Midwife, Ms D

Midwife, Ms E

Obstetric Nurse, Ms F

A Birthing Unit

A Report by the

Health and Disability Commissioner

Case 05HDC01760

Parties involved

Ms A	Consumer
Baby A	Consumer's daughter (deceased)
Ms B	Consumer's sister
Mr C	Consumer's previous partner
Birthing unit	Provider/Birthing and postnatal facility
Ms D	Provider/Midwife and Lead maternity carer
Ms E	Provider/Midwife
Ms F	Provider/Obstetric nurse
Ms G	Midwife and Lead maternity carer
Ms H	Managing director of birthing unit
Ms I	Birthing unit manager
Ms J	Birthing unit manager
Ms K	Student midwife
Ms L	Birthing unit midwife
Ms M	Midwife in city

Complaint

On 7 February 2005, the Commissioner received a complaint from Ms A about the services provided by midwife Ms D to Ms A and her baby, Baby A. The following issues were identified for investigation:

Ms D

- *The appropriateness and adequacy of the intrapartum care provided by midwife Ms D to Ms A in November 2004.*

Ms E

- *The appropriateness and adequacy of the management of labour provided by midwife Ms E to Ms A in November 2004.*

- *The appropriateness and adequacy of the resuscitation care provided by midwife Ms E to Baby A in November 2004.*

Ms F

- *The appropriateness and adequacy of the antenatal consultation provided by registered nurse Ms F to Ms A in November 2004.*

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Birthing unit

- *The appropriateness and adequacy of the antenatal services provided to Ms A by the birthing unit in November 2004.*

- *The appropriateness and adequacy of the labour and delivery services provided by the birthing unit to Ms A in November 2004.*

- *The appropriateness and adequacy of the neonatal care services provided by the birthing unit to Baby A in November 2004.*

An investigation was commenced on 15 April 2005.

Ms D

On 20 February 2006 the investigation was extended to include:

- *The appropriateness and adequacy of the antenatal care provided by Ms D to Ms A.*

- *The adequacy of the information provided by Ms D to Ms A during the antenatal period.*

This investigation has been significantly prolonged by a lack of cooperation from Ms D and Ms E. A private investigator was used to locate both providers, and a process server was required to serve the investigation papers. Ms D and Ms E delayed providing their responses for over 12 months from the time when they were first notified of the investigation.

Information reviewed

- Information from:
  - Ms A
  - Ms D
  - Ms E
  - Ms F
  - Ms B
  - Mr C
  - Ms J
  - Ms H, Managing Director, the birthing unit
  - Ms K
- Ms A's clinical records from the birthing unit
- Policy documents and Record of Settlement (employment contract) between the birthing unit and Ms D (attached)
- General information from the Ministry of Health

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- Independent expert advice obtained from Ms Nimisha Waller, midwife and general obstetric nurse, and Ms Terryll Muir, midwife and clinical midwife leader.

Overview

Ms A was pregnant with her fourth child in November 2004. She had a history of rapid births, and her second delivery was induced owing to concern about reduced fetal movement in the final weeks of her pregnancy.

Ms A's antenatal care was mostly provided by her Lead Maternity Carer (LMC),[1] Ms D, with some input from staff at the birthing unit. Ms A experienced two episodes of reduced fetal movements in the three weeks prior to the birth, but no additional antenatal testing was considered necessary by her LMC.

Ms A went into labour and contacted Ms D, who agreed to meet her at the birthing unit. However, Ms D did not arrive at the birthing unit until 40 minutes after the baby's birth. Baby A was therefore delivered by birthing unit midwife Ms E, who was alone on duty at the time and, despite several attempts, was unable to call in support. Baby A delivered rapidly, in the presence of meconium-stained liquor, and was unresponsive at birth. Attempts to resuscitate her were unsuccessful.

This report examines the quality and adequacy of the antenatal and labour care that was provided to Ms A and Baby A by Ms D and other birthing unit employees, and the systems and management strategies that were in place at the birthing unit at the time.

Information gathered during investigation

Background

Maternity services in New Zealand
Pregnant women in New Zealand are entitled to free maternity services from midwives or general practitioners to cover their pregnancy, birth and postnatal care. Women are entitled to choose where they want to have their babies, and who will provide their care. The choices include:

[1] The LMC takes responsibility for the care provided to the woman throughout her pregnancy and delivery, and for four to six weeks post-delivery.

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- a home delivery, assisted by an independent midwife;
- a primary maternity facility or birthing unit, assisted by an independent midwife, hospital midwives, or a general practitioner;
- a secondary maternity hospital assisted by an independent midwife, hospital midwives, a general practitioner, or an obstetrician.

A pregnant woman must choose a Lead Maternity Carer, who is funded by the Ministry of Health to provide maternity services. The LMC is primarily responsible for organising the woman's maternity care and developing a maternity care plan. The LMC's responsibilities are set out in the Maternity Services Notice, issued pursuant to section 88 of the New Zealand Public Health and Disability Act 2000 (section 88). The Maternity Services Notice requires LMCs to "be available twenty-four hours, seven days per week to provide phone advice to the woman or attendance if required for urgent problems, either personally or by the Back-up to the Lead Maternity Carer". When a pregnant woman goes into labour, the LMC is required to attend, or arrange suitable back-up to attend, within 20 minutes of being called. For births occurring at a primary facility, such as the birthing unit, the LMC is required to arrange a second authorised practitioner[2] to be available to attend the birth, as per clause 4.4.3 of section 88. Therefore, it is required practice for a second authorised practitioner, qualified to deliver and assist with a birth, to be available to attend every birth in New Zealand.

The Ministry of Health advised me that, at a minimum, any person applying for "authorised practitioner" status would need to be a health professional with a current practising certificate and the holder of a recognised qualification in midwifery or obstetrics. For the second authorised practitioner to be "available", he or she should be alerted when a woman goes into labour, to confirm the practitioner's availability to attend at short notice. Independent midwives often work in partnerships so that they can call on their partner to provide second authorised practitioner services.

[2] Section 88 defines an "Authorised Practitioner" as an Anaesthetist, General Practitioner, Midwife, Obstetrician, Paediatrician or Radiologist who has received written authorisation from the Ministry of Health to provide Maternity Services. An Authorised Practitioner includes both independent practitioners and practitioners who are employed by an organisation.

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National Service Specifications
Maternity facilities in New Zealand are governed by the Maternity Facility Service Specifications,[3] which were published by the Ministry of Health in September 2003. These Specifications form part of the contractual arrangements between the Ministry of Health and the District Health Boards (DHBs) throughout New Zealand.[4] The birthing unit receives its funding through a District Health Board, and is therefore covered by the National Service Specifications.

Birthing unit
The birthing unit is a primary maternity facility that caters for low-risk birthing and postnatal stays, and has facilities in two locations. The birthing unit referred to in this investigation was opened in 1995 as a fully-funded public maternity service, and was accredited by Quality Health New Zealand after a survey on 9–10 December 2002.[5]

Ms H, Managing Director of the birthing unit, explained that the birthing unit employs two types of midwife — LMC midwives and staff midwives. LMC midwives work as midwife practitioners, using the birthing unit as their base. They maintain their own case load of clients and provide support to other birthing unit LMC midwives, when required. Staff midwives and registered nurses are also employed by the birthing unit to provide cover for the facility, supporting the LMC midwives when they are caring for labouring women, and providing postnatal services to women who are staying at the birthing unit.

Women can book into the birthing unit under the care of a birthing unit midwife, an independent midwife, a general practitioner or in a shared-care arrangement. Women can stay at the birthing unit as a postnatal client after the birth, and can transfer to the birthing unit after giving birth at another facility.

The birthing unit has seven beds, two of which are birthing rooms. The birthing unit is certified to care for a maximum of five postnatal women, and can provide second authorised practitioner services for two women in labour.

Ms H provided details of the 24-hour service provided at the birthing unit. There is one staff midwife on duty at night, between 3pm and 7am, and one staff midwife and a

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[3] Referred to in the remainder of this report as the National Service Specifications.

[4] In 2002, the Ministry's Operational Policy Framework established a Nationwide Service Framework to ensure consistency and equity in core service delivery by DHBs. DHBs are expected to use the Nationwide Service Framework (NSF) in providing services, and this is linked to the DHB Funding Agreements. Clause 8.2.1 of the Operational Policy Framework 2002 states that, for services that are funded, a DHB and the Ministry must use the NSF service specifications. The DHB must therefore ensure that there is compliance with the Maternity Facility Service Specifications when funding services at the birthing unit.

[5] Accreditations by Quality Health New Zealand are valid for three years.

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health assistant on duty during the day, from 7am to 3pm. When a woman goes into labour, the birthing unit expects the LMC of each woman to conduct the delivery, and the staff member on duty to act as the second authorised practitioner. If the LMC is unable to attend, she is expected to arrange another LMC midwife to attend as her back-up. If neither the LMC nor her back-up can attend, facility staff can activate the emergency plan. A portable telephone unit has a list of midwives adhered to the back, with the telephone numbers listed in order of non-birthing unit LMC midwives who live closest to the facility, followed by non- birthing unit midwives, also listed by proximity. Ms H stated that "the facility staff are not on-call but there is an understanding with them and non-birthing unit LMCs that they will attend in an emergency".

Ms J, manager of the birthing unit, advised:

> "Midwifery cover is provided 24/7. The manager covers as the midwife on call for the facility when the registered nurses are on duty. The manager is on call to offer advice and reassurance, but the midwives in the team are expected to support and cover midwifery case loads."

Ms H explained that when Ms F, a registered nurse, was on duty and required assistance, she was expected to call on the woman's LMC midwife or, if she was unavailable, the clinical manager. If the manager could not be contacted, Ms F could then use the telephone list. Ms F confirmed that she would call the manager for advice if she was unable to access the LMC.

In summary, if a labouring woman arrived at the facility without her LMC, the facility staff are expected to:

- notify the LMC or her designated back-up;
- call other birthing unit LMC midwives on the emergency telephone list;
- call non- birthing unit LMC midwives who lived in the town; then,
- if there was any doubt, call the clinical manager.

Ms H explained that the LMC midwife carries the client's notes but, on booking in with the birthing unit, lodges the "front sheet" of the notes at the birthing unit. This includes a brief history, the expected due date, and any laboratory or scan results. Ms D's job description and employment agreement confirms she was aware of this requirement.

The birthing unit provided its policy for "transfer of women to secondary care". This outlines the procedure for the transfer of patients in an emergency, and has provides the contact details of the nearest main hospital and ambulance service.

Ms D

Ms D completed a Bachelors Degree in Midwifery in 2001 and registered as a midwife in the same year.

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Ms D advised me that she was employed by the birthing unit as an LMC midwife in August 2004. Her employment agreement with the birthing unit is dated 19 July 2004. Ms D's job was to provide LMC services to women delivering at the birthing unit. This involved being on call for emergencies and deliveries, and providing back-up services to others in her team when they were busy or off duty. Ms D advised me that she understood her contract with the birthing unit to mean that her back-up support for deliveries at the birthing unit was other LMC midwives or, if they were unavailable, the facility staff on duty. Ms D's position description as an LMC midwife stated that "all team members will be available for peer support when on call".

Ms J advised that all LMCs were supervised by the manager and provided with a copy of the facility's guidelines and policies as part of the access arrangement.

One month into her employment with the birthing unit, Ms D said that she was advised by Ms J that it was no longer financially viable for the birthing unit to retain a team of four midwives, and Ms D would be made redundant. As part of the discussions about her redundancy, Ms D agreed to continue working for the birthing unit on a part-time (.5) basis until January 2005. Ms D continued to provide LMC care for Ms A under this arrangement, but was required to give back the birthing unit cellphone, which included a toll-free number for clients, and her mileage allowance was withdrawn.

The birthing unit has highlighted that this agreement was made in consultation with Ms D. The withdrawal of the telephone and mileage allowance was made with regard to a reduced workload.

Ms D left the birthing unit on 31 December 2004. She is now a self-employed, independent midwife, offering only home birth services in another area.

Ms E

Ms E graduated in 2000 with a Bachelors Degree in Midwifery. While training as a midwife she worked for the birthing unit as a healthcare assistant. After she qualified as a midwife, and following a career break, Ms E began working at the birthing unit in August 2003 in a full-time position as a staff midwife.

The birthing unit sent Ms E on a resuscitation refresher course at the nearest hospital in April 2004, in order to assist her to update her resuscitation skills, which is a yearly requirement for midwives.

Ms E delivered a minimum of 40 babies as part of her midwifery training. Before Ms A's delivery, she had assisted at five births and had delivered two babies on her own.

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Ms F
Ms F is a registered general and obstetric nurse. She first registered as a general nurse in 1978 and has been employed at the birthing unit as a staff nurse since 1997.

Ms F explained that the nursing position involves working rostered shifts, and that most of the work is caring for postnatal mothers and their babies. In 2004 Ms F also qualified as a lactation consultant.[6] Ms F advised me that she is often in sole charge of the birthing unit at night.

Ms A
This was Ms A's fourth child and she was due to give birth in November 2004.

Ms A's previous three deliveries had been fast, occurring over two to three hours, and her babies were smaller than average, weighing between 2490g and 2590g. During Ms A's second pregnancy in 1999 there had been concerns about reduced fetal movements in the third trimester of pregnancy[7] and, for the safety of the baby labour was induced at 37 weeks' gestation.

Antenatal care
Ms A first met with her LMC, Ms G, on 13 May 2004. A scan and blood tests had already been ordered by Ms A's general practitioner in early pregnancy.

