributed to the death of Baby A.

On 28 September and 28 October 2004, Ms B, Mrs A and the ODHB were notified that the following issues were to be investigated:

- The appropriateness and adequacy of Ms B's assessment and management of Mrs A's pregnancy during the antenatal period.
- The appropriateness and adequacy of Ms B's assessment and management of Mrs A's labour.
- The appropriateness and adequacy of Ms B's communication with secondary services during Mrs A's pregnancy, labour and delivery.

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On 23 February 2005, the investigation was extended to include Ms C. She was notified that the following issues were to be investigated:

- The appropriateness and adequacy of the care Ms C provided to Mrs A during her labour and delivery in March 2004.

- The appropriateness and adequacy of Ms C's communication with secondary services during Mrs A's pregnancy, labour and delivery.

In May 2005, the Police advised that they were charging Ms B with manslaughter in relation to the death of Baby A. On 21 July 2005, my investigation was suspended and the parties were notified that I would consider whether to recommence the investigation at the conclusion of the Police proceedings.

High Court proceedings
The prosecution was the result of a request by a Coroner to the Police to investigate the circumstances of Baby A's death. Ms B was charged with manslaughter. The charge alleged that Ms B had "undertaken medical treatment, the doing of which was or might have been dangerous to life, namely the provision of midwifery services, omitted without lawful excuse to use reasonable knowledge, skill and care in administering such treatment". Ms B pleaded not guilty to the charge, and a jury trial commenced in the High Court in early March 2006. The trial concluded on 21 March 2006, when the jury returned a verdict of not guilty.

'No further action' decision
In April and May 2006, Mr and Mrs A and Ms B were interviewed by HDC to ascertain their views on the issues and lessons to be learnt from this case. This was to help me decide whether to proceed with the investigation. I also spoke to representatives and staff at the Otago District Health Board, and convened a meeting of expert maternity advisors — both midwives and doctors.

Section 38(1) of the Health and Disability Commissioner Act 1994 gives the Commissioner the discretion to take no further action on a complaint if the Commissioner considers that, having regard to all the circumstances of the case, any further action is unnecessary or inappropriate. In deciding whether to exercise this discretion, I may take into account actions already taken to ensure clinical safety or review the conduct of a health professional.

In this case, the following actions have been or are to be taken:

a) The Otago District Health Board (ODHB) has investigated the service Ms B and Ms C provided to Mrs A. As a result, supervision conditions were imposed on Ms B and Ms C in order for them to continue to have an access agreement with the Board.

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b) The Midwifery Council of New Zealand has reviewed Ms C's competence to practise. The Council has imposed a supervision order on Ms C requiring that she meet monthly with a peer/supervisor to discuss monthly practice issues and complete some courses on evidence-based practice. However, Ms C has appealed the order and successfully applied to the District Court for the order to be stayed from 22 November 2006 until the appeal has been heard. A date is yet to be set for the appeal to be heard.

   Ms B's competence has been reviewed and the review panel's draft report is scheduled to be considered by the Midwifery Council at its meeting on 5 and 6 December 2006. The report is expected to be finalised early in 2007 after Ms B has been given the opportunity to respond to the draft.

c) Ms B has undertaken a three-day intensive course, "Midwifery Skills for Emergencies". She has also enrolled in an "Advanced Life Support in Obstetrics" (ALSO) course and has begun further study through a School of Midwifery on a postgraduate paper.

d) The ODHB has developed "Referral to Queen Mary Specialists" guidelines with extensive input from Lead Maternity Carers (LMCs),[1] and obstetric and midwifery staff, to provide clarity with regard to the referral process.

e) The ODHB has enquired into steps taken by Waitakere Hospital, in West Auckland, to successfully improve relationships between midwives and specialists. It has enlisted the help of one of the senior clinicians involved in that initiative, Dr Robin Youngson, to lead a similar initiative at ODHB.

f) On 21 November 2006, with the University of Otago Bioethics Centre, I convened a public forum attended by midwives and obstetricians from Dunedin, representatives from their Colleges, students and members of the public, to discuss ethical, legal, and professional issues relating to informed consent in maternity care.

g) Finally, I note that the Ministry of Health is in the process of reviewing the national maternity services access agreement that covers the work of LMCs in maternity facilities. This review is not as a result of this case, but it is very timely.

In light of these various initiatives, I consider that it would be inappropriate to recommence my investigation into this matter. It would also be impractical. Since the conclusion of the trial, it has become clear that the recollection of key individuals is

[1] *Lead Maternity Carer* refers to the general practitioner, midwife or obstetric specialist who has been selected by the woman to provide her with comprehensive maternity care, including the management of her labour and delivery.

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now coloured by some of the testimony and the media debate that followed the verdict. My ability to obtain independent expert advice and to facilitate a fair, simple, speedy and efficient resolution of this complaint (as required by law) has been compromised.

Furthermore, I am also required to consider the views of the consumer. Both Mr and Mrs A have indicated that they do not support the complaint, and they do not want further investigation.

Nevertheless, having reviewed all the information, I believe that there are significant lessons to be learnt. The death of Baby A was a tragic outcome. It is important to consider what could be done differently to avoid similar events in future.

Information reviewed

Information was received from:

- Mrs A
- Mr A
- Ms B
- Ms C
- Dr F
- Dr D
- ODHB Chief Executive Officer
- Ms J
- Ms K
- Dr L
- A Coroner
- Midwifery Council of New Zealand

The complaint included copies of relevant correspondence regarding an internal investigation conducted by the ODHB into the circumstances of the delivery of Baby A. This included the hospital clinical notes for Mrs A, the ODHB's Queen Mary Maternity Facility Access Agreement, and the 21 March 2004 report of the Representative Maternity Committee's meeting on 19 March 2004 to consider the access agreements of Ms B and Ms C.

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The following responses to my provisional decision were received:

- Ms C, dated 12 October 2006
- Dr L, Ms K and Ms J (on behalf of ODHB), dated 16 October 2006
- Ms B's lawyer, dated 27 October 2006
- Mr and Mrs A , dated 8 November 2006

Information gathered during investigation

Mr and Mrs A moved to a city at the end of 2003 when Mrs A was in the 30th week of her first pregnancy. Mrs A spoke with independent midwife Ms B a number of times on the telephone before deciding to engage her as her LMC. Mrs A and Ms B met for the first time on 6 January 2004 for an antenatal check.

Antenatal care

When Ms B visited Mr and Mrs A at their home on 6 January, she completed the initial paperwork, including a medical history. Mrs A's estimated delivery date (EDD) was 5 March 2004. Ms B booked her into Queen Mary Maternity Centre (QMMC) for her delivery.

Mrs A told Ms B that she had been treated for Graves's disease (auto-immune thyrotoxicosis[2]). They discussed the need for Mrs A to consult a doctor for ongoing monitoring of this condition. Ms B documented this information and noted that she would visit again in one week to review Mrs A's old notes and start developing a birth plan. Ms B examined Mrs A and entered the details of the examination in the Midwifery Notes and the Antenatal Record.

Ms B also took a low vaginal swab from Mrs A. The swab was positive for Group B Streptococcus.[3] Ms B discussed with Mrs A the risks of this infection in relation to her labour (ie, labour occurring prior to 37 weeks, temperature over 38°C and early rupture of membranes) and delivery, and the treatment options.

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[2] *Thyrotoxicosis* is a syndrome due to excessive amounts of thyroid hormone in the bloodstream causing a number of symptoms such as rapid heartbeat.

[3] *Group B Streptococcus* is a gram-positive bacterium and a natural inhabitant of the female genital tract. It is the major cause of infection in the newborn. Colonisation by Group B Streptococci can result in an early onset or a late-onset illness. With the early onset form, symptoms of pneumonia become apparent within 24 hours. The pneumonia may develop so rapidly that as many as 20% of infants who contract the infection die within 24 hours. Late onset occurs at two to four weeks of age when meningitis tends to be the infection focus.

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On 15 January, Mrs A developed abdominal pain. Ms B referred her to QMMC where she was assessed by obstetric registrar Dr E. He was unable to determine the cause of her pain but, because she was in the 34th week of her pregnancy, admitted her to the antenatal ward for observation. As part of the examination, Dr E performed a portable scan. This showed that Mrs A's baby was in the breech position.

Mrs A was discharged the following day. During that admission she was seen by an endocrinologist, who requested that a scan be conducted to assess her thyroid function. (Ms B was not provided with a summary of the endocrinologist's assessment.)