A Midwifery Care Plan was documented by Ms G on 13 May 2004, noting Ms A's previous three births, including the length of the labours and the weight of the babies. Ms A's second delivery in 1999 was noted as being induced with "prostin gel".[8] Ms G advised me that she gave Ms A an antenatal book, which included a chart for monitoring fetal movements. However, Ms G's focus was on the early stages of pregnancy and social care. She explained that the fetal movement chart can only be used after 28 weeks of pregnancy.

Ms G saw Ms A on 16 June 2004 when she was 18 weeks pregnant, and on 30 July 2004 when she was 23 weeks pregnant. Ms G noted that Ms A had felt some fetal movements and advised her to "keep note of movements".

Ms K advised me that she was involved in Ms A's antenatal care as a student midwife, first assisting Ms G and, later, Ms D. Ms K confirmed that Ms G had discussed the previous births, and the significance of fetal movements and what to do in the event that Ms A had any concerns.

Ms D advised me that she first met Ms A on 21 July 2004 at the antenatal classes Ms D was facilitating for the birthing unit. Ms D said that she introduced herself to Ms A and explained that she would be taking over as Ms A's LMC when Ms G left.

[6] A lactation consultant provides breastfeeding advice and care.
[7] The final three months of pregnancy — between 27 and 42 weeks' gestation.
[8] A gel used by health-care providers to stimulate the cervix to soften in preparation for labour.

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Ms D saw Ms A again on 26 July 2004 when she presented at the birthing unit with a bruised eye and requested a scan. Ms D informed me that Ms A was concerned about an accidental blow by one of the children and wanted to check that everything was all right. Ms D gave her a form for an anatomy scan.

Ms A said that she did not ask for a scan at this time, and that this was Ms D's suggestion. The bruised eye had been caused by an accidental bump of heads with her young son. Ms A had no concerns about her pregnancy at this time.

LMC responsibility was transferred to Ms D on 1 August. On 17 August, Ms D reviewed Ms A's care at a routine antenatal appointment at Ms A's home. Ms A was 27 weeks pregnant.

Ms D stated:

> "We discussed briefly her birthing history. Her first birth was normal; she was induced in 1999 with prostin gel with her 2nd child. She was unsure but assumed it was for decreased movements. I had not been privy to any of her previous birth notes so relied on information that [Ms A] shared with me. Her 3rd baby she had birthed normally at the birthing unit in 2002. She said she had no complications with any of the births.
>
> Her main concern was that she birthed quickly. My advice to her was that we develop a birth plan. She was to inform me as soon as she had signs of labour. This was discussed in detail."

In response to my provisional opinion, Ms D confirmed that she did not review any previous records for Ms A. Ms H advised that all notes of any previous deliveries at the birthing unit remained on-site. Ms A's previous baby had been born at the birthing unit, and these records would have been available at the facility. Ms H added that "all LMCs are encouraged to make themselves familiar with client histories".

Ms D confirmed that based on the information Ms A had shared with her, she assessed Ms A as a low-risk pregnancy. In relation to risks, Ms D advised me that Ms A was aware that "she could contact me or go to the birthing unit at any time if she had any concerns", and said:

> "[Ms A] was aware of regularly monitoring baby movements and was encouraged to write this in her antenatal book and to make contact if movements were decreased."

Ms D said that she discussed Ms A's birthing history with Ms J, who was the clinical manager at the birthing unit and had been involved with the birth of Ms A's third baby. Ms D said they had agreed that the birthing unit was a suitable place for Ms A to give

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birth as her previous delivery had been normal. However, in response to my investigation, Ms J denied that this consultation took place. Ms J advised me that, had this conversation occurred, she would have recommended booking Ms A in at both the birthing unit and nearest hospital facilities. In light of her history, Ms A would be unlikely to arrive at the hospital in time.

In response to my provisional opinion, Ms D described the antenatal care she provided:

> "At every antenatal assessment I took her blood pressure, carried out urinalysis, palpation to assess growth and position of the baby, and listened to the foetal heart rate (FHR) for at the least 1–2 mins [minutes]. I regularly asked [Ms A] about baby movements and any concerns. We also discussed smoking, her diet and social aspects of her life that may have impacted on her pregnancy. Blood and scan results I felt were satisfactory."

On 25 August 2004, Ms A had an ultrasound scan, and the results were reported as normal.

On 31 August 2004, Ms A presented at the birthing unit for an antenatal appointment and was seen by Ms J. Ms D advised me that this was because Ms A had got the wrong date for her check-up. In response, Ms D arranged a follow-up appointment for 7 September 2004. However, on 7 September 2004, Ms A did not arrive at the birthing unit and was not home when Ms D went to her house. Contact was made the next day.

Ms A confirmed that there was some confusion about the times and dates for her antenatal appointments after Ms D took over her care. Ms D said that, from her perspective, she was often left waiting for Ms A, who did not attend her antenatal checks at the birthing unit. However, on a number of other occasions the birthing unit staff also completed antenatal assessments in Ms D's absence. As a result, Ms D agreed to see Ms A at her home.

Ms J recalled Ms A attending the birthing unit frequently for antenatal checks outside appointment times, and that Ms J had seen Ms A on several occasions herself. Ms J said that she discussed this situation with Ms D and asked her to ensure that she saw Ms A at regular times to establish a relationship before the birth.

Ms J explained that antenatal checks at the birthing unit were documented on a single A4 sheet. The sheet was designed to ask key questions to reveal more detail than usual because the midwife did not know the woman. The sheet was then placed in the LMC midwife's postbox to be added to the antenatal record, and the visit was recorded in a log book.

The checks completed by Ms J, or any other staff, were not included with the record, and have not been found by either Ms D or the birthing unit. However, Ms A confirmed that she saw Ms J at the birthing unit a number of times.

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Ms D carried out further antenatal checks on 12 September, 30 September, 12 October and 26 October 2004 when Ms A was 31, 33, 36 and 37 weeks pregnant. Ms D documented details of maternal observations, fetal growth and heart rate. She did not document any notes about fetal movements.

In response to my provisional opinion, Ms D stated that "there were no signs of IUGR [intra-uterine growth retardation[9]]. If so I would have investigated further and referred to secondary care."

Ms D recorded that there were discussions about the family and planning for the birth, but she did not provide a written birth plan. The discussions took place during her visit on 26 October 2004.

Reduced fetal movements

Ms D did not routinely record in the antenatal assessment record any notes or observations about fetal movements. The observations recorded on the antenatal record that do record fetal movement were made by Ms G on 16 June and 20 July and by Ms K on 30 September 2004. Ms D said that she was assured by the antenatal assessments that the baby was growing and developing well.

Ms A noticed that her fetal movements had slowed down at around 39 weeks. She usually gave birth around 37 weeks, and felt it was unusual for her to still be pregnant.

Ms A saw Ms D for a routine antenatal check on 10 November 2004. Ms A said that Ms D assured her that the slowing down of fetal movement was normal at this stage of pregnancy, and did not offer any further advice. The discussion about reduced fetal movements is not noted in Ms A's antenatal record, and Ms D did not refer to it in her description of this visit.

Ms D initially denied that Ms A informed her of reduced fetal movements at any time. However, in response to my provisional opinion, Ms D said that they had discussed Ms A's concerns about reduced movements "sometime in the last month". Ms D had confirmed with Ms A that the fetus had moved more than 10 times that day.[10] Ms D felt that the fetus was "a good size" and that reduced fetal movement was "normal at this stage in her pregnancy". She advised Ms A to continue monitoring the movements using the chart in her antenatal book, and to make contact if she had any further concerns. Ms D said that she ensured Ms A had the 0800 telephone numbers for the team of midwives at the birthing unit.

[9] Fetal growth below the average expected for the gestational age.

[10] Research-based practice suggests that 10 fetal movements in a day is the *minimum* criteria to assess the health of the fetus by activity. This observation should be taken into account with the fetal heart reading and growth rate of the fetus.

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Ms K recalls that, at one appointment, Ms A was concerned and "did question Ms D about reduced fetal movements". Ms K is unable to recall exactly when this occurred but said that Ms A asked Ms D for advice about what to do if the movements were slow, as this had occurred in her last pregnancy. Ms K said that Ms D did not advise Ms A to do anything further.

A few days later, Ms A waited at home for an arranged visit from Ms D. Ms A had become more concerned about the fetal movements and the length of her pregnancy, and wanted an assessment.

Ms D said that she received a text message from Ms A to ask whether Ms D would still be visiting. Ms D replied that she was busy at a hospital and could attend an appointment in one or two days' time. Ms A said that she tried to contact Ms D by cellphone but did not get a response, so went to the birthing unit at around 4pm.

Ms F, registered nurse, was alone on duty at the birthing unit that evening. When Ms A arrived and explained her anxiety about the fetal movements, Ms F tried to call Ms D on her cellphone but was unsuccessful. Ms F decided to assess Ms A to offer reassurance. Ms F was able to find a partial set of maternity notes, which consisted of name stickers and a copied front page of the maternity care plan. This contained some details of the previous births as recorded by Ms G. There were no observations about the current pregnancy and no issues were highlighted.

Ms F asked Ms A whether there had been any unusual vaginal symptoms or abdominal pain. Ms F listened to the fetal heart via a sonic aid[11] and recorded the heart rate as 137 beats per minute. She did not record any range or variability but recalls that the heartbeat was "strong, loud and clear" and that she listened for five minutes. Ms F added that "there were no indications she [Ms A] was in labour". Ms F asked Ms A to "continue to pay attention to the fetal movements and report the results to Ms D". Ms F also suggested that Ms A go home but return if concerned. Ms F explained:

> "The reason I used a sonic-aid to hear the baby's heart beat was because I am competent in their use. This was the first time in my eight years at [the birthing unit] that I have come across this situation. I have not been trained in interpreting CTGs [cardiotocographs][12] and couldn't get hold of the LMC to read it."

Ms F documented a "consultation report for LMC" and left a message on Ms D's mobile phone reporting the reduced fetal movements and her actions.

Ms D recorded the following in the antenatal record:

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[11] A sonic aid is a device used to listen to the beating of the fetal heart. Some devices record the beats per minute in a visual display.

[12] A CTG (cardiotocograph) records the fetal heartbeat and uterine activity onto graph paper for analysis of fetal well-being and uterine activity.

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> "Received a call from [the birthing unit] that [Ms A] had come in for A/N [antenatal] check and had expressed concerns about ↓ [decreased] baby movements — check done and all was well BHR [baby's heart rate] listened to and heard."

Ms D advised me that she did not know whether a sonic aid or CTG monitor was used by Ms F. Ms D did not telephone Ms F or Ms A to confirm what action had been taken.

Ms D said that she was "satisfied with what the results were at that time and had intended to follow up".

Labour and delivery

Ms A's contractions started the next day at 11pm. Given her history of fast labours, Ms A had agreed to contact Ms D early, and called her at midnight. At the same time she also called her sister, Ms B, and her previous partner, Mr C.

Ms D said that prior to Ms A's giving birth Ms D had a particularly busy week with several high-needs clients requiring urgent attention. Ms D had just returned home from working a 24-hour period at hospital with a client who required a Caesarean section when Ms A informed her of the labour.

Ms D stated that she received the call at 1am. She initially said she was disappointed that Ms A had not informed her of the labour at the early point they had previously agreed. They arranged to meet at the birthing unit "as soon as possible".

Ms D later recalled that Ms A told her she was tidying up the house before going to the birthing unit. This led Ms D to believe that the labour was "probably very early".

Ms D advised me that, after she finished the call, she went inside to wash, change her clothes, have a cup of coffee and find her money card, as she needed petrol on the way to the birthing unit, which was a 40–50 minute drive from her house. Ms D said that she left home at 1.35am and travelled via another town to purchase petrol. Ms D advised me that she did not ring the birthing unit, and "assumed that by the calm sound of Ms A's voice when she rang, that I would have ample time before Ms A left her home".

Ms K advised me that she received a call from Ms D just after midnight. Ms D notified Ms K that Ms A was in labour and that she would call in to pick up Ms A's notes. Ms K said that she waited up for Ms D but, when she did not arrive for some time, Ms K went to bed. Ms D arrived at Ms K's house at 1:30am to pick up the notes. Ms K said that Ms D did not appear to be in any hurry and asked Ms K to make her a cup of coffee. Ms K did so and then encouraged Ms D to leave for the birthing unit. Ms K confirmed that she lives 10 minutes' drive away from the birthing unit, and that Ms D left at approximately 1.40am.

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Ms D disagrees with Ms K's account, and said that she rang Ms K after 1.10am. Ms K had planned to attend Ms A's birth, but told Ms D that she would be unable to at this time. Ms D said that she went to Ms K's house in another town, and it took several attempts to rouse Ms K. When Ms D did wake her, it was Ms K who encouraged her to have a coffee and a break. While having coffee with Ms K, Ms D said that she received a call from Ms A's phone at 2.01am. As it was not Ms A on the phone, Ms D said that she queried whether everything was all right and left immediately for the birthing unit.

Meanwhile, Ms A had arrived at the birthing unit at 1.15am. She was met by midwife Ms E, who was alone on duty with one postnatal client in the facility. Ms E said that when a labouring woman was expected at the birthing unit without her LMC, it was usual practice for the LMC midwife to phone ahead with information about the patient, including any risk factors or equipment required such as the birthing pool. There had been no phone call from Ms D, and Ms E was not expecting Ms A.

Ms E admitted Ms A and noted that she was having strong contractions. Ms A told her that these had started at 11pm. Ms E helped Ms A to a delivery room and began to prepare for the birth. Ms E checked the equipment, including the neonatal resuscitation equipment, as she would normally do when assisting at a delivery. She said that she expected Ms D to arrive at any moment to conduct the birth. Concerned at the delay, she asked Ms A whether the midwife was on her way. Ms A reassured her that Ms D was aware of her labour and had said she was on her way.

Ms E said that because the birthing unit is a low-risk facility, she did not expect there to be any problems for Ms A. Ms E believed that Ms D would contact her if there were any concerns or any delay.

While Ms A went to the bathroom, Ms E went to look for Ms A's records. Unable to find any documentation, she returned to Ms A and helped her back from the bathroom and into the delivery room. Ms A asked for Entonox gas[13] as pain relief.

At 1.30am Ms E recorded the fetal heart rate as 130 beats per minute, and thought that she could see the baby's head. She felt that the delivery could be imminent, and recalls being concerned at the prospect of a delivery without a second midwife to assist. The labour progressed quickly and Ms E saw bulging membranes[14] of a very dark colour. She realised that this was because the liquor[15] had been discoloured by meconium,[16]

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[13] Entonox is a mixture of 50% oxygen and 50% nitrous oxide. Women in childbirth can self-administer the gas via a mask or mouthpiece to provide pain relief.

[14] Two thin layers of tissue that line the uterus and provide protection for the fetus. The fetus and surrounding liquor are contained within the inner membrane. The second membrane lines the uterine wall and the placenta.

[15] The fluid surrounding the fetus.

[16] Contents of the lower bowel of a fetus. The presence of passed meconium during labour may indicate fetal distress.

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and became increasingly alarmed. Aware that the baby might be compromised, she prepared the resuscitation equipment.

Ms A recalls being asked by Ms E to call Ms D again. Ms H has confirmed that, as Ms D was Ms A's LMC, she was the midwife on call for Ms A that night. Ms A attempted to call Ms D, but she did not answer her phone. At 1.40am Ms A's sister, Ms B, arrived and Ms E asked her to telephone Ms D. Ms B used her sister's telephone but again there was no reply from Ms D.

At 1.45am Ms A's waters broke and the baby's head was born. Ms E saw thick meconium and only a small amount of liquor. She used a small catheter to suction fluids from the baby's airway to try and help the baby to breathe. She again asked Ms B to telephone for help, and gave her the birthing unit portable telephone unit from her waistband, instructing her to ring the numbers on the back of the phone. Ms A confirmed that her sister had to leave her side to make telephone calls.

Ms B does not recall using a phone with a list of numbers attached to it in the delivery room, but confirmed that Ms E asked her to find a list of staff to ring. Ms B recalls finding the list in the office and trying to ring staff members using the office telephone. The first two contacts answered but said they were not on call. Others did not answer, and Ms B left messages where she could on mobile and home telephones. She returned to the delivery room and informed Ms E that she had been unable to contact anyone. Ms E asked her to try again, and Ms B contacted midwife Ms L, who agreed to attend.

Meanwhile, with the next contraction, Baby A was born. Ms A said that she waited for a cry from the baby but none came.

Resuscitation

Although the exact time of birth is not recorded, Ms E documented cutting the cord at 1.48am, and noted: "? FHR < 60" (possible fetal heart rate at less than 60 beats per minute[17]), with "(NOT HEARD)" added in the text.

Ms E took Baby A to the resuscitaire and began resuscitation. She opened the airway by tilting the baby's head, and began to give oxygen under intermittent pressure. Ms E said that she was unsure whether the chest was rising. She also attempted to give cardiac compressions. When Baby A was one minute old, Ms E thought she had seen Baby A's muscles twitch, and so she assessed the Apgar[18] score as 1. She reassessed

[17] The normal heart rate for a baby after delivery is anywhere between 110–165 beats per minute.

[18] APGAR refers to the model of care used to ascertain the well-being of a newborn at one minute and five minutes after birth. Observations include the baby's respiratory effort, heart rate, muscle tone and response to stimuli, with a maximum score of 10.

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Baby A at five minutes of age and, as there were no signs of life, gave an Apgar score of 0.

Ms A said that she realised her baby was not breathing after the birth. She saw the baby "shudder and then lay still".

Ms B was outside the delivery room trying to call for help when Mr C arrived. He said that Baby A had been born by the time he arrived. He saw Ms E suction her airway and begin to give oxygen with a bag that she squeezed. Mr C assisted with the bag for about 15 minutes while Ms E performed chest compressions. He estimated that this continued for about 20 minutes. He also believed that Baby A did try to take a breath, and that "her whole body gave a twitching movement".

Ms E said that she felt unable to leave the baby as she was on her own. She could not use the telephone or access the neonatal drugs, which, following a number of thefts, were locked in a cupboard in another room.

Further equipment such as a laryngoscope[19] was at hand, but Ms E did not feel competent to use it, and was afraid of causing further trauma to the baby. She said she knew that Baby A was very ill, and she saw a rapid decline in colour in the face. Ms E said that she desperately needed someone to help her.

At 2.20am, Ms L arrived in response to a message left on her telephone by Ms B. Ms L said that she arrived five minutes after being called. She was told by Ms E that Baby A had died.

Ms L telephoned Ms I, the birthing unit's manager, for assistance. Unable to contact Ms I, Ms L left a message. She said she also tried to call Ms D but received no reply.

Ms D said that she arrived in the birthing unit carpark at approximately 2.30am. She recalls being contacted once by Ms A's phone at approximately 2.05am. Ms D said that she was on her way and asked whether everything was all right, but the caller did not respond. She added that she then tried to call the birthing unit at 2.20am but there was no reply. Ms B recalled using her sister's cellphone before the delivery to try to contact Ms D, and said that Ms D answered but could not hear her. No one recalls the birthing unit telephone ringing at 2.20am. This would have been at about the time of Ms L's arrival. Ms L told Ms D that the baby had died.

In the delivery room, Ms D took over Ms A's care and completed the third stage of delivery.[20] Ms D checked Baby A for any abnormalities,[21] and weighed and dressed her. The baby weighed 3260g and had no obvious abnormalities.

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[19] An instrument used to examine the larynx. The purpose in neonatal resuscitation is to look for any blockage and insert a breathing tube.

[20] The "third stage" refers to the period of time after the birth of the baby until complete delivery of the placenta and associated membranes.

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Ms L, who had been unable to contact Ms I, then contacted Ms J and asked for assistance with finding the protocol for a neonatal death, and asked for additional support. Ms J arrived at 3.20am, one and a half hours after the delivery. She said that this was the first time such an event had occurred at the birthing unit. She called obstetric colleagues at the hospital maternity unit for advice. Following their guidance, she then called the on-call general practitioner and the Police.

Subsequent events

Ms D stated:

> "I had meetings following this event. I expressed my sadness with several of the staff members of the birthing unit. I was asked to give a written report of the events as they occurred. I had now been awake [for] 24 hours and very tired, but still made myself available to assist in bringing together documentation for the policy and procedures when a stillbirth occurs. There was no policy document physically available on site. Information I shared was honest and from the heart and may have been taken out of context."

Ms J disagrees with Ms D's assertion that there was confusion about what to do in the event of a stillbirth. She stated that all the policies required had been found quickly that morning. At that time, the staff considered that Baby A had been born alive and therefore it was thought to be a neonatal death. This was a first neonatal death for the staff. Ms J took advice from colleagues at the hospital to ensure that the correct legal requirements were followed.

Investigation and actions by the birthing unit

Later the same day, Ms I met Ms D to discuss the care she had provided to Ms A. Ms I recorded:

> "Judging by notes attended all A/N [antenatal] visits. No drugs, no alcohol, smoker…"

> "[Ms D] openly acknowledges this [is a] big lesson to learn. Can't presume it will all be ok. [Ms D] has explained her absence by the fact that she was tired and felt that [Ms A] was a good, low risk woman and would be fine with B/C staff. No gas [petrol] in car."

Ms I visited the A family the following day. She took a statement concerning the events from Mr C. The birthing unit completed an in-house investigation of the events.

---

[21] Assessment for abnormalities assists with identification of the cause of death.

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On 1 December 2004 Ms H issued Ms D with a written warning concerning the care she provided to Ms A. Ms H particularly noted the inadequate state of readiness, time taken to attend, poor risk assessment, inadequate response to reduced fetal movements; and inadequate communication with colleagues.

In response, Ms D said:

> "I do not agree with the statements made by the birthing unit staff [Ms I] and [Ms H] about what I said during meetings with them. These meetings were very brief and I believe they have interpreted for themselves what I said. I have not countersigned those statements."

Ms D also alleged that the birthing unit did not provide any support or advice to help her to deal with the matter.

Ms D continued to care for Ms A for three weeks into the postnatal period until Mr C asked her to stop visiting. Ms D handed over care of Ms A to Ms I.

Mr C explained that the family blamed Ms D for not acting on the reduced fetal movements and for being so slow in attending the delivery when she knew they needed her. Mr C recalled that Ms E had been extremely distressed by the whole event, but the family felt she had done her best. She had told the family that she had not been qualified for very long.

In her complaint, Ms A said of Ms D:

> "I feel due to her lack of attention, I now have a box of ashes instead of my little girl and a big hole in my heart."

Coroner's report

The coroner's report noted that the delivering midwife told Police that there were no difficulties with the delivery, and the resuscitation lasted for 30 minutes. It recorded:

> "At autopsy no apparent cause of death apparent. Although the history states that breathing occurred, the features at autopsy with the unexpanded lungs which sink in water does not support this. There may have been some breathing movements but there does not appear to have been aeration of the lungs. The reason for this is not apparent at autopsy. No physical obstruction to breathing is seen.
>
> In the absence of any obvious entanglement with the cord during delivery and the presence of a history that states breathing occurred. The cause of death in my opinion should be peripartium anoxia.[22]

[22] Inadequate oxygenation around delivery.

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> The autopsy findings however would be equally compatible with a very late stillbirth."

The coroner concluded: "I do not have sufficient evidence to make a specific finding that [Baby A] made any attempts to breathe. I therefore find that [Baby A] was stillborn on the […] of November in [the town]"

Commissioner's note

The records that were provided as part of my investigation included two sets of handwritten notes from Ms E, describing the labour.

The first set is handwritten on an institution's notepaper and is written in the present tense. These are referred to as Notes #1. The second set is handwritten on birthing unit Clinical Notes paper. These are referred to as Notes #2.

Both sets were presented for my investigation with no explanation as why there were two records. The two sets of notes detail two distinctly different births. Notes #1 describe a more fraught and anxious delivery with the fetal head delivering ten minutes before the body. Notes #2 contain far less descriptive detail and state that the delivery of the body took place less than two minutes after delivery of the head.

As I was unable to contact Ms E until very late in my investigation, I sought expert advice on both sets of notes.

Ms E subsequently confirmed that Notes # 2 were written on the morning of Baby A's birth and represent the clinical record. The second set, Notes #1, were written a few days later as a personal record to allow Ms E to work through her own reaction to the events.

An entry in the clinical record from Ms J notes that Ms E and Ms L were "writing notes of events" at 3.35am. Ms H confirmed that the clinical paper (Notes #2) recorded the most accurate account and explained that Ms E did not have access to the clinical record when writing Notes #1.

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Delays in the investigation

Ms A initially complained to the birthing unit in February 2005, and the birthing unit forwarded the complaint to my Office on 21 February 2005. On 15 April 2005 all parties were notified of my intention to investigate the matter.

Response of Ms D
Ms D did not respond to the initial notification and on 10 May 2005 she was successfully contacted by telephone. Ms D confirmed that she had received the notification and had sought guidance from the New Zealand College of Midwives (NZCOM). I agreed to receive her response by 3 June 2005 and she provided updated address details.

Calls were made to NZCOM on 8, 16, 21 and 22 June 2005. These failed to illicit a response from Ms D. My Office wrote to NZCOM on 28 June 2005 and received no response. Ms D was again called on 8 August 2005 and she agreed to email her response. No communication was received.

On 19 September 2005, Ms D was issued with a formal notice requiring information pursuant to section 62 of the Health and Disability Commissioner Act 1994 (the Act). No response was received. On 14 October 2005 the Midwifery Council was informed that Ms D had not responded to my investigation despite multiple contacts with her and her legal representative (NZCOM).

A document server was instructed to serve Ms D on 19 October 2005 and my Office advised NZCOM. A call was made to Ms D's legal representative on 3 November. However, NZCOM declined to provide a current address for Ms D.

On 29 November I wrote to the Midwifery Council expressing my concerns with Ms D's failure to co-operate with my investigation. In February 2006, the Midwifery Council advised Ms D to comply with my investigation or risk an investigation by the Council for professional misconduct.

Documents were successfully served on Ms D on 21 February 2006 and Ms D responded to my Office on 6 March 2006. However, after review of her response, further clarification was required and several attempts were made to contact Ms D. Ms D finally responded in August 2006.

In response to my provisional opinion, Ms D stated:

> "I feel a remiss that repeated attempts have been previously made by HDC to receive a response from myself. I now realise that this has been unhelpful to me and the process. I offer by way of explanation that I felt overwhelmed and demoralised with anxiety about the process and my future. I apologise for any inconvenience caused.
>
> …

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I sincerely apologise to all involved in this case for the length of time it has taken to resolve this matter."

Ms E's responses
Ms E informed me that she did not receive my initial notification of the investigation in April 2005 owing to a change in address. She had not notified the Midwifery Council of any such change, and the birthing unit was unable to provide any new address details.