Dr E advised Mrs A that, because her baby was in the breech position, she needed a follow-up scan and an antenatal clinic appointment with one of the obstetricians. Dr E wrote to Ms B detailing his assessment of Mrs A and told her that an appointment had been made for Mrs A to have a scan on 4 February.

On 27 January, Ms B visited Mrs A and gave her a book on breech pregnancy. Ms B examined Mrs A and recorded that the pregnancy was progressing normally. Ms B later stated:

> "In regards to the baby being in breech presentation, I advised [Mrs A] to listen carefully to the advice of the Obstetric team and that it would be prudent for [Mr A] to attend those appointments as well, so they were both clear about the information they were given. They did this.
>
> I advised them to read widely on the topic, and to talk amongst family and friends for family and cultural wisdom. They were aware they had a choice between an elective Caesarean section and a trial of vaginal breech birth."

On 4 February, Mrs A attended the QMMC antenatal clinic and had a follow-up scan, which confirmed that the baby was still breech. She was seen by obstetric registrar Dr F, who told her that a procedure called an "external cephalic version" (ECV) is sometimes successful in turning the baby to the head-down position. Dr F advised Mrs A that if the ECV was unsuccessful she should have a Caesarean section at 39 weeks. QMMC's policy for breech deliveries is Caesarean section at 39 weeks. This is also the recommendation of the Royal Australian and New Zealand College of Obstetrics and Gynaecologists.

Mrs A made it clear to Dr F that she did not want a Caesarean section. Dr F gave her two information sheets about Caesarean section, and asked her to consider undergoing an ECV. Dr F advised Mrs A that if she delivered vaginally she would need to take antibiotics during labour. Dr F wrote to Ms B after the examination stating, "I have advised her that the advice from Queen Mary Specialists would be that an elective Caesarean section be carried out at approximately 39 weeks."

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Ms B saw Mrs A later that day. They discussed her appointment at the antenatal clinic, and the endocrinology assessment. Mrs A had been advised that there was no indication that her thyroid condition was affecting the pregnancy, and that she was to continue with her current therapy. Ms B told Mrs A that if the baby remained in the breech position, and she continued to have good health, she would "be most happy to support them in labour". Ms B noted that they needed to write up a birth plan and that it would be "useful" to talk to independent midwife Ms C. Ms B advised Mrs A "briefly" about Group B Streptococcus infection.

Ms B asked Ms C to be her back-up and support midwife for Mrs A. Ms B stated that she chose Ms C as her support midwife because Mrs A wanted a natural breech birth, and Ms C had "extensive midwifery experience".

On 9 February, Ms B and Mrs A again discussed her positive Group B Streptococcus swab. Mrs A agreed to talk over the treatment options with her husband.

A week later, Mrs and Mr A saw Dr D at QMMC. Dr D talked them through the ECV procedure. She explained that she would try to turn the baby by applying gentle pressure on Mrs A's abdomen. The optimal time to apply the pressure is 10 minutes. Dr D advised Mr and Mrs A that if the baby did not turn within this time she would not continue with the procedure. Dr D confirmed the position of Mrs A's baby by manual palpation and ultrasound scan. The baby was average size, in the breech position, with flexed (bent) legs and a normal amount of amniotic fluid. Dr D was unable to turn the baby. She performed a cardiotocograph (CTG)[4] to check the baby's well-being after the attempted ECV. The baby had a normal heart rate.

Dr D telephoned Ms B to discuss the advice she had given Mrs A. Ms B recalls that the report was "brief" and that Dr D "recognised that Mrs A was keen to proceed with her plan to labour and birth vaginally". Dr D did not provide Ms B with a written report of her examination.

Ms B visited Mrs A again on 25 February and noted that they again discussed Mrs A's options for delivery. Mrs A decided to write out her own birth plan. Ms B advised her to write what she did and did not want in relation to midwifery care, medical involvement, pain relief, intervention and where she wanted to labour.

Mrs A entered her detailed birth plan in the midwifery notes as follows:

> "…
> * Doctors only to be involved if [Mr A, Mrs A, Ms B and Ms C] think medically necessary

[4] A *cardiotocograph or CTG* is the external electronic monitoring of the fetal heart rate. A CTG can indicate any abnormalities in the 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.

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> * Pain relief — natural (e.g. water, massage, etc), gas then pethidine
> * Epidural only if C-Section occurring
> * If Strep B positive, antibiotics only taken if risk factors involved as we have discussed with [Ms B]
> * Want to use [a birthing room]. If unavailable, next biggest room
> * If [a birthing room is] available, want to have pool. May use it for labouring only
> * Labour at home with [Ms B] calling in until getting to stage I can't cope any longer, then to hospital
> * C-Section only if [Mrs A] or baby medically require it e.g. fetal distress, lying in wrong position — star gazing etc, or if baby not coming out after a reasonable amount of time and effort pushing
> * I do not want continuous monitoring unless [Ms B or Ms C] think it is necessary
> * Naturally managed 3rd stage unless it becomes medically necessary to have injection."

Ms B discussed the birth plan "at length" with Mr and Mrs A. Dr D's letter regarding the attempted ECV had not arrived at this time. Mrs A and Ms B discussed their recollections of Dr D's advice. Ms B said:

> "It was clear that [Dr D] had spent some time discussing the risks of vaginal birth to [Mrs A and Mr A], and it was also clear, [Dr D] was aware that [Mrs A and Mr A] had been very carefully considering their options, were making thoughtful and informed choices, and that they had chosen to pursue the option of a trial of vaginal breech birth."

At this visit Mrs A informed Ms B that she had discussed the Streptococcus issue with her husband. Their decision was that she would have a repeat swab to confirm the presence of the organism. When the result of this swab was also positive for Group B Streptococcus Ms B advised Mrs A about alternative ways to minimise infection. This was because Mrs A had decided to have antibiotics only if risk factors were present. Ms B advised Mrs A not to have a bath during labour until she was contracting strongly. Ms B also advised that once the uterine membranes ruptured, Mrs A's temperature would need to be regularly assessed, and she needed to be aware of any change in her body temperature. The number of vaginal examinations during labour should also be limited to the minimum necessary.

On 26 February, Ms C visited Mrs A. Ms C later said her role in Mrs A's labour and delivery was to provide back-up support for Ms B. This meant that if for some reason Ms B was unable to attend Mrs A in labour, Ms C would cover for her. Ms C would also come into QMMC as a support person for Ms B during the delivery. Ms C stated:

> "As [Mrs A and Mr A] had chosen not to involve doctors unless medically necessary, [Ms B] wanted a like-minded midwife to provide support. We had

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worked well together on another challenging case. [Ms B] and I felt comfortable with each other's practice in that if one had to leave a labour the other would continue care and advice in a similar manner. …

During a telephone discussion [Ms B] informed me that the couple were … a very private couple. I was informed [Mrs A and Mr A] had had a discussion with an obstetrician and had decided they did not want to have an elective Caesarean section.

I met with [Mrs A and Mr A] on 26.2.04 to discuss the birth and what my involvement would be as the support midwife. I left them with the Catharina Schrader Stichting book 'Technology, a threat to the normal birth process'. They told me they had read 'Breech Birthwise' by Maggie Banks and had written a birth plan. We went through the birth plan together, as I needed to know their wishes if I was the one called to attend [Mrs A] in labour. We talked about medical involvement and [Mrs A and Mr A] stated that unless a problem arose that they did not want a doctor to be present for the birth.

We talked about pain relief options and [Mrs A] was adamant that she didn't want an epidural. She wanted the opportunity to use water in labour but not to birth in water. I suggested that having a resuscitaire in the room would be appropriate in the event the baby needed help with resuscitation.

We talked about the birth position and what they should expect to see when the baby was being born. My involvement would be to attend if [Ms B] was unable to be at the birth and to come to the hospital near the end of labour to assist if needed."

Ms C met with Mr and Mrs A again on 1 March. They discussed the birth plan again and what to expect in labour. Ms C talked about meconium and advised that it is normal to see some meconium with breech births, near the end of first stage. Ms B visited Mrs A again on 8 and 13 March.

Labour — Day 1

On Day 1, Mrs A advised Ms B that she had been experiencing periodic uterine "tightenings" for 24 hours. A scan the previous day had shown that the baby was "not too big" and that there was good volume of amniotic liquor.