Ms E was contacted on 28 February 2006 by a private investigator and document server. Ms E provided her evidence in an interview under oath on 16 March 2006.

The difficulties in locating Ms D and Ms E, and their subsequent delay in responding to requests for information, significantly hindered and prolonged my investigation. This conduct reflects poorly on their professional integrity and will be brought to the attention of the Midwifery Council.

Independent advice to Commissioner

Ms Nimisha Waller, midwife and general obstetric nurse, provided independent expert advice on the care provided by Ms D, Ms F and Ms E. Additional advice was sought from Ms Waller once I received responses to my provisional opinion. Her advice is attached to this report as Appendix 1.

Ms Terryll Muir, midwife and clinical midwife leader, provided independent expert advice on the care provided by the birthing unit and Ms D. Additional advice was sought from Ms Muir after I received responses to my provisional opinion. Her advice is attached to this report as Appendix 2.

Responses to provisional opinion

The birthing unit Ltd
In response to the provisional opinion, Ms H, Managing Director of the birthing unit Ltd, submitted:

"…

[Policies]

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[The birthing unit] policies have been accredited by Quality New Zealand according to the Standards required by the Ministry of Health and these were in place at the time of the incident.

All policies are available in both hard and soft copy on site. There are clinical policies which cover all likely maternity emergencies. Calling for assistance is part of these policies but not specified as a policy in itself. The **process** of calling for assistance is not defined in the standard but [the birthing unit], at the time of the incident, had established a **process** which used a list of midwives by domicile (the closest to the facility).

[The birthing unit] therefore does not accept that it is in breach of Right 4(2) in relation to emergency systems as they have been accredited against the published standard.

[National Service Specification]

…

b. The specifications do not require a second authorised practitioner, qualified to deliver and assist with a baby, to be present for every birth in New Zealand. It is erroneous to say that this is 'also usual' (page 4). Many women chose to have only their partner and LMC present during the labour and birth. It is not uncommon practice. Clause 5.2.2 (b) The facility staff are available to 'provide occasional support, if requested by the LMC'. That clause does not imply that the facility will provide a second midwife as a matter of course.
c. The facility specification requires that there is qualified assistance available and that may be a RGON with a ([birthing unit]) midwife available.
d. The [birthing unit] does not and did not require the LMCs to perform the back up midwife role. The Clinical Manager has this responsibility in the first instance, and [Mrs I] was available at home on the night of the incident. It has not been established why her phone did not ring and was diverted to messaging. We accept that this may have been some form of human error but it was not either policy or process that was at fault.
e. The reviewing midwife has not taken into account the challenges that rural services face because of distance.

The [birthing unit] does not accept that it is in breach of Right 4(2) of the Code in respect of midwifery back up and support to in the absence of the LMC.

[Emergency drugs]
Emergency drugs are managed according to the standard. The policy reflects these requirements and I draw your attention to Standard 3, Storage of Medicines in the policy (enclosed). We are at loss to see how a facility can meet the requirement of both the Standard which requires controlled drugs to be locked away from

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unauthorised persons and the Code, in relation to this type of incident. Had the LMC been present accessing the drugs it would not have been an issue.

The [birthing unit] does not accept that it has breached Right 4(4) of the Code in respect of the availability of drugs.

The [birthing unit] facilitated [Ms A] in laying the complaint to the Commissioner. The [birthing unit] treats the maintenance of standards and policy seriously and has, in all cases met the Standards as required by the Ministry

[Ms D] had been made redundant but she has also been the subject of disciplinary action in relation to her practice The [birthing unit] had acted responsibly in all aspects of managing this employee.

This has been a sad and emotional case for all concerned."

Ms D

In response to the provisional opinion, Ms D submitted:

> "It is with deep regret that I find myself in this situation and would firstly like to acknowledge the grief and loss that [Ms A] and her family have expressed. I sincerely hope that the outcomes of this process may go toward addressing their loss.
>
> …
>
> I have noted there are some discrepancies from participants about what I said and did during antenatal visits and the labour process. I dispute most of the comments made by [Ms J] and give my account of what I said and did throughout [Ms A's] pregnancy and birth.
>
> …
>
> I acknowledge the following:
>
> - I should have gathered previous written notes of [Ms A's] obstetric history rather than relying only on history recorded by booking midwife or verbal information from others involved in her previous birth.
> - My documentation was inadequate and did not reflect the care carried out at each antenatal visit.
> - I should have followed up any of [Ms A's] concerns more thoroughly and promptly and especially should have asked [Ms A] to come from [the town] into [the hospital] where I was at the time she called and do the check up there.

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- I should have asked for support and backup from colleagues when over tired, whether they were from [the birthing unit] or not.
- I acknowledge my shortcomings and take full responsibility and accept the consequences for this unforeseen and unfortunate event.

The changes I have made since this event:

- I have aligned myself within a collective of experienced [city] midwives for honest, positive collegial support, feedback and mentorship. I am very clear about my responsibility and know my backup is without question when working within this collective.
- I have improved my antenatal assessments by, making in-depth investigations when first meeting a client and before registering as LMC,
- Ensuring that if they have had previous obstetric history, I am to get a full copy of written reports and documentations pertaining to those births.
- If possible a written report of medical history from their doctor.
- Sharing this information with the woman inclusive of her own perspective of her birthing history.
- That I explain my own philosophy and scope of practice and ensure that we both fully understand what this means.
- To refer on to another midwife if our midwifery partnership is in question.
- Alongside all the required antenatal assessments I am making a special point to ask at every antenatal check up that my clients monitor their baby movements and document this.
- If there are any deviations from what is normal, I advise that they make immediate contact with either myself or one of the midwives in our collective.
- If unable to do this for whatever reason, then they must go into a birthing facility or hospital to have a check done.
- I have since the event explained why it is important and the possible consequences if not followed up immediately.
- I also continue to advise them of their rights and that they have access to any maternity facility in the country 24/7.
- I am making a more detailed documentation of all assessments and discussions that take place at antenatal checkups by:
  - Documenting in one set of notes and leaving this with the clients.
  - Asking that she read what I have written to confirm it is true and correct, to ensure that I haven't missed anything out.
  - To countersign each visit made.
  - That I am realistic about the resources I have available i.e. petrol, cell phone, backup midwife, to be able to provide adequate care to every client and if this is in question then I must advise my client and refer on.

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I am limiting my caseload to 1–2 a month and choose to do only home birthing women.

- I have made a request to the New Zealand College of Midwives (NZCOM) that I have a review done as soon as possible.

In conclusion:
I sincerely apologise to all involved in this case for the length of time it has taken to resolve this matter.”

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

(1) Every consumer has the right to have services provided with reasonable care and skill.

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

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

RIGHT 6
Right to be fully informed

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

(a) an explanation of his or her condition; and
(b) an explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option.

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CLAUSE 3
Provider Compliance

(1) A provider is not in breach of this Code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in this Code.

(2) The onus is on the provider to prove that it took reasonable actions.

(3) For the purposes of this clause, "the circumstances" means all the relevant circumstances, including the consumer's clinical circumstances and the provider's resource constraints.

Other Relevant Standards

Maternity Services Notice issued pursuant to section 88 of the New Zealand Public Health and Disability Act 2000:

"**3.0 OBLIGATIONS OF THE LEAD MATERNITY CARER**

3.1 The Lead Maternity Carer will take responsibility for the care provided to the woman throughout her pregnancy and postpartum period including the management of Labour & Birth.

3.2 The Lead Maternity Carer is required to make every effort to attend as necessary during labour and to attend each Birth. In the occasional circumstances where it is not possible to attend the Birth due to, for example, holidays or the requirement to be with another woman in labour, the Lead Maternity Carer will make appropriate other arrangements.

3.3 The Lead Maternity Carer will be available twenty-four hours, seven days per week to provide phone advice to the woman and attendance if required for urgent problems, either personally or by the Back-up to the Lead Maternity Carer.

3.6 The Lead Maternity Carer is required to make every effort to attend a woman within, on average, twenty minutes of the woman's arrival at the Maternity Facility or Birthing Unit where she will give birth.

Appendix 1 in the Section 88 Notice outlines the Guidelines for Consultation with Obstetric and Related Specialist Services. The guidelines stipulate that consultation with a specialist is recommended when moderate to thick meconium is discovered during the first and second stages of labour.

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4.4 Labour & Birth

4.4.1 The Lead Maternity Carer will be responsible for ensuring that all of the following services are provided (subject to clause C3.9) where a payment for this service is claimed:

(a) all primary care from time of Established Labour including initial assessment of the women at her home or at a Maternity Facility and regular monitoring of the monitoring of the progress of the woman and baby;

(b) management of the Birth; and

(c) all primary care until two hours after delivery of the placenta, including updating the Care Plan, suturing of the perineum (if required), initial examination and identification of the baby at birth, initiation of breast feeding (or feeding), care of the placenta and attending to any legislative requirements regarding birth notification by health professionals.

…

4.4.3 For a Birthing Unit, in addition to clause C4.4.1, the Lead Maternity Carer will:

(a) arrange for a second Authorised Practitioner to be available to attend the Birth; and

(b) ensure an Authorised Practitioner remains with the woman until she is discharged."

New Zealand College of Midwives Standards for Practice: 2nd edition 2002:

"**Standard three**
The midwife collates and documents comprehensive assessments of the woman and/or baby's health and wellbeing.

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

Standard seven
The midwife is accountable to the woman, to herself, to the midwifery profession and to the wider community for her practice".

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New Zealand College of Midwives Code of Ethics 2nd edition 2002:

"Midwives have a responsibility to ensure that no action or omission on their part places the woman at risk."

Maternity Facility Service Specifications 2003:

"**1.2 Nature & Scope of Service**

The Maternity Facility, in conjunction with the Lead Maternity Carer (LMC), provides inpatient services during labour and birth and the immediate postnatal period until discharge home.

4.1 Entry and exit criteria

The service commences with admission of the woman in Established Labour (or for induction) and ends when the woman is clinically ready for discharge home.

5.2 Facility Midwifery/Nursing Services

You will supply sufficient qualified staff in order to provide a safe experience for the mother and baby. Specifically, you will supply the following:

5.2.2 Labour & Birth

a) You will ensure that a Midwife is available 24 hours/day, 7 days/week to provide support to the LMC (or to the Authorised Practitioner subcontracted by the LMC) during labour and birth.

b) You will:

- notify the LMC of the woman's arrival at the facility (although it is expected that the woman will contact the LMC directly);
- provide care according to the woman's needs, until the LMC arrives;

c) You will supply midwifery/nursing support for, on average, 20 minutes per woman per labour and birth episode, although the actual supply on a per woman basis will vary according to circumstances. This excludes the 20-minute period prior to the LMC's arrival at the facility.

5.2.3 Inpatient Postnatal Care

a) You will provide Midwives to supply 24 hours/day, 7-days/week care (or Nurses with a Midwife available on-call). This care is

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directed by each woman's LMC and is supplied in accordance with the woman's written Care Plan.

5.4 Emergency transfer to Secondary/Tertiary Maternity Services

5.4.1 You will have a formal policy for management of emergencies, which is appropriate to the distance of the Maternity Facility from the Secondary/Tertiary Maternity Service, and includes the procedure for contacting the Secondary/Tertiary Maternity team and arranging emergency transport services.

5.4.2 While there are inpatients, you will ensure there are always Midwives/Registered nurses on site that are available to attend any emergency.

Opinion

This report is the opinion of Tania Thomas, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

Opinion: Breach — Ms D

Ms A's complaint raised questions about her care during her pregnancy and the birth of Baby A. Ms A questioned the adequacy of Ms D's antenatal care, particularly in the light of her previous pregnancies and her anxiety about reduced fetal movement, and Ms D's failure to attend or provide back-up support for Ms A's labour. Sadly, my investigation has found Ms A's concerns to be well justified.

Under Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code), Ms A had the right to services provided with reasonable care and skill. She also had the right to information that a reasonable consumer in her circumstances would expect to receive, as stated in Right 6(1) of the Code.

In my view, Ms D failed to provide services with reasonable care and skill, and failed to provide Ms A with sufficient information. The reasons for my decision are detailed below.

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Risk assessment
Ms A had a history of fast labours and smaller-than-average babies. In 1999, her labour was induced at 37 weeks owing to concern about reduced fetal movements.

Ms A met with Ms G when Ms A was 12 weeks pregnant, and Ms G asked Ms A about her previous deliveries. Ms K advised me that Ms G discussed the significance of reduced fetal movements and the need to watch for this in Ms A's current pregnancy. Ms A was advised to monitor the fetal movements and contact Ms G or the birthing unit if she had any concerns. Ms G noted details of the three previous births on Ms A's midwifery care plan, including the induced birth in 1999.

Ms D took over responsibility for Ms A's care in August 2004 when Ms A was approximately 25 weeks pregnant, and completed her first antenatal assessment as the LMC when Ms A was 27 weeks pregnant. Ms D advised me that she discussed "briefly" Ms A's birthing history and that Ms A confirmed she had been induced in 1999 for decreased fetal movements. Ms D noted: "I had not been privy to any of her previous birth notes so relied on information that [Ms A] shared with me."

In response to my provisional opinion, Ms H confirmed that the birthing unit holds notes for any previous admissions, and that these could be easily accessed. Ms D acknowledged that she did not gather the previous notes from Ms A's obstetric history, and said:

> "I should have gathered previous written notes of [Ms A's] obstetric history rather than relying only on history recorded by booking midwife or verbal information from others involved in her previous birth."

Ms D said that she had discussed with Ms J whether the birthing unit was a suitable place for Ms A to birth. However, Ms J denied this conversation, and said that she would have advised Ms D to consider both the birthing unit and the hospital as suitable facilities.

My expert advisor, Ms Nimisha Waller, said that the history of three small babies should have alerted Ms D "to a possible reason for induction in the previous pregnancy and a potential risk of a small baby in this pregnancy".

Ms Waller also said that standard three of the New Zealand College of Midwives Standards for Practice required Ms D to review all the available documentation so that an appropriate care plan could be developed. Ms Waller criticised Ms D for not accessing the previous obstetric notes, and said that she should not have relied on her colleagues and Ms A for information to complete her assessment. In her review of the previous notes, Ms Waller identified that more complex investigations had been required for Ms A in the past. Ms D was unable to factor these issues into planning Ms A's care because she had not collated all of the available information.

When an LMC assumes a woman's maternity care, it is her responsibility to take a detailed history, to collate any relevant information, and to assess any risks to the

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pregnancy. In my view, Ms D's assessment of the potential risks for Ms A's pregnancy was superficial and inadequate, meaning that Ms D did not have an appropriate plan of care in place for Ms A. This constitutes a breach of Right 4(1) of the Code.

Information and response to concerns
Ms D advised me that when she took over as LMC she provided Ms A with information about the significance of reduced fetal movements, and that Ms A was aware of how to monitor these from her previous pregnancies.

Observations about fetal movements are noted on the antenatal entries dated 16 June, 20 July and 30 September 2004. These entries were not made by Ms D — they were made by Ms G and Ms K, and Ms D has not recorded in Ms A's antenatal notes any discussions about fetal movements. In response to my provisional opinion, Ms D acknowledged that her "documentation was inadequate and did not reflect the care carried out at each antenatal visit".

Ms D initially denied that Ms A mentioned reduced fetal movements at any time. Ms D has since said that Ms A did mention reduced fetal movements some time in the last month, and told Ms D that there had been at least 10 movements that day. Ms D said she advised Ms A that this was "normal at this stage in the pregnancy" but to track the movements in her antenatal chart. Ms D did not note the incident of reduced movements in the records, nor did she advise Ms A about the possibility of CTG monitoring.

Ms A said that she raised some concerns about reduced fetal movements at the antenatal visit on 10 November 2004 but that Ms D said "it was normal" and she did not need any further tests to monitor the baby. Ms K recalls that Ms A raised these concerns at some point, though she is unsure when. She said that Ms D did not offer any further advice at that time.

Ms A was entitled to information about how her birthing history impacted on her current pregnancy, and the treatment options that were available in the event that she experienced reduced fetal movements during this pregnancy. Ms Muir advised me that "reduced fetal movements are known to be associated with unexpected stillbirth and because of this should always be investigated". The treatment options included a CTG, commencing a kicking chart and, if necessary, an ultrasound scan and a discussion about where to birth. Ms Waller confirmed that fetal movements should be routinely checked at each antenatal assessment.

I am satisfied that Ms A was aware of the significance of reduced fetal movement and the need to mention this as an issue. Ms K has confirmed that Ms A had been counselled on this issue by Ms G, and that she raised the matter with Ms D. However, Ms D's response to the concerns raised on 10 November 2004 was inadequate.

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Ms A was also concerned about reduced fetal movements and, when Ms D did not attend her scheduled antenatal appointment, Ms A went to the birthing unit, where she was assessed by the registered nurse, Ms F. Ms F listened to the fetal heart with a sonic aid but did not perform a CTG. She subsequently left a message for Ms D about Ms A and her concerns.

Ms D acknowledged that she received the message and knew Ms A had concerns about reduced fetal movements. Ms D said that she was unsure at the time whether a CTG had been used. She did not contact Ms F or Ms A to clarify the information or check what action had been taken. In response to my provisional opinion, Ms D said that she was "satisfied with what the results were at that time and had intended to follow [them] up".

The test, in these circumstances, is what information a consumer would reasonably expect to receive in the circumstances. Ms A was sufficiently concerned about her baby's movements to go into the birthing unit for reassurance. This was the second time in a week that Ms A had raised concerns about reduced fetal movements. She was entitled to information about her condition and any further treatment options that were available. There is no indication that Ms D had any discussion with Ms A about her concerns and other tests that were available, or that she arranged for another midwife to explain this to Ms A in her absence.

Both experts have agreed that, in these circumstances, Ms D should have contacted the birthing unit to ensure that a CTG had been done. Ms Muir advised that a CTG was required and that Ms D should have either arranged this herself or organised for another midwife to provide this service. The New Zealand College of Midwives Code of Ethics states that midwives have a responsibility to ensure that no action or omission on their part places the woman at risk.

In response to my provisional opinion, Ms D acknowledged that she should have "followed up on [Ms A's] concerns more thoroughly and promptly and especially should have asked [Ms A] to come from [the town] into [the hospital] where I was at the time she called, to do the check up there".

In my view, Ms D did not respond appropriately to Ms A's concerns, and did not provide Ms A with sufficient information about her condition and the options available for assessing the health of her baby. Because she had not taken a detailed history when she took over Ms A's care, Ms D underestimated the risks associated with reduced fetal movements for Ms A's pregnancy. However, even if reduced movements had not been a particular risk for Ms A, Ms Waller has confirmed that fetal movements should be routinely discussed, and Ms Muir has advised that concerns about decreased movements should prompt a CTG or other increased monitoring.

In my view, Ms D's response to the concerns raised about reduced fetal movements fell well below acceptable standards, and is in breach of Right 4(1) of the Code. Ms D also failed to discharge her duty to provide Ms A with information about the

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significance of reduced fetal movements and the options available for increased monitoring, in breach of Right 6(1) of the Code.

Labour care

As Ms A's LMC, Ms D was primarily responsible for attending Ms A's labour and delivery. If she was unable to attend, it was her responsibility to arrange for appropriate back-up or support.

Under the Maternity Services Notice, issued pursuant to section 88 of the Public Health and Disability Act 2000, Ms D had a contractual obligation to arrange proper back up.[23] Ms Muir advised that if Ms D could not attend Ms A she was responsible for ensuring that another midwife did so. Ms H confirmed that LMC midwives were expected to arrange their own back-up if they could not attend for any reason. Ms D had been provided with the guidelines and policies of the hospital by Ms J.

It is clear that the only back-up arranged by Ms D was the staff at the birthing unit. This was very loosely applied, and at times it was a registered nurse, rather than an authorised practitioner as required by Section 88 for the clinical assessment of a maternity patient.

Ms A went into labour at 11pm and said that she rang Ms D at around midnight.

Ms D reported that she had been working for 24 hours at hospital prior to Ms A's call advising her that she was in labour. Ms D said that Ms A contacted her at 1am the next day and that Ms A sounded calm, so Ms D believed she had time to wash, change her clothes, have a cup of coffee and get petrol for her car before travelling to the birthing unit. In response to my provisional opinion, Ms D said that Ms A was "tidying her house", so Ms D assumed she was in early labour. However, in a prior response Ms D said that she had agreed to meet at the birthing unit "as soon as possible".

Ms K advised me that she received a call from Ms D just after midnight to say that Ms A was in labour and that Ms D would call in to pick up Ms A's notes. This agrees with Ms A's time of first contact with Ms D at midnight. Ms D arrived at Ms K's house at 1.30am to pick up the notes — one and a half hours after the first contact. Ms K said that Ms D did not appear to be in any hurry and asked Ms K to make her a cup of coffee. After the coffee, Ms K said that she encouraged Ms D to leave for the birthing unit. Ms K confirmed that she lives 10 minutes' drive away from the birthing unit, and that Ms D left at approximately 1.40am. Therefore, Ms D should have arrived at approximately 1.50am.

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[23] Clause 3.3 of the Section 88 Maternity Services Notice.

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Ms D has restated that she received the initial call at 1am. She went to Ms K's home to retrieve Ms A's notes, and it was Ms K who insisted that they have coffee. Ms D said she received the call from Ms A's phone while at Ms K's home and, because it was not Ms A, she became concerned and left for the birthing unit. However, this statement is inconsistent with Ms D's earlier account. Ms D initially said that she was travelling when she received a call from Ms A's cellphone at 2am, but the call did not connect. She tried to call the birthing unit at 2.20am, but otherwise had no contact with Ms A until she arrived at the birthing unit at 2.30am.

Ms Waller advised that, as LMC, Ms D was required by the section 88 Maternity Services Notice to attend at the birth within 20 minutes or to arrange for another midwife to cover her delay. In circumstances where Ms D had just returned from another birth, Ms Muir advised that it was reasonable for Ms D to take longer than usual, but that she needed to notify the birthing unit of her late arrival and to pass on any relevant information such as Ms A's history of quick labours and reduced fetal movements. Ms Waller confirmed that, at a minimum, Ms D needed to call ahead and warn the birthing unit that Ms A was on her way. Added to this delay was a further stop and another coffee.

Ms E confirmed that she was given no warning of Ms A's arrival, and was unaware of her previous concerns about reduced fetal movements and quick labours.

Ms D was aware that Ms A was in labour and going to the birthing unit at approximately midnight. She knew that Ms A lived within a few minutes of the facility. Ms D knew that someone would be at the facility to look after Ms A. Ms D did not tell Ms E that Ms A was likely to deliver quickly, or that there had been an episode of reduced fetal movements. She did not attempt to make any arrangements for a second person to be at the birth to assist, and left her colleague to deliver the baby alone. Ms D eventually arrived at 2.30am.

In response to my provisional opinion, Ms D acknowledged:

> "I should have asked for support and backup from colleagues when over tired, whether they were from the [birthing unit] or not. I acknowledge my shortcomings and take full responsibility and accept the consequences for this unforeseen and unfortunate event."

Ms D's actions and her delay are inexcusable. These actions were without regard for the safety of the mother and baby, and are in breach of Right 4(1) of the Code.

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Opinion: Breach — Birthing unit

The birthing unit is certified to provide maternity services pursuant to the Health and Disability Services (Safety) Act 2001 and is accredited by Quality Health New Zealand. Accreditation means that a facility has been evaluated, within a set of parameters and criteria, to have in place the necessary provisions to provide adequate and appropriate maternity care.

As a maternity services provider subject to the Code, the birthing unit is required to comply with professional standards under Right 4(2) of the Code. The term "professional standards" describes the general standard that can be expected of a birthing facility providing maternity services with reasonable care and skill. To assist me in determining that standard in this case, I have sought expert advice (discussed below) on the midwifery cover that should be available during labour and birth, the emergency systems that should be in place at a birthing facility, and the appropriate availability of medications used in resuscitation.

Maternity facilities such as the birthing unit are also governed by the National Service Specifications that were published by the Ministry of Health in September 2003. While I do not purport to enforce the Ministry of Health's contractual arrangements, the National Service Specifications give clear guidance on the level of service that is expected by the Ministry and the District Health Boards throughout New Zealand, and I therefore consider them to be a relevant professional standard under Right 4(2) of the Code.

Clause 5.2.2 of the National Service Specifications requires a maternity facility to provide the following for labour and birth care:

- a midwife available 24 hours a day, 7 days a week to support the LMC during labour and birth;
- notification to the LMC of the woman's arrival and provision of care according to the woman's needs until the LMC arrives;
- occasional support, if requested by the LMC, and physical assistance, if required;
- midwifery/nursing support for, on average, 20 minutes per woman per labour, excluding the 20 minutes prior to the LMC's arrival at the facility.

Clause 5.2.3 describes the requirements for postnatal care provision, and clause 5.4.1 requires a maternity facility to have a formal policy for management of emergencies, including a procedure for contacting the secondary/tertiary maternity team.

In my view, at the time of the events giving rise to this complaint, the birthing unit did not have adequate midwifery cover for labour and births, and did not have adequate emergency systems in place. This is in breach of Right 4(2) of the Code. It also did not

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provide adequate access for the administration of emergency drugs in a resuscitation situation. This is in breach of Right 4(4) of the Code. The reasons for my decision are discussed below.

Labour and birth midwifery cover
Ms H provided details of the 24-hour service provided at the birthing unit. Ms H explained that there is one staff midwife on duty at night, between 3pm and 7am, and one staff midwife and a health assistant on duty during the day, from 7am to 3pm.

Ms H explained that, when a woman went into labour, the birthing unit expected the LMC of each woman to conduct the delivery, and the staff member who was on duty to act as the second practitioner. If the second person was a registered nurse then the manager would be available for advice.

In response to my provisional opinion, Ms H stated that this arrangement met the requirements of the National Service Specifications as "they do not require a second authorised practitioner, qualified to deliver and assist with a baby, to be present for every birth in New Zealand". Ms H commented that it is not usual practice for there to be two authorised practitioners present for every birth in New Zealand. I do not find this statement to be accurate.

Clause 4.4.3 of the section 88 notice requires the LMC to arrange a second authorised practitioner to be *available* to attend a labour and birth occurring in a birthing unit. How a person is "available to attend" will depend on the circumstances in each case, including the LMC's decision whether to have the second person attend, and the woman's preferences. My interpretation is that the second authorised practitioner, qualified and certified to practise obstetrics or midwifery, should be either present, or on standby and able to be immediately available, as the legislation does not provide a maximum response time in which the practitioner should be able to attend, as it does for an LMC. The Ministry of Health has advised that to be "available", the second person needs to be aware that she may be required to attend. I agree that this is entirely reasonable. The second person must be made aware that the woman has gone into labour, and confirm the ability to attend at short notice. The Ministry explained, by way of example that independent midwives often work in partnerships so that they can call on their partner to provide the second authorised practitioner services.