At 8pm Mrs A's uterine membranes spontaneously ruptured (waters broke). There was old thin meconium[5] in the draining liquor. Ms B recorded that the baby was

[5] *Meconium* is the first fecal material evacuated from the fetus' or newborn's rectum, and appears green to very dark green. It is normal for meconium to be expelled during the first one to two days after birth. Meconium can be present in the amniotic fluid as a green staining. Although not always a sign of fetal distress, meconium in the amniotic fluid is highly correlated with its occurrence. Meconium in the amniotic fluid reveals that the fetus has had an episode of loss of sphincter control.

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active with a normal heart rate of 136 to 144 beats per minute (bpm). Ms B recorded Mrs A's baseline vital recordings. Her temperature was 36.3°C, blood pressure 130/80mmHg and pulse 88bpm. These were all within the normal range.

Ms B and Mrs A discussed whether a vaginal examination was required at that time to assess progress of labour. Ms B also talked to Ms C about this, documented their agreed plan to postpone the vaginal examination, and noted that she would visit again at 9.30pm. Mrs A was to contact her if the pains increased.

Day 2
At 1.30pm the following day, Mrs A's labour pains had increased in strength. They were occurring every five minutes and lasting a minute. Ms B performed a vaginal examination and found that the cervix was 4cm dilated. She monitored the fetal heart rate at 15- and 30-minute intervals while Mrs A was in labour.

Dr D had advised Mrs A to present to QMMC early in her labour or if her membranes ruptured. Mrs A was not keen to go to the hospital until her labour was well established. She wanted privacy during her labour. Ms B said that this was the reason they discussed and agreed upon a plan that ensured Mrs A and her baby were monitored carefully and consistently at home in early labour.

At 4pm Ms B recorded Mrs A's vital signs, noting her temperature to be 37.8°C, her pulse 92bpm and blood pressure 134/88mmHg. The baby's heart rate was recorded at 145 to 152bpm. Mrs A told Ms B that she wanted to transfer to QMMC. She was admitted to a room in the Delivery Suite (the room she had requested in her birth plan) at 4.40pm. At 5pm Ms B advised Ms C that Mrs A had been admitted.

Mr and Mrs A were very clear in their plan about the role of secondary services in Mrs A's labour. Mrs A had had considerable contact with the QMMC obstetric team during her pregnancy, but had not seen the same obstetrician twice. She had received differing opinions about how her labour should be managed. Mr and Mrs A knew that there might be different obstetricians on call when Mrs A was admitted in labour. They were concerned that they might be given another opinion. For this reason, they did not want a further obstetric consultation unless it was medically warranted. During the antenatal checks, Mr and Mrs A had discussed with Ms B their wishes about obstetric involvement in the labour and delivery.

Ms B contacted Ms C to advise her that she had examined Mrs A vaginally. Ms B estimated that Mrs A was 8cm dilated, the presenting part of the baby — the bottom — had moved from –2 to the spines,[6] and there was meconium present. The fetal

[6] *–2 to the spines* 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 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

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heart rate was recorded at 165 to 175bpm. Ms B noted: "Very active baby." She took the baby's activity and the reactive CTG to be a reassuring sign that the labour was "actively progressing". Ms B asked Ms C to come to the hospital.

When Ms C arrived at 5.30pm, Mrs A was standing and leaning against a trolley, pushing hard with her contractions. Ms B asked Ms C to examine Mrs A and check her findings. Ms C found that Mrs A was 8 to 9cm dilated. The baby's bottom was at station 0, with the foot a little lower. There was meconium present at the vulva. Ms B held the CTG abdominal transducer against Mrs A's abdomen to listen to the fetal heart rate. The fetal heart rate was 168 bpm with good beat-to-beat variability. There were no decelerations. Mrs A was using Entonox gas for pain relief.

Ms C checked the resuscitaire because she believed the delivery was imminent. Meanwhile, Mrs A was feeling hot and her temperature was recorded as 37.2°C. Ms B advised Mrs A that, as her membranes had now been ruptured for more than 18 hours, she was at risk of infection and would need antibiotics.

At about 6pm, Ms B again discussed with Mrs A the need to start antibiotics. Ms B did not receive a clear response and, anxious to get an intravenous line sited, she began preparing intravenous equipment and antibiotics. However, she was unable to site an intravenous line because Mrs A was in very active labour.

At around 6pm, the QMMC Delivery Suite co-ordinator, midwife Ms G, was informed that Mrs A was a primigravida[7] breech who did not want any medical intervention or involvement. Ms G informed Ms B that this decision put her in a difficult position because breech presentations should be referred to secondary obstetric care. Ms B informed Ms G that the labour was progressing well. Ms G asked Ms B to tell her if she needed the assistance of an obstetrician. Ms B assured her that she would do so.

At 6.20pm the fetal heart baseline rate was 165 with a range of 158 to 170bpm. Ms B advised Mr and Mrs A that the heartbeat was "a little high" or tachycardic,[8] and said that they might need to call an obstetrician if it did not settle. At 6.50pm Ms B noted

below the ischial spines, the distance is stated as plus stations (+1cm to +4cm). At a +3 or +4 station, the presenting part is at the perineum (synonymous with crowning).

[7] *Primigravida* refers to a woman experiencing her first pregnancy.

[8] *Tachycardic* refers to a rise in the fetal heart rate above the normal rate of between 105 and 155bpm. The rate fluctuates slightly (5 to 15bpm) when the fetus moves or sleeps. Fetal tachycardia occurs when the rate is 160 beats or more a minute (for a 10-minute period). Moderate tachycardia is 161 to 180bpm. Marked tachycardia is more than 180bpm. Marked fetal tachycardia may be due to fetal hypoxia (lack of oxygen), maternal fever, drugs, or abnormal heart rhythm.

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that the fetal heart range was 160 to 165bpm, reactive with no decelerations.[9] The fetal heart rate remained within this range until 7.20pm, when it settled to between 156 to 160bpm. Ms B and Ms C were reassured by this. As Mrs A was having strong, expulsive contractions they considered that the birth was imminent and no longer saw the need to call for obstetric intervention.

Over the next 45 minutes Mrs A periodically changed position to assist the effectiveness of her pushing. The midwives checked the fetal heart rate every five to ten minutes with a sonicaide. At 7.30pm the heart rate slowed to 152bpm and 10 minutes later was heard at 144bpm.

Delivery

At 7.45pm the foot was seen at the perineum. At 7.50pm one of the baby's feet, which was tucked up under its bottom, birthed. Mrs A pushed hard, and five minutes later the bottom appeared. At 8pm the baby was delivered to the level of its umbilicus. When the baby was delivered to chest level, Ms C asked Ms B to check the cord for a pulse. Ms B was unable to detect a pulse and asked Ms C to assist her to deliver the baby. However, before Ms C was able to put on a glove, Baby A was delivered. This was timed at 8.07pm. Ms C clamped and cut the cord, and took Baby A to the resuscitaire.

Resuscitation of Baby A

Ms C started to administer oxygen to Baby A using a Neopuff — a face mask that covers the baby's mouth and nose. She introduced a laryngoscope to visualise the vocal cords and saw that the baby had inhaled meconium. Ms C suctioned the airways and commenced cardiac compressions when she was unable to detect a heartbeat. Ms B made an urgent call for a paediatrician.

Fetal heart rate during delivery

7.45pm — 120bpm
7.50pm — 160bpm
7.55pm — 144bpm
8pm — 120bpm
8.05pm — no heart beat
8.07pm — delivery

[9] *Decelerations* or 'dips' are periodic decreases in the fetal heart rate resulting from pressure on the fetal head during contractions. The deceleration follows the pattern of the contraction, beginning when the contraction begins and ending when the contraction ends. The tracing of the deceleration wave shows the lowest point of the deceleration occurring at the peak of the contraction. The rate rarely falls below 100bpm and returns quickly to between 120 and 160bpm at the end of the contraction.

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Baby A's Apgar[10] score was zero out of a possible ten at one minute after her birth. Her score was still zero after five minutes.

At about 8.11pm Ms G saw paediatric registrar Dr H run down the delivery suite corridor towards the room. Ms G followed her into the room. She saw Baby A lying on the resuscitaire with Ms C and Ms B on either side. Baby A was white and floppy. Ms G noted that the resuscitaire timer indicated that Baby A had been on the resuscitaire for four minutes.