The National Service Specifications also anticipate that there will be two authorised practitioners available for birthing unit births. Clause 5.2.2(a) of the National Service Specifications specifically requires the facility to ensure that a midwife is available "24 hours/day, 7 days/week to provide support to the LMC … during labour and birth".
The issue, then, is whether the rostering arrangements at the birthing unit were such that the appropriate midwifery support was available to the LMC for labours and births, in accordance with the relevant standards.

The information I have received indicates that there were times when registered nurse Ms F was alone on duty at the birthing unit. The birthing unit is entitled to provide

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postnatal services from a registered nurse with a midwife on call (clause 5.2.3(a)). Ms H has advised that, if a labouring woman arrived at the facility while Ms F was on duty, the on-call midwife was the woman's LMC. In response to my provisional opinion, Ms H said that the "specifications require that there is qualified assistance available and that may be a RGON with a (birthing unit) midwife available".

I do not agree that this rostering arrangement meets the requirements set out in the National Service Specifications. The suggestion from the birthing unit is that Ms F had midwifery support available, if required, by calling in the clinical manager. Ms F, as a registered nurse, did not fall within the definition of an authorised practitioner who was "available to attend" as required by the section 88 notice, nor was she a "midwife" providing support to an LMC for labours and births, as required by clause 5.2.2(a) of the National Service Specifications. The National Service Specifications required the birthing unit to provide 24/7 midwifery support for a labour and birth. It is only in relation to postnatal services that the birthing unit is entitled to provide services from a registered nurse with a midwife on call (clause 5.2.3(a)). Therefore, it was necessary for the birthing unit to provide midwifery support for a labour and birth, whether the registered nurse was on duty or not.

Ms Muir confirmed in her advice that:

> "without employed LMCs also being on-call for emergency care, unforeseen circumstances or as a second midwife to non-employed LMCs, then the [birthing unit] would not meet the requirements set in the service specifications when the rostered facility shift was covered with a registered nurse".

In relation to the times when the registered nurse was on duty at the facility alone, Ms J said that "the manager is on call to offer advice and reassurance, but the midwives in the team are expected to support and cover midwifery case loads". This is acceptable, as the LMC is responsible for arranging the second practitioner for labour and birth services. My concern is that the information provided by Ms H and Ms J suggests that the manager provided midwifery cover from home when a registered nurse was on duty by being available by telephone to offer "advice and reassurance". This means that the manager expected to be called by the registered nurse for general advice but she was not made aware of specific admissions, labours and births occurring at the unit so that she could attend immediately.

Both expert advisors have said that it would be most appropriate for the second authorised practitioner to be present — not necessarily in the room, but on site. Ms Waller has considered the rural aspect to this requirement and has said that the delivering midwife should contact the second person, and that the second person should then be en route. Ms Muir considers that for the second practitioner to be "at home but within 20 minutes from the facility would be reasonable".

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In my view, the birthing unit's arrangement did not meet the standard of having a midwife available to provide support during labour and birth 24 hours a day, 7 days a week. "Support" requires more than advice and reassurance by telephone. It requires the manager to be available to attend as the second practitioner for those births where an LMC requires support. As the Ministry and the expert advisors have indicated, the expectation is that the second midwife will be alerted of the admission so that she is available to physically attend, or attend at short notice. The birthing unit did not have a policy to alert the manager of any admissions, labours and pending births where the second practitioner would be the manager. In my view, the second midwife should be on site, or at the least en route.

I acknowledge that the rostering arrangements at the birthing unit may well be reflective of many smaller units throughout New Zealand. However, in my view, it is inconsistent with the relevant standards to have a registered nurse available to support an LMC providing care during labour and birth, with a midwife available by telephone, yet unaware of the labour and birth taking place. It is also unacceptable for any practitioner to manage a labour and birth without informing the second authorised practitioner, and that second person intending to be on site for the birth.

On-call system for emergencies
Ms H has stated that if the LMC were unable to attend a labour and birth, he or she would be expected to arrange another LMC midwife to attend as back-up. This is correct and conforms to section 88 requirements. The LMC is responsible for ensuring that a midwife, or an authorised practitioner, will attend within 20 minutes in the LMC's absence.

For emergencies or unforeseen circumstances, such as when the LMC could not be contacted, the staff at the birthing unit were instructed to contact the clinical manager.

Ms Muir advised:

> "It would appear that the [birthing unit] relies on the presence of the LMC to ensure that this requirement is met. From the information available to me it is unclear as to whether the employed case loading LMC midwives also provide 24-hour cover to support the facility staff for emergency care, unforeseen circumstances or as a second midwife to non employed LMC's. If they do, then the [birthing unit] does provide sufficient qualified staff to ensure a safe experience for the mother and baby. However, if the employed case loading LMC midwives are only on call for their own women and provide on call cover for each other but not for emergencies, unforeseen circumstances, or for non employed LMC midwives, then the [birthing unit] does not appear to be meeting the requirements set in the service specifications."

In response to my provisional opinion, the birthing unit confirmed that the employed case loading LMCs are not required to perform the back-up midwifery role, and stated that "the clinical manager had responsibility in the first instance".

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Both experts have agreed that it is reasonable to expect a manager to be on call 24/7 with an effective on-call system of contact. The manager should arrange for an alternative person to be on call for the times she/he cannot be available.

The only on-call system at the birthing unit was for the manager to attend any emergency, which, in my view, was inadequate. I do not consider it logistically reasonable for a manager to be on call for every hour outside of the working week without adequate provision of an alternative service. This would mean that the manager would need to remain near the facility and have immediate access to a vehicle at all times. The unrealistic application of that arrangement has been proven unsound by this event.

In my opinion, a reasonable birthing facility should have an on-call roster to provide midwifery support. An effective on-call system would mean a dedicated mobile or pager for the on-call person. This requires a physical handover to ensure that there is no misunderstanding of who is on call. A pre-programmed telephone at the facility would then require only a single number to call the pager and initiate response. The on-call person should arrange their time and activities so that they are able to attend an emergency call in a reasonable time period.

An LMC could have a road accident, or be delayed for a number of reasons, and it is important that systems are in place to provide cover for such eventualities. Maternity services cannot be geared purely for the optimum outcome, but must have a plan for the emergency situations that can, and do, occur. This does not mean practising defensively, but practising safely with appropriate regard for the well-being of the woman and her baby.

This type of on-call system is also required when the registered nurse is on duty, so that he/she can alert the on-call midwife when a labouring woman is expected at the unit. This would ensure that the woman had a second midwife available to her, as is required by the National Service Specifications (as discussed above).

When Ms E attempted to use the birthing unit's telephone list system to rally support she was unable to contact some of her colleagues, and others were reluctant to attend because they were not on call that night.

The birthing unit has said that Ms I, manager, was available that evening but, unfortunately, her telephone went to messaging instead of ringing. Ms H stated that "this may have been some form of human error but it was not either policy or process that was at fault".

However, I do not agree. In my view, Ms E would have received adequate support if a reliable on-call system had been in place. The policy of having only the manager on call was logistically unreasonable and provided inadequate support for Ms E.

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Emergency plan

The birthing unit employees were advised that they could use a telephone list to call in support in the event that the LMC or her back-up did not attend, or in the event of an emergency. A portable telephone unit has a list of all staff stuck to the back, with the numbers listed in order of the birthing unit LMC midwives who live closest to the facility, followed by non-birthing unit midwives, also listed by proximity. Ms H stated that "the facility staff are not on-call but there is an understanding with them and non-[birthing unit] LMCs that they will attend in an emergency".

On the evening when Ms A arrived in labour, Ms E was unable to reach Ms D, and was not informed of any back-up arrangements. She therefore followed the emergency plan by asking Ms B to call the numbers on the birthing unit telephone list. Ms B found that some of the calls were not answered, and some people responded that they were not "on call that night". The first to arrive was Ms L, who said that she had received her call just five minutes beforehand. She arrived 32 minutes after the delivery. This means that it took approximately 30 minutes to find someone to attend. This is an unacceptably slow system to get help in an emergency. This further highlights the need for an effective strategy to be in place, and for staff who are on call to be aware that they are on call and may be required to attend directly.

My expert, Ms Waller, said that the telephone system requires revision, as no one actually responded within a reasonable time on the day of the birth. She also had significant reservations about a relative bearing the responsibility for making those calls. I agree, especially in these circumstances where the telephone system was inadequate to the purpose and created an enormous amount of stress for the family member.

Clause 5.4.1 of the maternity facility Service Specifications specifically requires the birthing unit to have a formal policy for management of emergencies, which includes a procedure for contacting a secondary/tertiary maternity team and arranging emergency transport services.

In response to my provisional opinion, Ms H stated that:

> "The [birthing unit] policies have been accredited by Quality Health New Zealand according to the standards required by the Ministry of Health and these were in place at the time of the incident.
>
> All policies are available in both hard and soft copy on site. There are clinical policies which cover all likely maternity emergencies. Calling for assistance is part of these policies but not specified as a policy in itself.
>
> The **process** of calling for assistance is not defined in the standard but the [birthing unit], at the time of the incident, had established a **process** which used a list of midwives by domicile (the closest to the facility)."

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I acknowledge that the birthing unit does have a policy for the emergency transfer of patients. This policy provides details about who to call to arrange transport services to a secondary care facility. It does not, however, provide easily accessible contact details of emergency maternity services at the unit. I have received no information to indicate that those numbers were on the telephone list or that Ms E was aware of such a policy.

In response to my provisional opinion, Ms H queried my finding that the emergency management systems in place at the birthing unit were inadequate when those systems had been assessed as part of an accreditation by Quality Health New Zealand.

Under the Health and Disability Services (Safety) Act 2001, facilities such as birthing units must be certified by an auditing agency designated by the Director-General of Health. The purpose of the audit is to review the facilities, premises and systems used by a facility and to consider whether these comply with the relevant contractual and legislative requirements. The auditing and certification process is an important mechanism for ensuring consistency and quality of services throughout New Zealand.

At the time of the events giving rise to this complaint, the birthing unit had last been audited in December 2002. This was prior to the National Service Specifications coming into effect in September 2003. Accordingly, at the time of the audit, Quality Health New Zealand would not have been assessing the birthing unit's compliance with clause 5.4.1 of the National Service Specifications.

In my view, the wording in clause 5.4.1 is clear. A birthing facility is required to have a formal policy for the management of emergencies, and that policy must include the procedure for contacting the secondary or tertiary team and arranging emergency transport. In this case, the birthing unit's policy for responding to maternity emergencies was spread over several different policies, and I have received no information to indicate that there was a procedure for contacting a secondary/tertiary maternity team.

When Ms E was faced with an emergency situation she relied on a list of telephone numbers for the staff who lived closest to the facility. The telephone list cannot, in my view, be considered a formal policy for the management of emergencies as required under clause 5.4.1 of the National Service Specifications, and it did not provide Ms E with any guidance on how to arrange emergency transport services.

In my opinion, the telephone list system did not go far enough to constitute a formal emergency management policy. At the very minimum, the telephone list should have included numbers for the secondary/tertiary maternity team and emergency transport services.

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In my view, the emergency, rostering and on-call systems at the birthing unit were inadequate and did not comply with professional standards, in breach of Right 4(2) of the Code.

Resuscitation systems
At the time of Baby A's resuscitation, neonatal resuscitation medication was locked in another room. Ms H has explained that this was because of problems with the medication being stolen. Both experts have said that this was unacceptable.

In response to my provisional opinion, Ms H said that she was "at a loss" to comprehend how medication is to be locked away, yet available to the LMC. I would suggest that the required second authorised practitioner would assist in this regard. The birthing unit has correctly identified that the LMC, Ms D, was not there. Had she been, there would not have been an issue with accessing the medication. This is why a reliable on-call system needed to be in place, so that Ms E could have contacted one person, an on-call midwife, to assist her.

Both expert advisors have confirmed that the medications used in neonatal resuscitation are not controlled drugs, and are not required to be in a locked cupboard as the birthing unit suggest. Both experts agree that the medications need to be easily available to the practitioners and are routinely kept with the resuscitation equipment.

While I appreciate the difficulties concerning the safety and placement of medication, it is imperative that the medication is readily available for the midwives to use in an emergency. When the resuscitation medication is locked away from the resuscitation area it will lead to delays. If two practitioners are present, the medication is obtainable, but if, as in this case, only one practitioner is present, then access to life-saving medication is effectively denied.

It is not acceptable to have emergency medication located away from the neonatal resuscitation equipment. In failing to provide services in a manner that minimised the potential harm to, and optimised the quality of life, the birthing unit breached Right 4(4) of the Code.

Opinion: No Breach — Birthing unit

Vicarious liability
The effect of section 72 of the Health and Disability Commissioner Act 1994 is that a breach of the Code by an employee will be treated as being a breach of the Code by his or her employer, unless the employer can show that it took such steps as were reasonably practicable to prevent the breach.

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Ms D had been employed by the birthing unit to work as an LMC as part of its midwifery team. Ms D was responsible for complying with section 88 and the relevant professional standards. However, the birthing unit also had a duty, as her employer, to ensure that she was appropriately providing those services, and that any obvious omissions were addressed.

In my view, the failure to provide adequate antenatal and labour care by Ms D was not attributable to the systems used by the birthing unit, but to individual clinical decisions by Ms D. Accordingly, the birthing unit is not vicariously liable for Ms D's breaches of the Code in this instance.