Dr H recalled that she asked for the paediatric consultant, Dr I, to be called while she took over the resuscitation of Baby A. Dr H and Ms G listened to Baby A's chest with a stethoscope and felt the end of the cord for a pulse. They were unable to detect a heartbeat. Dr H attempted to intubate Baby A but was not confident that she had introduced the endotracheal tube correctly. She continued to administer oxygen via the Neopuff. The midwives continued the chest compressions. At seven minutes by the timer on the resuscitaire, Dr H asked for adrenaline to be administered. Ms G prepared the drugs. A second dose of adrenaline was administered at 10 minutes. Shortly after this, Dr I arrived and successfully intubated Baby A. She was then transferred to the Neonatal Intensive Care Unit.

The contemporaneous midwifery notes record:

> "2011 Paed [paediatrican] here — attempt to intubate, consultant paged — no heartbeat felt
> 2018 0.3mls adrenaline IM [intramuscular] in LS [left side] leg — further attempt to intubate. Adrenaline 0.5mls IM in LS leg
> 2027 Consultant paed here — intubation + cardiac massage heart-rate present. Adrenaline 0.5mls IM in RS leg.
> 2035 Umbilical catheter inserted 20mls saline given as a bolus
> 2040 Bicarbonate given — further bolus of saline
> 2045 Baby to NICU [neonatal intensive care unit] in transport incubator ventilated. Baby floppy, eyes fixed and dilated."

[10] An *Apgar score* is used to ascertain and record the condition of the baby, looking at colour, respiratory effort, heart rate, muscle tone and reflex response, with a maximum score of 10.

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At 10.30am on Day 3, a paediatrician told Mr and Mrs A that Baby A was very sick. They discussed options. At 6.10pm, in the presence of the Mr and Mrs A and the primary care nurse, the paediatrician removed Baby A's endotracheal tube and turned off the monitoring equipment. At 5.02am on Day 4, Baby A died in the presence of her family.

Subsequent responses from parties

Otago District Health Board
On 4 July 2005, the Otago District Health Board's (ODHB) Chief Executive Officer advised that on 19 March 2005, the ODHB's Representative Maternity Committee had convened to review Ms B and Ms C's access agreements with the Board.

Following this meeting, the ODHB decided that there should be oversight of Ms B's and Ms C's practice. The terms of the oversight were negotiated between Ms B and Ms C and the ODHB on 8 April 2005. They agreed on the following terms in relation to births within the DHB facilities:

"

- On admission to the delivery unit all cases are to be discussed with the co-ordinating midwife. The birth plan and referral processes will be reviewed.
- Any variation from the recommendations in the referral guidelines (Appendix 1 section 88) are to be reported … to the obstetrician on call at the time of admission. This includes any refusal of the woman to take obstetric advice.
- All women booked will be informed of these restrictions.
- The midwives will undertake education regarding the monitoring of the fetal heart in labour.
- The midwives are not to undertake mentoring duties, second midwife duties, or student midwife education."

In relation to the midwives' practice in the community they agreed:

"

- There will be a monthly meeting between the midwife and a designated supervisor who will review all case notes of women who have pregnancies at 28, 36 and 41 weeks gestation with a view to assessing the need for referral for obstetric consultation.
- Where a home birth is planned the midwife will notify the designated supervisor at the commencement of labour. The supervisor will make a visit at some stage of the labour depending on the length of the labour, and at any time she identifies as necessary to assess progress. The supervisor will also be

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called to be present at the birth. The supervisor will act as 'second midwife' at the birth.

- The midwife will not attend home births where the mother has been given advice by the consulted obstetrician, supported by the referral guidelines, that a home birth is not appropriate."

Ms K, Group Manager and Ms J, Midwifery Director were primarily responsible for the organisation and review of this oversight.

However, on 16 March 2005, Ms C wrote to Ms K advising that she wished to terminate her access agreement with QMMC, effective from that day. Ms C stated: "[I] understand that this effectively dissolves any restrictions placed on me by the O.D.H.B."

On 21 April 2005, Ms B wrote to the ODHB's Chief Executive Officer agreeing to the terms of supervision and the ODHB's role in reviewing and overseeing the supervision, and to undertake education in relation to fetal heart rate monitoring in labour.

On 29 May 2006, the ODHB Senior Management Team, Women's Health — Dr L, Ms K and Ms J — advised me that they recognise that there is continuing tension between primary and secondary maternity care providers. They consider that the tensions are "inevitable" given the pressure of service provision, an outdated facility and the difference in the training of midwives and doctors. The senior management group consistently seeks to diminish the "us and them environment". However, the tensions have been greatly exacerbated by this case. They consider that the best care will only be provided to women and their families if the various maternity providers work in a "collegial, collaborative manner where skills and expertise of individuals complement each other". They consider that this requires the promotion of respect within and between the professions of midwifery and medicine.

ODHB is in the process of investigating the model of intervention successfully utilised at Waitakere Hospital where similar issues were causing problems.

Ms B

On 10 December 2004, in response to the complaint, Ms B stated:

> "It has been alleged by different individuals of the Otago District Health Board that I actively excluded obstetric involvement [in Mrs A's care]. This I categorically deny. … I have a very long history of consistent appropriate referral to obstetric services. My practice involves choosing to care for many clients that for various reasons have issues which may affect the wellbeing of themselves and their babies. As a result of this I have frequent involvement with obstetric colleagues.

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[C]ontrary to those statements that were made, that I attempted to 'exclude obstetric involvement', I suggested to [Mrs A and Mr A] the possibility of calling an obstetrician. [Mrs A] was concentrating totally and completely absorbed in birthing her baby. [Mr A], never having attended a birth, was overwhelmed, and struggling to take in more information. As I did not get a clear response from them, and as the birth was imminent, I didn't go ahead and call for obstetric support. In retrospect the reasons for this decision were that in view of the imminence of the birth, I was reassured that the baby was fine because of her activity and the consistently good variability of the heart rate[11] with no hint of decelerations. However, I was aware that the fetal heart base line was mildly tachycardic, and this made it a decision point regarding calling for obstetric advice. I am sure that if the birth hadn't been so imminent at this point that we would have indeed consulted re the heart rate if the tachycardia had persisted. [Mrs A and Mr A] and I talked about this afterwards. [Mrs A] was still not keen to have any other people coming in, although she would have consented if we had put pressure on her. It was impossible to obtain her specific consent or otherwise at this time, as her overwhelming urge at that stage was to birth the baby. Having said that, the birth plan made it clear [Mrs A] was not determined to have a vaginal birth at all costs.

The question regarding why I didn't have the obstetric team on 'stand-by' is relevant, and some background information about practicing midwifery within the context of Queen Mary becomes appropriate. … Sometimes women make choices, and with the advice of one obstetrician, that are then overruled by the obstetrician of the day, who may not necessarily agree with the original decision. Great pressure is then brought to bear upon the midwife to get the woman to 'change her mind'. …

The reason I did not have secondary services 'on stand-by' is that [Mrs A's] labour was progressing well, the fetal heart rate was reassuring and the baby active in labour.

Always on reflection, I keep asking myself why I did not ask the paediatric registrar to be on the ward when the baby was born. I realise that the outcome may not have been any different had she been there, as it wasn't until the consultant arrived that intubation of [Baby A] was achieved, and active resuscitation had been initiated immediately by myself and [Ms C], then supported by the paediatric registrar.

[11] *Fetal heart rate variability* is considered to be one of the most reliable indicators of fetal well-being. Baseline variability (the normal variation of the fetal heart rate within the normal range) increases when the fetus is stimulated, and slows when the fetus sleeps. If no variability is present, it indicates that the natural pacemaker activity of the fetal heart has been affected.

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> I am well aware that it is not common practice in New Zealand hospitals to have a vaginal breech birth, but that it is also usual practice not to have a paediatrician at the birth where the labour has progressed well, and the baby has been active throughout, and the second stage is of normal duration, with the fetal heart sounds regular. I follow these usual practices, but I would like to explain the thinking in this case and the contextual background concerning the mother's wishes.
>
> One reason for not asking for the paediatrician to be present, … is that I was outside of my 'usual system'. In this case, I had a mother who clearly and firmly wanted no involvement from others unless it was shown to be necessary. Although this is not necessarily my normal practice, I believe I continued to be engaged by her only because I showed a willingness to respect her fundamental wishes. … [The ALSO course syllabus] 'safety in maternity care' … discusses how mistakes can be made when one is operating outside a usual system. One explanation is a slip in an automatic routine; another is using the wrong rule to solve a problem, i.e. the rule I was applying here was the labour including second stage was progressing well, the baby was active, and the fetal heart variable, so the baby was OK, i.e. we didn't need a paediatrician. The rule I could have alternatively been applying was the baby was breech, which carries inherent risks, so call a paediatrician. …
>
> I chose to apply the first rule-based analysis as described above rather than the second as [Mrs A] did not want extra people there unless medically indicated, and it wasn't until 2 mins before the birth, that a real problem emerged. As I have said elsewhere, it was not physically possible to ring the call-bell, and catch the baby at the same time. The call-bell was across the room. The focus was on the expeditious birth of the baby, which is what occurred."

Ms B advised that since these events she has participated in a three-day intensive course, "Midwifery Skills for Emergencies". She has enrolled in an "Advanced Life Support in Obstetrics" course and begun work on a postgraduate paper at a School of Midwifery.

Mrs A

On 28 April 2006 Mrs A advised that she had understood the options available to her in relation to the delivery of Baby A. Each time she went to the hospital she saw a different doctor. She saw a specialist for her thyroid problem, as well as the obstetricians. They all had different theories. Mrs A said that prior to Baby A's birth, she went to the library and obtained a booklet on breech babies. Ms B and Ms C also gave her information to read.

Mrs A said that "hindsight" is a good thing. She cannot clearly remember what she understood the risks to be at the time because so much had happened since and she cannot be sure what she knew then compared with what she knows now. However, she believed all the risks had been fully discussed.

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Mrs A said that every doctor she saw told her something different. One would say, "Good on you for trying a vaginal birth." The next one would say, "No. You are not having a vaginal birth." Mrs A said that with all this conflicting information she could not make a birth plan. She said that the problem was that there was no continuity of care.

Mrs A said that she "left the door open". She would have consented to a Caesarean section, "if it was needed". She said that she always knew a Caesarean was a possibility. Before going into labour, she and Ms B discussed the fact that they might need to call an obstetrician. This was also discussed when she first arrived at the hospital. The baby's heart rate was slightly up, but Mrs A thought that was due to the move to the hospital and did not want to see an obstetrician. They decided to wait and see.

Mrs A said that she knew how risky a breech delivery was. She had read about breech deliveries. She said, "There are risks associated with all births, even a head down baby can be a risk. All I wanted to do was try." She said that she had made her mind up to try a vaginal delivery. She had seen the statistics for how many babies die in these circumstances and remembered thinking it was relatively low.

Mrs A was critical of the difficulty the paediatric registrar had intubating Baby A and the lack of an accessible call bell in the labour room. The bell was on the wall. This meant that when Ms B and Ms C were busy trying to deliver Baby A, and Mr A was helping her, one of them would have had to leave what they were doing to call for help. Mrs A questioned whether a portable call bell, like a medical alarm, could be provided for the midwife to wear around her neck.

Mrs A was also very critical of relationships between QMMC staff and LMCs. She was concerned about what she felt was an intrusion into her privacy by QMMC staff. She said that when she went back to QMMC to have her second baby, staff who had not been involved in her care during Baby A's birth, knew about her and pointed her out. She stayed in the hospital only a few hours because of this attention. Mrs A said that the same thing occurs when she visits friends at QMMC.

Mrs A subsequently chose Ms B as her midwife for the birth of her second baby.

Responses to Provisional Opinion

Otago District Health Board

On 16 October 2006, Ms K, Ms J and Dr L responded to my provisional opinion on behalf of the ODHB. In addition to clarifying various points of detail, they noted the "very challenging 'post criminal proceedings' context" and commented:

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> "We wish to state that we agree with the provisional decision you have made … [in] this highly complex case, highlighting the appropriate learning points."

Ms C
On 23 October 2006 Ms C responded to the provisional opinion. Ms C stated:

> "I wish to make clear, that this decision [to withdraw from my access agreement with the ODHB] was not made lightly and it was only when the conditions became unworkable in March 2005, that I withdrew [from] my access agreement.
>
> I wrote to the ODHB outlining the process I had undertaken and requested that the conditions be lifted. This was declined. In March of 2005, the community supervision became unworkable with all but one supervising midwife being unavailable. When we first provided a list of midwives who would be available for supervision there were a number that were unacceptable to [Ms J]. Of the ones who were approved only one was going to be available in March of 2005. Combined with her workload, sole supervision was going to be an onerous task. To continue providing care for the women who approached me to provide their care, I felt I was left with no other choice than to withdraw [from] my access agreement. All women were fully informed of the situation and options for care and all wished to continue with me.
>
> As there had been no issues raised regarding my practice and I had undertaken education, ie ALSO in 14/15th August 2004, Birthspirit — Midwifery Skills for Emergencies Intensives, 27–29th July 2004, a [polytechnic] Midwifery Clinical update, on-line professional development, December 2004. I asked for these restrictions to be lifted. The ODHB refused and so I withdrew from the access agreement.
>
> Any death is devastating to both the family and the midwives involved. The family need to understand the circumstances surrounding the death and what could have been done to prevent the death happening, to aid their grief process. For me, this process involved peer audits from two expert witnesses and a full and frank discussion with [Mr and Mrs A] and their extended family. …"

Ms B
Ms B's barrister responded on behalf of Ms B. Ms B's barrister stated:

> "As a preliminary comment, we observe that you have determined that your investigation should not be taken further. We respectfully concur with that decision for the reasons you have outlined. You do, however, go on to make a number of observations which will be made public. We are concerned that those observations are not made against the background of a full investigation as many of them are unfair to [Ms B] and, we suspect, would not have been made had you completed your investigation. …

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Access agreement review
[Y]ou refer to the tension between some of the independent midwives and members of ODHB maternity service and refer to a previous case where these have been highlighted. … We respectfully submit that it is not appropriate, or indeed fair, to link the story of [Baby A] to the access agreement review. We feel that because of the link you have made, the reader is left with a sense that the problems that occurred were somehow as a result of the failure of the access agreement. … The access agreement provisions, and particularly the section 88 guidelines were complied with by [Ms B] and it seems to us that this is what is important and should be recorded in your decision.

Further, even though the national guidelines regarding vaginal breech birth were published after the birth of [Baby A], [Ms B] took account of every guideline and advised [Mrs A] appropriately in relation to the points that feature in the guidelines.

In summary, we do not believe that there is any evidence which supports a conclusion (or even comment) that 'there is no obligation on the part of an access agreement holder to comply with Board policy'; suffice to say, this implies that [Ms B] was not complying with Board policy and we do not understand the basis for such comment. There was no Board policy about breech birth at the time of [Baby A's] birth.

Medical personal on 'standby'
… We emphasise that in 20 years of practice prior to [Baby A's] birth, and in providing LMC care for a further 150 clients (a further 150 deliveries) since her birth, there has never been a complaint or criticism of [Ms B] in relation to her involvement of obstetricians and paediatricians. This is, in our view, very telling and it is clear that she does appropriately involve other professionals. …

[Y]ou have used the expression 'standby'; [the clinical director of the unit] had, we are instructed, made it clear on numerous occasions that the doctors would not do 'corridor consultations'. [The clinical director of the unit] insisted on either a formal consultation with his team being involved from that time, or nothing at all. It follows that had [Ms B] advised the obstetricians/paediatricians to be on 'standby' then they would have either insisted on full involvement (something [Mrs A] did not want) or would have refused because they were not allowed full involvement.

We believe that a further, and vital, consideration in this regard is the climate that existed in the hospital at the time. [Ms G], the Queen Mary Maternity Centre co-ordinator, was on duty at the time of [Mrs A's] admission. She was aware that there was a vaginal breech delivery taking place. She was also aware that [Ms B] did not want the obstetricians notified (because of [Mrs A's] overwhelming desire for privacy and subsequent insistence that the medical team be involved only if necessary) and that she would advise [Ms G] if there were any problems.

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[Ms G] described [Ms B] as being very free giving information (generally) and said that she would not get involved unless [Ms B] required help.

In our view, the actions of [Ms G] are significant because she agreed not to involve the medical people shortly after [Mrs A] was admitted and she clearly felt confident that Ms B would involve the obstetricians if she felt it was necessary. …

Further, at the time, there was no protocol at Queen Mary Hospital requiring [Ms B] to notify the obstetricians that [Mrs A] was present. [Ms B] had acted entirely appropriately in terms of referrals; she recognised that this was a level 2 situation and she referred [Mrs A] to secondary care.