Opinion: No Breach — Ms E

Ms E was on duty alone at the birthing unit on the night of the birth. Unexpectedly, Ms A arrived at the birthing unit in labour. She did not know Ms A's history or anything about her current pregnancy. Unable to access any documents to assist her, she remained unaware of Ms A's history and was assured by Ms A that Ms D was on her way.

Ms Muir has advised that, pursuant to the National Service Specifications, it was the facility's responsibility to call Ms D. However, this call had already been made by Ms A, and this was confirmed by Ms E. My expert, Ms Waller, has said that it was reasonable for Ms E not to call Ms D and confirm Ms A's arrival.

Ms E expected Ms D to attend the birth, and believed that she would do so imminently. Ms E admitted Ms A and began to prepare for the birth. She checked the equipment, including the neonatal resuscitation equipment, as she would normally do when assisting at a delivery. Ms E has explained that she did not expect there to be any problems for Ms A. She believed that Ms D would contact her if there were any concerns or any delay.

At 1.30am Ms E recorded the fetal heart rate as 130 beats per minute, and thought she could see the baby's head. She felt that the delivery could be imminent and recalls being concerned at the prospect of a delivery without a second midwife to assist. The labour progressed quickly and, when Ms E saw bulging membranes of a very dark colour, she realised that the baby might be compromised and prepared the resuscitation equipment.

While preparing for the birth, Ms E asked Ms A's sister, Ms B, to call the numbers on the emergency list, but Ms B's attempts to rally support were unsuccessful.

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Ms Waller advised me that, while some aspects of Ms E's care during labour fell below an acceptable standard, her actions were reasonable in the circumstances. Ms Waller noted that Ms E should have taken a detailed history upon admission and carried out an assessment of Ms A and her baby. This would include an abdominal palpation and recording of baseline observations such as temperature, blood pressure and heart rate. Ms Waller noted that, since Ms E did not have Ms A's notes, a thorough assessment and history were important and would have allowed Ms E to form a plan for the remainder of the labour.

Ms Waller noted that Ms E listened to the fetal heart rate only once at 1.35am, and said that usually the fetal heart rate should be monitored every 15–30 minutes in the first stage of labour, and every five minutes in the second stage of labour. Ms Muir noted that although Ms E did listen to the fetal heart rate on one occasion, she did not do regular assessments of the baby between 1.30am and 1.45am. Ms Muir concluded:

> "I believe the care given is below normal expectations but reasonable under the circumstances when [Ms E] was on her own and only had a short time to prepare the environment."

I agree with my expert that some aspects of Ms E's care fell below an acceptable standard. However, clause 3 of the Code states that a provider is not in breach of the Code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in the Code. Clause 3(3) confirms that "the circumstances" include the consumer's clinical circumstances.

In my view, Ms E was left in an unenviable position by her colleague, Ms D. Ms E had only recently qualified, and had attended only a small number of births on her own. Ms E was aware that Ms D had been called, and expected her to arrive at any time. Ms D did not attend within 20 minutes, did not arrange a replacement midwife, and did not telephone in with any details about Ms A's history. Ms E's own attempts to recruit support were unsuccessful because the emergency care system at the birthing unit failed her (discussed above). In these circumstances, I consider that clause 3 of the Code applies, and Ms E's actions were reasonable in the circumstances.

Resuscitation
At 1.45am Ms A's waters broke and the baby's head was born. Ms E saw thick meconium and only a small amount of liquor. She used a small catheter to suction fluids from the baby's airway to try and help the baby to breathe.

Baby A was born with the next contraction, and Ms E recognised that she was in a very poor condition. Ms E began to give oxygen and chest compressions. She has described how she saw Baby A change colour during the resuscitation attempt. Unable to leave the baby, as that would have meant stopping resuscitation, she continued to direct the family in efforts to obtain help. Drugs that are normally used in resuscitation were locked in another room. Although Ms E had the key, she felt she could not stop

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the resuscitation to go and get these. Ms E continued her resuscitation attempts for about 30 minutes.

A laryngoscope, which would have helped to open the baby's airway and ensure it was clear, was available, but Ms E did not feel comfortable using it. Ms Waller said that this was reasonable. The use of a laryngoscope is not regularly taught in midwifery training, and is regarded as advanced life support. Ms Muir has agreed with this view.

Ms Muir noted that when fresh or thick meconium is discovered during labour, the referral guidelines in the section 88 Maternity Services Notice recommends a specialist referral. It would therefore have been appropriate for Ms E to call in urgent obstetric or paediatric assistance. Having said that, however, both experts agree that it is unlikely that even a paediatric team, specialists in this kind of situation with advanced equipment and drugs, would have been successful in reviving Baby A.

Ms Waller noted that "this type of situation where you as a midwife are on your own when active resuscitation is required is one most of us would hope would not happen to us". I agree with my experts that some aspects of the resuscitation could have been handled differently, but am mindful that Ms E was operating under extremely demanding circumstances. I am satisfied that clause 3 of the Code applies, and Ms E's actions were reasonable in the circumstances.

Opinion: No Breach — Ms F

Ms A was worried about reduced fetal movement. She had expected Ms D to come to her home for an antenatal check. When she did not attend, Ms A went to the birthing unit, where she was seen by Ms F, a registered nurse who was not qualified to do antenatal assessments. Ms F tried to contact Ms D but Ms D did not answer.

Ms F said that she wanted to give Ms A some reassurance by listening to the fetal heart. She felt that this was within her practice and she was competent in the use of the sonic aid. Ms F was able to get a copy of the front page of the maternity notes, which recorded Ms A's history of fast deliveries and low birthweight babies. I note from Ms Waller's advice that Ms F would not be expected to interpret this information into part of a clinical assessment.

Ms F and Ms A heard the fetal heart for about five minutes, and they were reassured. Ms F recorded a heart rate of 137 beats per minutes but did not record a range or variability. Ms F again tried to contact Ms D, and this time left a message about what she had done.

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Ms Waller has explained that hearing the heartbeat is not the same as studying the pattern provided by a CTG. As noted by both experts, a CTG was necessary and should have been done by Ms D as the LMC, or another midwife or obstetric practitioner in her absence.

Ms Waller has advised that it would have been better if Ms F had left a message for Ms D in the first instance, and provided more opportunity for her to call back while Ms A was still at the birthing unit. I agree that this would have been ideal.

My experts have advised that, in the circumstances, Ms F's care was of a reasonable standard. She acted appropriately in passing on information to Ms D. The responsibility for arranging a CTG and any further care was Ms D's. Therefore, I conclude that Ms F did not breach the Code of Health and Disability Services Consumers' Rights.

Other Comment

Ms D

Ms D joined the birthing unit in July 2004 as a team midwife. By September discussions were underway to reduce the team by half. Ms D was given notice of her intended redundancy on 31 January 2005. As part of the redundancy notice arrangements, the petrol allowance and mobile telephone were withdrawn in October.

In my view, this arrangement, and the long period of redundancy notice, may have contributed to tensions between Ms D and the birthing unit. As my expert Ms Waller has noted, it would have created a tense environment for ongoing relationships, and may have impacted on communication between Ms D and the facility.

Nevertheless, while it may have made things difficult, I do not accept that it prevented Ms D from meeting her responsibilities according to professional and legislative requirements.

Antenatal records

The records show that Ms D saw Ms A often and carried out the expected number of antenatal visits at appropriate times during the pregnancy.

Ms A and Ms J have confirmed that there were additional antenatal assessments by the birthing unit staff, and that these assessments would have been recorded on an A4 sheet and posted in Ms D's postbox. I have received only one such assessment, from Ms F two days before the birth, as part of my investigation. As LMC, Ms D was responsible for overall supervision of Ms A's care, and should have added these assessments to Ms A's antenatal records. This would have highlighted any concerns raised by Ms A during these visits, and added considerably to the continuity of Ms A's care.

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CTG service
Since the events giving rise to this complaint, Ms H has advised me that the birthing unit has introduced a new policy for registered nurses to instigate a CTG in the event that a client is concerned about reduced fetal movements. I note, however, that Ms Waller has questioned who will read the CTG, what training will be provided to ensure correct usage of the machinery, and whether there would be extra training appropriate to a registered nurse.

Ms Muir has advised that the National Service Specifications do not require the birthing unit to provide antenatal care when a woman has an LMC. In my opinion, it remains preferable for registered nurses employed by the birthing unit to consult with a woman's LMC about the need for a CTG in these circumstances. If the LMC is uncontactable, then the registered nurse should either have access to an on-call midwife, or refer the woman to a tertiary or secondary service able to provide antenatal care.

Recommendations

Ms D
Ms D has provided apology letters for Ms A and Ms E. I will forward these with my final opinion to the respective parties.

In addition:

- I will refer Ms D to the Midwifery Council for review of her competence to practice;
- Ms D is to provide evidence that the midwives to whom Ms D currently provides reciprocal cover and care for maternity patients have been made aware of the learning objectives outlined by Ms D.

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Birthing unit
I recommend that the birthing unit take the following action:

- Take appropriate steps to ensure that the neonatal resuscitation medication is readily accessible at all times.

- Review the telephone contact system for midwives and place an effective on-call plan into operation.

- Review rostering systems to ensure compliance with the National Service Specifications for Primary Maternity Facilities.

- Review emergency procedures and dedicate a policy to that effect.

Follow-up actions

- Ms D will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

- A copy of this report will be sent to the Midwifery Council, the Nursing Council, the Coroner and the Ministry of Health.

- A copy of this report, with details identifying the parties removed except the names of the birthing unit and Ms D, will be sent to the relevant District Health Board.

- A copy of this report, with details identifying the parties removed except the name of the birthing unit, will be sent to Quality Health New Zealand.

- A copy of this report, with details identifying the parties removed, will be sent to DHB New Zealand, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes, on completion of the Director of Proceedings' processes.

Addendum

The Director of Proceedings considered the matter and laid a charge before the Health Practitioners Disciplinary Tribunal. The Tribunal concluded that given a reported lack of foetal movements, the midwife failed to respond appropriately by ensuring a kick chart was commenced, or a CTG undertaken and interpreted. The midwife also failed to attend in a timely manner, failed to notify of an anticipated delay, and failed to

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provide adequate information or handover to the maternity facility.The Tribunal found these actions amounted to such a significant departure from the accepted standards that discipline was warranted, it upheld the charge of professional misconduct.

Penalties included supervision/monitoring of the midwife for a period of two years; a limit of no more than four midwifery cases per month for a year; a recertification audit by the Midwifery Council; a New Zealand College of Midwives Midwifery Standards review; a fine of $2,080.00, and a penalty of censure.

The Director decided not to issue proceedings before the Human Rights Review Tribunal.

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Appendix 1 — Independent advice to Commissioner

On 31 January 2006, the following expert advice was obtained from Ms Nimisha Waller:

"…

My qualifications are RN (includes General and Obstetrics), RM, ADM, Dip Ed (UK) and currently completing a Masters in Midwifery Thesis at Victoria University in Wellington. I have been a midwife for 22 years, the last 8 years in New Zealand. I have worked in community and hospital tertiary settings as well as in education both here and in the UK. I am currently a Senior Lecturer in Midwifery at Auckland University of Technology and take a small caseload of women as a Lead Maternity Carer.

…

My response to the advice required is as follows:

1. **Was the check provided to [Ms A] by [Ms F] [two days before the birth] appropriate? Please explain.**

[Ms A] arrived at the [birthing unit] [that day] at 4.30pm as she was unsure of her baby moving. She was seen by [Ms F] who is a Registered General and Obstetric Nurse. [Ms F] has documented in the Consultation report enclosed that [Ms A] wanted someone to listen for fetal heart rate and she was feeling fine even though she was due and there were no niggles or problems at this stage. [Ms F] listened to the fetal heart rate with sonic aid and has documented this as *'137bpm, strong and regular and [Ms A] happy with this"*. The follow up action she has documented is '*Just needed reassurance, message left on [Ms D's] mobile as unable to contact her'*.

[Ms F] in her letter dated 9th May 2005 states that this was the first time in eight years at the [birthing unit] that she has come across a situation such as [Ms A] walking in and wanting reassurance due to baby's lack of movements. On page 1 she states that it was frequently stressed to staff working in the unit that they needed to work in conjunction with Lead Maternity Carers (LMCs). The position details of a staff nurse enclosed in the file in relation to '*Applies knowledge and skills from theory and research to her practice as a Registered Nurse'* under 1.2 states that '*the person monitors the woman and initiates appropriate intervention in response to clinical observations and psychological awareness in consultation with LMC'*. Therefore [Ms F] should have contacted [Ms D] when [Ms A] walked into the [birthing unit]. [Ms F] says she did contact [Ms D] but only got an answer phone message and therefore she did not leave a message at this point as she thought she would first assess [Ms A] and ring [Ms D] again. This is reasonable

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though it would have been better to have left a message as hopefully [Ms D] may have contacted [Ms F] prior to [Ms A] being discharged.

[Ms F] states that '*she does not instigate CTGs as a part of her practice and do not know how to read the results'*. She further states that '*she does not see interpreting CTGs as being within her scope of practice*'. In relation to instigation of CTG, [Ms H], Managing Director of the [birthing unit] states that *'since this incident it is now our policy for nursing staff (and not just midwives) to initiate CTG recordings for all women who report lack of fetal movements'*. When [Ms A] was seen by [Ms F] such a policy was not in existence and for [Ms F] not to have initiated a CTG is reasonable. Whether [Ms D] as an LMC was aware of Registered General and Obstetric Nurses not initiating CTG at time of this incident is not clear from the information sent for consideration.