…

[T]here were significant tensions between midwives and obstetricians which impacted on Ms B's decision not to request obstetric assistance to be on 'standby' (notwithstanding that [the clinical director of the unit] refused to have such a system). The last thing that [Ms B] wanted was a team of doctors barging in to [Mrs A]; given [Ms G's] candid acknowledgement that such occurrences had happened in the past, it seems that this was a real and justified concern of [Ms B].

…

Further, there is nothing to say that had an obstetrician been on 'stand by' that the situation would have been any different. It would be unrealistic to think that because an obstetrician was on 'standby', Baby A would have survived. …

Other matters

[Y]ou refer to the fact that [Mrs A] 'had not taken into account the reality of trying to make a subsequent decision in the midst of active labour'. We understand that one of the main reasons a birth plan is made is because, when a woman is in labour and focused on birthing, it is vital that a midwife has a very clear understanding of what that mother wants. It is for this reason that a woman's birth plan is discussed in depth at the time that it is made. You have criticised [Ms B] for failing to recognise 'the impracticality of this plan'. We do not believe that this criticism is warranted. [Ms B] discussed the birth plan in detail with [Mrs A]. … [Ms B] is adamant that during her labour [Mrs A] was able to make decisions and was cognisant of what was happening. … For example, despite being advised to take antibiotics in labour on two occasions [Mrs A] refused to do so. …

We respectively suggest that the plan was not impractical; had [Ms B and Ms C] determined that there was a need for obstetric or paediatric assistance prior to the delivery of [Baby A] then it was readily available. It is clear that [Ms B] did explain the risks appropriately to [Mrs A]. Further, there is no evidence to suggest that the 'impracticality of the plan' led to the tragic outcome.

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The comments we have made in relation to your provisional finding that [Ms B] did not recognise the 'impracticality of the birth plan' are equally applicable to your finding that there was no 'back-up' plan. We have already traversed the issue of notification of the obstetric team upon [Mrs A's] arrival. [Ms B] was conscious of the fact that [Mrs A] was an unusually private person, that she had indicated that she did not want obstetric assistance unless it was medically necessary, there was a history of stand-up arguments between midwives and obstetricians in the corridors at Queen Mary and there were incidents where obstetricians had barged into delivery suites against the wishes of woman in labour and their midwives. We consider that your decision should focus far more strongly on these issues and, in particular, the climate that was prevalent (and seems to have been acknowledged as being present prior to the trial of [Ms B] and following the trial) at Queen Mary at the time.

…

You then go on to refer to 'two subsequent opportunities' for [Ms B and Ms C] to revisit the 'labour management decisions'; you use this as a basis for justifying your findings that there was no 'back-up plan'.

The first example is the administration of antibiotics. [Mrs A] refused to take antibiotics; her husband A, agreed that this was the case under cross-examination during the trial. … [Mrs A] had refused to take antibiotics despite the fact that [Ms B] had prepared the intravenous line and endeavoured to place a tourniquet on [Mrs A's] arm. …

[Mrs A] had been advised by the obstetrician she had seen ante-natally that she should take antibiotics if she was Group B Strep positive. [Mrs A's] refusal to take antibiotics was a legitimate choice made by her and, as we have said previously, she would not agree to taking them in her second pregnancy if she was Group B Strep positive. In any case, the issue of [Mrs A] being Group B Strep positive did not have any impact on [Baby A].

Secondly, you refer to [Ms B], at 6.20pm, becoming concerned about the foetal heart rate and suggesting calling an obstetrician. Significantly, [Mr A] gave evidence that he recalled a discussion about doctors coming in and that [Mrs A] did not give her consent.

We note your comments about a midwife having a duty to use 'her knowledge and experience to minimise the risk to the mother and baby'; suffice to say, we concur entirely with your comments. These comments are, however, made in a general sense; we think it is clear from the evidence [Mrs A] gave at trial that she was well informed about the risks to her and her baby. [Ms B] did not blindly support [Mrs A's] choices, and we think this should be made clear.

…

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Summary

There are significant issues raised in this case. Perhaps the most important issues relate to why did [Mrs A] lack confidence in the obstetric staff and why did she not feel supported by them in her decision making. This seems to have been the starting point; surely if [Mrs A] felt that she received supportive, helpful advice from the obstetric staff with an emphasis on consistent, continuity of obstetric care then she may have been more willing to involve them; we feel very strongly that this is one of the critical points of this case.

We also feel that, without a full investigation having taken place, your criticisms of [Ms B] are unfair and unwarranted and we trust that your report will be amended to reflect this."

Ms J

On 7 November 2006, Ms J was asked whether, in March 2004, the ODHB had a protocol regarding breech births. Ms J advised that there was a protocol that was "old and outdated" and in March 2004, the ODHB was in the process of reviewing its maternity service protocols, including the protocol on breech births. The ODHB intended that the revised protocol would be in line with the national guidelines, and that the review would involve the independent midwives. However, in light of the difficult context following this case, the review was delayed.

Mr and Mrs A

On 8 November 2006 Mr and Mrs A responded to my provisional opinion. In addition to clarifying points of detail, Mr and Mrs A stated:

"…

My understanding was that the hospital and the specialists were the back-up plan and safety net, and that they were on site and available to me at any time, if we wanted it.

…

The whole issue of GBS [Group B Streptococcus] and antibiotics has been made to be a huge big deal, when in fact it is not an issue.

The guidelines I read, stated that you can have ruptured membranes for 18–24 hours before considering antibiotics. [Baby A] was born approximately 24 hours after the rupture of membranes. The second risk for GBS, is a temperature above 38°C. At no time during labour was [Mrs A's] temperature above 38°C. The third risk for GBS is a premature baby. This was not relevant. So therefore, the only contributing factor was that it was more than 18 hours but not over 24 hours since the rupture of membranes.

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Guidelines also state that for the antibiotics to be effective, they need to be administered at least 4 hours before the birth of the baby. When a mother is given antibiotics in labour for GBS, the antibiotics not only kill the GBS, but also all the 'good' bacteria. Information that we have read, shows that when a mother with GBS is given antibiotics in labour, there is a 50% chance of the baby dying of another infections eg E.coli, as over against only a 15% chance of the baby dying as a result of GBS, in a mother with GBS who chooses not to take antibiotics.

It is also of great importance to note that, the post mortem of [Baby A] showed that there was no infection of any type present at the time of birth, so as you should be able to see by now, the GBS and antibiotic saga is just a fizzing nothing.

…

We have NEVER had any difficulties with the care we received from [Ms B], hence the reason for engaging [Ms B] as the LMC for our second child. We are also concerned as to how you can make comments and make up to a 26 page report, when you haven't done a full investigation, so therefore do not have all the facts and information.

The court case and its publicity has caused us enormous stress and we have suffered physically, emotionally and mentally. We cannot take any more publicity and the associated stress. We DO NOT want any report, decision or opinion made available for any publication of any sort, or to be made available by any means, to the public."

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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 with reasonable care and skill.

…

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

RIGHT 6
Right to be Fully Informed

(1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including —

…

(b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; …

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Relevant standards

Section 88 of the New Zealand Public Health and Disability Act 2000 (effective from 1 July 2002):

"APPENDIX 1

GUIDELINES FOR CONSULTATION WITH OBSTETRIC AND RELATED SPECIALIST MEDICAL SERVICES

1.0 PURPOSE OF GUIDELINES

This document provides guidelines for best practice based on expert opinion and available evidence. It is the intention that the guidelines be used to facilitate consultation and integration of care, giving confidence to providers, women and their families.

For the purposes of these guidelines, referral to specialist services includes both referral to Secondary Maternity or to a specialist, as defined in this Notice. …

2.0 CIRCUMSTANCES WHERE GUIDELINES MAY BE VARIED

The guidelines acknowledge that General Practitioners, General Practitioner Obstetricians and Midwives have a different range of skills. The guidelines are not intended to restrict good clinical practice. There may be some flexibility in the use of these guidelines:

(a) The practitioner needs to make clinical judgements depending on each situation and some situations may require a course of action which differs from these guidelines. The practitioner will need to be able to justify her/his actions should s/he be required to do so by their professional body.

It is expected that the principles of informed consent will be followed with regard to these guidelines. If a woman elects not to follow the recommended course of action, it is expected that the practitioner will take the appropriate actions such as seeking advice, documenting discussions and exercising wise judgement as to the ongoing provision of care.

(b) It is also recognised that there may be some circumstances where the requirement to recommend consultation places an unnecessary restriction on experienced practitioners, particularly where there is no immediate access to specialist services. The individual practitioner can come to an appropriate arrangement with the specialist.

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It is agreed that, in accordance with good professional practice, a practitioner must record in the notes the reasons for the variation from the guidelines.

…

5.0 LEVELS OF REFERRAL

These Guidelines define three levels of referral and consequent action

Level 1
The Lead Maternity Carer **may recommend** to the woman (or parents in the case of the baby) **that a consultation with a specialist is warranted** given that her pregnancy, labour, birth or puerperium (or the baby) is or may be affected by the condition. *Where a consultation occurs, the decision regarding ongoing clinical roles/responsibilities must involve a three way discussion between the specialist, the Lead Maternity Carer and the woman concerned. This should include discussion on any need for and timing of specialist review.* The specialist will not automatically assume responsibility for ongoing care. This will depend on the clinical situation and the wishes of the individual woman.

Level 2
The Lead Maternity Carer **must recommend** to the woman (or parents in the case of the baby) **that a consultation with a specialist is warranted** given that her pregnancy, labour, birth or puerperium (or the baby) is or may be affected by the condition. *Where a consultation occurs, the decision regarding ongoing clinical roles/responsibilities must involve a three way discussion between the specialist, the Lead Maternity Carer and the woman concerned. This should include discussion on any need for and timing of specialist review.* The specialist will not automatically assume responsibility for ongoing care. This will depend on the clinical situation and the wishes of the individual woman.

Level 3
The Lead Maternity Carer **must recommend** to the woman (or parents in the case of the baby) **that the responsibility for her care be transferred** to a specialist given that her pregnancy and labour, birth or puerperium (or the baby) is or may affected by the condition. *The decision regarding ongoing clinical roles/responsibilities must involve a three way way discussion between the specialist, the Lead Maternity Carer and the woman concerned.* In most circumstances the specialist will assume ongoing responsibility and the role of the primary practitioner will be agreed between those involved. This should include discussion about timing of transfer back to the primary practitioner.

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

"**Standard two**

The midwife upholds each woman's right to free and informed choice and consent throughout the childbirth experience.

Criteria
The midwife:

- Shares relevant information, including birth options, and is satisfied that the woman understands the implications of her choices

…

- understands the implications of her choices
- Clearly states when her professional judgment is in conflict with the decision or plans of the woman
- Discusses with the woman, and colleagues as necessary, in an effort to find mutually satisfying solutions …

Standard six

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

Criteria
The midwife

…

- identifies deviations from the normal, and after discussion with the woman, consults and refers as appropriate
- works collaboratively with other health professionals and community groups as necessary
- has the responsibility to refer to the appropriate health professional when she has reached the limit of her expertise.

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Decision

This case raises important issues about informed consent and the responsibilities of midwives when mothers want to deliver their babies in a way that may be contrary to medical advice. It raises key questions about the duty of midwives to the unborn child, particularly when the child's well-being may be compromised by the mother's choices. It highlights tensions between the midwifery and medical approach to maternity care, and the critical importance of effective communication and good cooperation to ensure safe, good quality care.

Informed consent

Although Mrs A chose to go to the hospital, she wanted to have her baby as naturally as possible, with few people present in the birthing room. Mrs A had specified that she would prefer no medical intervention, but she had "left the door open" to accept secondary medical care if necessary. Her birth plan, which she wrote in the 38th week of her pregnancy, specified that she would consent to interventions if she, Mr A and the midwives were in agreement that intervention was "medically necessary".

A number of factors placed Mrs A and her baby at high risk with a vaginal birth. This was her first baby, and the baby was in a breech position. Additionally, Mrs A was being treated for thyrotoxicosis and, in the last weeks of her pregnancy, she had a positive vaginal swab for Group B Streptococcus. This meant that under certain circumstances, both she and the baby were at risk of serious infection, and antibiotics could be needed during labour.

In light of these factors, Ms B as the LMC, and Ms C as the back-up midwife, needed to keep Mrs A well informed about the risks and the actions necessary to ensure that she and her baby would be safe, and updated about risks and options as her labour progressed.

Mrs A believed that she had made informed choices about the management of her labour and delivery, having consulted obstetricians, books, and the midwives. In her detailed birth plan, Mrs A specified that the decision regarding medical intervention would be made after discussions between herself, her husband and the midwives. Mrs A had not previously experienced childbirth or the difficulty of trying to make decisions in the midst of active labour, when concerns are being raised. As discussed below, she was seemingly unaware of the practical difficulty of calling in medical staff at the last minute, if they had been excluded until that stage.

In her response to my provisional opinion, Ms B advised that Mrs A was "cognisant of what was happening" during her labour and well able to make decisions, an example being her refusal during the labour to have antibiotics. Ms B submitted that there is no evidence that any "impracticality" of the birth plan led to the tragic outcome.

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I acknowledge that Mr and Mrs A had given a great deal of thought to their choices and sought information from a variety of sources. All the evidence indicates that Ms B had discussed the birth plan in detail with Mrs A.

Consumers are free to make choices that others in a similar situation would not make, and that they may later regret (with the benefit of hindsight). The important proviso is that the consumer needs to be well informed about the risks of a proposed approach — as required by Right 6(1)(b) of the Code. It appears that Mrs A was generally well informed. However, I am not convinced that she realised that her plan to leave "the door open", if necessary, was flawed given the tense relationship between primary and secondary maternity care providers at QMMC, and the practical difficulty of calling in doctors who had been excluded until the eleventh hour.

Safety net

When, despite advice to the contrary, Mrs A chose to try to deliver her baby vaginally, Ms B had a duty to communicate clearly that her baby was at risk, and that a safety net needed to be in place, in case things went wrong.

At the heart of the Code of Health and Disability Services Consumers' Rights is the right to co-operation among providers to ensure quality and continuity of services. Furthermore, Standard 6 of the *Midwives Handbook for Practice* requires consultation and referral. Ms B appropriately complied with this requirement by referring Mrs A to specialists earlier in the pregnancy, but when Mrs A arrived at hospital, the obstetric team was not notified and a paediatrician was not put on standby.

Although there was no formal protocol on breech births, Ms B knew that it was the usual practice at QMMC for a breech delivery to be transferred to the obstetric team, that a Caesarean section was the preferred delivery option, and this had been recommended to Mrs A by Dr F and Dr D. Ms B subsequently acknowledged that it is not common in New Zealand hospitals for a woman to have a vaginal breech delivery. She explained that in this case, she was operating outside her "usual system" and supporting a woman who was seemingly well informed, but firmly wanted no medical involvement unless necessary. As a result, she may have "us[ed] the wrong rule to solve a problem". In an effort to comply with Mrs A's wishes she continued to view the labour as progressing normally, and the baby as active with a normal heartbeat. Ms B accepts that "the rule" she could have applied was that the baby was breech, with inherent risks, and that obstetric and paediatric back-up was required.

In response to my provisional opinion, Ms B submitted that given the "history of stand-up arguments between midwives and obstetricians in the corridors of Queen Mary" and "the climate that was prevalent", it was simply not realistic to have obstetricians/paediatricians on standby — "they would have either insisted on full involvement (something Mrs A did not want) or would have refused because they were not allowed full involvement".

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I note, however, that Mrs A now says that her "understanding was that the hospital and the specialists were the back-up plan and safety net, and that they were on site and available to me at any time, if we wanted it". This suggests that Mrs A did not appreciate the practical difficulty of calling in medical staff at the last minute, if they had been excluded until that stage.

There was a subsequent opportunity for the midwives to revisit the labour management decisions. At 6.20pm Ms B became concerned by the fetal heart rate and suggested calling an obstetrician. It seems that Mrs A did not consent to any doctors coming in. Mrs A was fully absorbed in birthing her baby, and Mr A was "struggling to take in more information". In these difficult circumstances, with the fetal heart rate appearing to settle, Ms B did not call for obstetric support because she considered the birth was imminent.

In the debate that followed the High Court proceedings, a group of 60 midwives at Auckland District Health Board were polled on how they would respond to a mother with a baby in breech position who decided not to take medical advice to have a Caesarean section. Seventy-nine percent said they would discuss the risks and options with the mother and proceed with a vaginal delivery. Sixty-one percent said they would not notify the hospital obstetrician of the mother's arrival if the mother did not wish this to happen. The results of this informal survey indicate that not all women are being adequately informed, and that the majority of midwives will keep obstetric staff in the dark if that is the mother's wish.

The *Midwives Handbook* states that the midwife is to uphold each woman's right to free and informed choice and consent, but a midwife must clearly inform the woman when her professional judgement is in conflict with the woman's decisions. It is not just a matter of supporting a mother in her choices. In my view (with which I note Ms B "actively concurs"), the midwife has a duty to use her knowledge and experience to minimise the risk to the mother and baby. It would be an unusual woman who would risk the life and well-being of her baby in order to adhere to her choices for her labour and delivery, if the midwife is clear about the risks her choices pose.

It must, however, be repeated that Mrs A was generally well informed about the risks to her baby and herself. I accept the submission that "[Ms B] did not blindly support [Mrs A's] choices". Further, I acknowledge that the fractious environment at QMMC made it difficult to ensure that a safety net was in place.

Fetal distress

Ms B said that it was not until two minutes before the birth that any real problem emerged, and Mrs A supports this view.

However, at the trial there was conflicting evidence about whether there was an earlier point at which Ms B and Ms C should have recognised that Baby A could be in distress, reassessed the situation and sought obstetric and paediatric backup. There

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were differing expert views about whether Ms B and Ms C failed to identify a concerning fetal heart pattern that started with tachycardia at 6.20pm. It was suggested that they were falsely reassured when the heart rate appeared to settle at 7.30pm. One expert stated that when there was a further episode of tachycardia at 7.50pm, although the birth was imminent at that time, they should have been aware that all was not well with this baby, and advised Mrs A of the risk to her baby and called for backup. Another expert could not see the deceleration in the baby's heart rate, said the tachycardia was mild and variable, and stated that the midwives were right to be reassured. Without further investigation, I am unable to make a final determination on this matter.

Relationships and communication
Above all else, this case highlights the need for effective communication between professional groups, particularly those who are responsible for the care of "at-risk" women.

Ms B has sought to explain why she did not alert the obstetricians and paediatricians and, at the very least, have them on standby after Mrs A arrived at QMMC, and during the labour. Ms B has noted that relationship issues at the maternity unit provide relevant and important context to these events. She gave the example of women who had made choices with the advice of one obstetrician, and had then been overruled by another obstetrician at the unit. She said that pressure was brought to bear upon the midwife to get the woman to "change her mind". Mrs A also spoke of relationship problems at the unit, and expressed concern that medical staff would not respect the choices of women in labour. I accept that the tensions that existed at QMMC were a significant contributory factor in Mrs A's case.

Ms B's clients commonly include women at the outer limits of risk who, for a variety of reasons, prefer not to have medical intervention in their labour and delivery. Her concern is that, if these women are not confident that their midwife will support their wishes, they will refuse to book into the hospital and expose themselves and their babies to greater risk by not having any maternity supervision and/or having a home birth. To this end she acts as her clients' advocate, working with the obstetric teams to ensure the best results for the mothers and babies.

I have discussed the issues arising from this case with a number of maternity advisors. The consensus of opinion is that there was evidence of poor relationships between practitioners and that these relationships influenced how events were managed.

The ODHB recognises that there are ongoing tensions between primary and secondary maternity care providers, and this case has exacerbated these tensions. Co-operation and collaboration between midwifery and medical colleagues is vitally important if women are to receive good quality maternity care. For whatever reasons, it appears that this did not happen.

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As noted above, the ODHB's review provided an opportunity to examine the lessons to be learnt. The ODHB is in the process of pursuing initiatives to improve relationships and communication between practitioners.

Criminal proceedings
Another lesson from this case relates to the criminal proceedings. As I have noted publicly, in my view the criminal prosecution of a health practitioner should occur only in exceptional circumstances. The risk of such prosecutions is that they discourage health practitioners from acknowledging and reporting errors, and drive mistakes underground.

There is growing recognition in New Zealand and overseas that patient safety is best promoted by focusing on the systems that contribute to adverse events, and learning from mistakes. Rather than seeking to "name, blame, and shame" individual practitioners (such as in criminal proceedings), the modern approach is to prevent recurrences by recommendations to improve individual and system performance.

There is a place for the criminal law in the clinical setting where a health practitioner kills a patient by reckless acts or omissions. But in cases of unexpected patient death, even where gross negligence may be proved, a manslaughter prosecution is likely to do more harm than good. It delays and frustrates the regular mechanisms for health practitioner accountability. Most importantly, no health practitioner is likely to share their mistakes in a peer review setting if Police search and seizure is a possibility. The real causes of patient deaths will remain hidden, and the potential to learn from mistakes will be lost.

The prosecution in this case has taken a toll first and foremost on Ms B and Mr and Mrs A, but also on the ODHB staff and the wider midwifery profession, and has cast a long shadow on my investigation. It highlights the need for careful reflection by the Police and the Crown prosecutor whenever such a prosecution is contemplated.

Access agreements

Ms B and Ms C are independent LMC midwives who at the time of these events had an access agreement with the ODHB. The access agreement is a contractual arrangement between a self-employed LMC and a maternity facility. It authorises the LMC to access the facility to provide "labour and birth and inpatient postnatal care to the practitioner's maternity clients". As noted above, there has been tension between some independent midwives and some members of the ODHB maternity service. In part this tension has arisen because the philosophy of care of some LMCs is at variance with the Board's policies and procedures, and there is no obligation on the part of an access agreement holder to comply with Board policy.

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I accept Ms B's submission that the events of Baby A's birth cannot be linked to the access agreement. However, I am concerned that if LMCs have an agreement to access a birthing facility, they should be bound by the safety and quality policies and procedures of the facility. Obviously it is important that local LMCs have input into the development of such policies, and that they are evidence-based . These are issues I have highlighted in previous HDC opinions, notably 04HDC04652, 17 January 2006.

I acknowledge that LMCs who are members of the New Zealand College of Midwives (as are approximately 80%) agree to follow the practice guidelines promulgated by the College. All LMC practitioners are bound by the requirements of the standard section 88 guidelines. Nonetheless, investigations of maternity care lead me to believe that, on occasion, there is a wide variation in professional standards. A small number of LMCs take safe practice to the outermost limits.

The national maternity service agreement is currently under review by the Ministry of Health. It is to be hoped that the new agreement will provide a framework to support the provision of safe, high quality care in maternity facilities.

In this case, there were no formal protocols relating to breech births, but there was an understanding at the ODHB that there was a preference for breech babies to be delivered by Caesarean section at 39 weeks. The reasons why that did not occur in this case have been thoroughly examined and relate to tensions between the obstetric and midwifery staff, and the mother's wishes, rather than to the ODHB protocols and access agreement conditions. Ms B complied with the access agreement conditions, the College *Midwives Handbook for Practice* and the section 88 guidelines.

Women in New Zealand, like Mrs A, believe that a "safety net" is in place if they choose to delivery their baby in a public hospital. That belief is illusory if there are barriers (including fraught relationships) to LMCs communicating important information to fellow health professionals who may be called to assist. In my view, where a consumer and her LMC use a birthing facility, the practitioner should alert staff at the facility to the labour in progress and give a broad overview of the situation. The facility staff (including obstetric staff) need to be able to discuss the situation with the LMC. Good communication between practitioners (particularly primary and secondary care services) is essential so that risks can be discussed and contingency plans put in place in the interests of the woman and her baby.

Conclusion

In conclusion, in light of the actions taken by the ODHB, the Midwifery Council, Ms B and Ms C in response to these events, and taking into account the strongly held views of Mr and Mrs A , I have decided to take no further action on this complaint and to discontinue my investigation.

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Follow-up actions

- A copy of this report will be sent to the Midwifery Council of New Zealand, and a partially anonymised copy will be sent to the New Zealand College of Midwives, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, and the Ministry of Health.

- A partially anonymised copy of pages 1–3, 4 (first paragraph only) and 24–38 of my final decision (deleting the names of all parties except Otago District Health Board, Queen Mary Maternity Centre, Waitakere Hospital, and Dr Robin Youngson) will be placed on the HDC website, www.hdc.org.nz, to draw media and public attention to the important issues raised by this case. I acknowledge Mr and Mrs A's wish to maintain the privacy of their health information and, for that reason, have deleted the remainder of the report from the copy to be placed on the HDC website. However, given the public interest in this case, and the fact that (as a result of the High Court proceedings) a lot of information is already in the public domain, I have decided that the key parts of my decision (notably the 'Overview' and the 'Decision') should be made publicly available in an anonymised form.

- I have asked the Otago District Health Board to advise me by 28 February 2007 of the outcomes of the initiatives currently under way to improve relations between maternity practitioners in Otago.

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