In relation to interpretation of CTG [Ms F] is correct in seeing this to be outside her scope of practice. In the United Kingdom (UK) where I have worked with RGONs they could only instigate the CTG when the midwife was in the room or they were able to call the midwife or a Registrar to interpret the CTG. In a large tertiary unit in New Zealand RGON's do initiate CTGs to help midwives but do not interpret the CTG and they seek a midwife or a registrar when an interpretation is required.

[Ms F] states that she is not trained in interpreting CTGs and couldn't get hold of an LMC to read it. Since it is a policy now at the [birthing unit] for nursing staff to instigate CTG when there is reduced fetal movements it would be useful to have some comments on:

What steps have been taken to ensure that the LMC will be available to read the CTG?

If fetal heart rate abnormalities are present and the LMC or a midwife is not in the unit what action should the RGON take and how would they know abnormalities are present if they are not trained in interpretation of CTGs?

[Ms F] says that all she was able to access in hospital notes was the booking-in form, stickers and copied front page of the midwifery care plan. The full case notes were not available to her. The usual practice is that the LMC midwives or the women hold the full notes. [Ms F] is an experienced RGON and a lactation consultant however she had not come across this situation in eight years she had been at the birthing unit. [Ms F] in this instance was able to pick up fetal heart rate and she listened for five minutes. From documentation it appears that [Ms F] did ask [Ms A] questions regarding how she was feeling and whether there were any problems and she did suggest to [Ms A] to come back if concerned. However she did not know about history of reduced fetal movements in previous pregnancies.

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[Ms F] did leave [Ms D] (LMC) a message that [Ms A] had been to the birthing unit and was worried about lack of baby's movements and wanted to hear the heart beat. [Ms F] informed [Ms D] that a sonic-aid was used and she got a strong and regular heart beat at 137 beats per minute and that [Ms D] would probably contact [Ms A] and for [Ms A] to come back if she was concerned. However there seems to be slight miscommunication with the message as [Ms D] in antenatal notes [two days before the birth] has documented '*received call from The [birthing unit] that [Ms A] had come in for antenatal check and [Ms A] had expressed concerns about decreased baby movements — check done and all well. Baby's heart rate listened to and heard*'. [Ms D] could have interpreted this as that the Authorised Practitioner had done [Ms A's] antenatal check and that all was well. However it was still [Ms D's] responsibility as an LMC to check that a CTG had been done for decreased fetal movements as she was aware of [Ms A's] previous obstetric history though this pregnancy was with a new partner.

[Ms F's] check on [Ms A] is appropriate as the policy at that time was not to initiate CTG by nursing staff. She did listen to fetal heart rate for five minutes and the heart rate was 137 bpm though if she listened for five minutes there would be a range in that five minutes that could have been documented. In the follow up phone call to LMC, [Ms D], [Ms F] mentioned listening to fetal heart rate with a sonic-aid but for further clarity could have added that a CTG had not been done. Though [Ms F] is an experienced RGON and a lactation consultant she is not a midwife and she should not have to take on the responsibility of a midwife which she was doing in this instance. Her role should be to contact the LMC and in consultation with LMC may listen to the fetal heart rate for initial reassurance while the LMC is on the way as it should be the LMC or an 'authorised person' who should do the assessment and plan of further care. The [birthing unit] probably has a policy of who to contact if the LMC is unable to be contacted or is busy providing care elsewhere, for example, a back up midwife or a midwife in the unit — [Ms H], Managing Director would be able to further comment on this. There needed to be a follow up of [Ms A's] concern of reduced fetal movements as a CTG had not been done.

2. Is [Ms F] an 'authorised practitioner' as described by section 88 of the New Zealand Public Health and Disability Act 2000 (section 88)?

Under 'Definitions of Terms' in the document an 'Authorised Practitioner' means an Anaesthetist, General Practitioner, Midwife, Obstetrician, Paediatrician or Radiologist who has completed a Ministry of Health's application form for authorisation of practitioner and has received written authorisation from the Ministry of Health to provide Maternity Services. An Authorised Practitioner includes both practitioners working in their individual capacity and practitioners who are employed by or affiliated to an organisation.

Part A of the document 'Application and Terms of Notice' under 2.0 'Authorisation' states that '*An Organisation must complete a separate application*

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form for each employee or affiliated member who wishes to be an Authorised Practitioner'. [Ms H], Managing Director of the birthing unit would be able to confirm on whether such an application was completed for [Ms F]. [Ms F] is employed by the birthing unit as an RGON and as she is not an Anaesthetist, General Practitioner, Midwife, Obstetrician, Paediatrician or Radiologist one can assume that a separate application form to be an Authorised practitioner was probably not completed by the birthing unit. Therefore [Ms F] is probably not the authorised person as described by section 88 of the New Zealand Public Health and Disability Act 2000 (section 88).

3. Was the care provided to [Ms A] by [Ms E] appropriate, according to notes #1? Please explain.

At 1.15am [on the day of the birth] [Ms A] arrived at the [birthing unit] unannounced. [Ms A] had been contracting since 11pm [the previous day]. On admission [Ms A] was experiencing some lower abdomen pain, contractions were established and membranes were intact. There was small cervical blood show per vagina. Apparently [Ms A] had notified [Ms D] about her labour on her way into the birthing unit at approximately 1am.

At 1.20am [Ms A] was orientated to Delivery Room 1. She went to the toilet to pass urine and had bowels open. At this time some anal pressure was felt as well as a strong overwhelming contraction. Birth equipment was prepared and [Ms A] requested gas for pain relief. [Ms A] moved back into Room 1.

At 1.30am [Ms A] was feeling hot so cold cloths were applied to her forehead and fan turned on. Entonox was given and she was encouraged to drink water. [Ms A's] sister [Ms B] arrived at this stage. [Ms A] was becoming more vocal.

At 1.35am another contraction was felt which was long and strong. Fetal heart rate is recorded as 135–138bpm. The presenting part was seen at this stage.

At 1.38am [Ms E] asked [Ms B] to ring LMC to see how far she was from the [birthing unit]. They were unable to make contact. [Ms B] was asked to ring the manager of the [birthing unit] ([Ms I]). A message was left on [Ms I's] phone. [Ms B] was then asked to try and contact [Ms L].

At 1.40am suction was turned on and was ready at the end of the bed. Baby's head was advancing at this stage.

At 1.45am the membranes ruptured spontaneously with the delivery of the head and revealed thick meconium and not much fluid. [Ms E] suctioned the baby's airway while the head remained on the perineum.

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At 1.55am the baby spontaneously birthed with the next contraction 'showing little signs of life'. [Ms E] thought the baby gave a muscle twitch and gave an APGAR score of 1 at 1 minute.

[Ms E] could not find any heart rate and the baby did not make any respiratory effort. She continued, unsuccessfully, to resuscitate the baby for approximately 20 minutes.

During the course of the resuscitation, [Mr C], previous partner to [Ms A], who had arrived after the birth, offered to help [Ms E]. [Mr C] has said that he used a bag and mask on the baby while [Ms E] did chest compressions.

At 2.15am [Ms L] (Senior LMC Midwife) arrived and was told by [Ms E] that the baby had died. [Ms L] assisted [Ms E] with active third stage management. At 2.30am the Lead Maternity Carer, [Ms D] arrived and completed the third stage.

[Ms A] arrived at the [birthing unit] in established labour at 1.15am. [Ms E] is a midwife and her care regarding orientating [Ms A] to the delivery room and preparing the equipment for birth is reasonable. [Ms E] was meeting [Ms A] for the first time and since she did not have the full set of notes it is unclear whether she was aware of [Ms A's] previous precipitate labours.

Notes #1 do not reflect [Ms E's] taking a detailed history and doing an assessment of [Ms A] or the baby on admission. There is no documentation of an abdominal palpation to assess whether the baby was lying in the right position (this was [Ms A's] 5th pregnancy and chances of abnormal lie can be higher), fundal height agreed with gestation (previous babies have been small) and the fetal heart rate was within normal range as from notes it appears that [Ms E] was aware of reduced fetal movements 2 days ago. Since [Ms E] did not have full set of notes history taking and abdominal palpation would be an important part of an initial assessment. There is also no documentation of maternal vital signs to give a baseline in labour. Taking initial history and assessment of a woman and baby in established labour is essential to ensure mother and baby are satisfactory and the information gained will enable the practitioner in developing of a plan of care for the remainder of labour. The peers would view lack of history taking, assessment and plan of care in this instance with mild to moderate disapproval as [Ms A] had arrived in established labour and preparation needed to occur for birth however the priority is that the mother and baby are well.

[Ms A's] baby was born 40 minutes after she arrived at the birthing unit. During this time only one fetal heart rate auscultation have been done by [Ms E]. The presenting part was seen at 1.35am and the baby was born at 1.55am therefore total time in second stage of labour was 20 minutes. There is one auscultation of fetal heart rate in first stage of labour and none in the second stage of labour. Evidence recommends that the fetal heart rate is auscultated every 15- 30 minutes in an established first stage of labour and every 5 minutes or after every contraction in

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second stage of labour. Documentation in Notes #1 does not reflect this. The NZCOM Standards of Practice (2005) under '*The third decision point in labour — when the woman wants continuous support from a midwife*" state "*continue regular assessment of a woman and baby and progress of labour'*. This NZCOM standard was the same in 2002 Handbook for Practice. There was no initial assessment of [Ms A's] pregnancy and labour and just one assessment of baby's wellbeing during labour. This is not reasonable standard of care. However it needs to be acknowledged that [Ms A's] labour was quick and [Ms E] was on her own trying to get ready for the birth of [Ms A's] baby. The peers would view lack of monitoring fetal wellbeing with moderate to severe disapproval as [Ms A] had history of reduced fetal movements 2 days prior to birth as well as a previous history of small babies and reduced fetal movements though this pregnancy was with a new partner.

[Ms E] did not contact [Ms D] when [Ms A] arrived at the birthing unit as she was informed that [Ms A] has contacted [Ms D] on the way to the birthing unit. However she asked [Ms B] at 01.38am to ring LMC, [Ms D], to find out where she was when presenting part was visible at 01.35am. Ringing LMC earlier would have been ideal as [Ms A] had history of quick labour however it is reasonable to have done so at 01.38am as it is not clear whether [Ms E] was aware of history of precipitate labours or that this was [Ms A's] fifth pregnancy.

The baby's head was born at 01.45am and the rest of the baby at 01.55am. It appears that there is ten minutes interval between the head birthing and the rest of the baby. Usually the rest of the baby is born with the next contraction approximately five minutes after the birth of the head. The Coroner's report states that the midwife confirmed that there were no difficulties at birth but immediately realised that the baby was not breathing and resuscitation was commenced. It is beneficial for the midwife to document this in clinical records at the time of birth.

At 2.20am consent was given to give 10IU of Syntocinon intramuscularly for third stage of labour. Between 1.55am and 2.20am [Ms E] needed to provide care for the baby who needed active resuscitation. Therefore there was a delay in managing third stage of labour until [Ms L] arrived at 2.15am. As [Ms E] was on her own it was reasonable for her to prioritise her care to the baby prior to [Ms L's] arrival. It does raise the issue of if there was an emergency with [Ms A] such as postpartum haemorrhage at the same time the baby needed resuscitation how would [Ms E] have managed on her own? It appears from the letter by [Ms H] that the expected standard is that the LMC will arrive within 30 minutes of the client or have organised another LMC to attend birth. Unfortunately in this instance the standard was not met as the LMC did not arrive within 30 minutes and another LMC had not been organised. The LMC apparently did try to ring the birthing unit at 02.20am and the call was not answered. However LMC had been informed by

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[Ms A] about getting ready to go to the birthing unit at 01.00am, which is over an hour and ten minutes. From the documentation in the file it appears that the LMC ran out of petrol and to find a petrol station open at that time of night can also be a challenge. [Ms H] says that Senior Clinician on call that night was [Ms D]. Therefore one would expect the person to be prepared in case of being called. LMC [Ms D] is better placed to comment further on this.

[Ms E] suctioned the baby's airways while the head remained on the perineum. If suctioning is initiated the usual practice is to suction the mouth and then the airways to remove residual meconium. Initiating suctioning when the head remained on the perineum in presence of thick meconium is reasonable practice as this management was recommended in Newborn Resuscitation Guidelines in 2004.

Commencing resuscitation with an Apgar score of 1 for muscle twitch can be considered to be reasonable as baby being stillborn was not identified by [Ms E]. Though [Ms E] had not auscultated a fetal heart rate in second stage of labour she had heard baby's heart rate 20 minutes before birth. However there is no documentation of further suctioning under visualisation when the baby was taken to the resuscitaire as meconium is documented as 'thick'. Usually mouth, nose and pharynx are suctioned under direct visualisation with the use of the laryngoscope particularly in a baby that is not vigorous. [Ms E] initiated intermittent positive pressure ventilation (IPPV - bag and mask) and chest compression. This type of situation where you as a midwife are on your own when active resuscitation is required is one most of us would hope would not happen to us. [Ms E] asked [Mr C], a support person to help with resuscitation. [Mr C] says that he used a bag for a time of about 10–15 minutes while the midwife did the chest compressions. The notes do not document the resuscitation procedure fully apart from 6 litres of oxygen used (a minimum of 5 Litres/minute oxygen flow is recommended) and CPR. It is unfortunate that a paediatrician was not contacted to help [Ms E] with the procedure when she was unable to locate the birthing unit staff. [Ms H] in her letter of 8th June 2005 under point 7 says that emergency paediatric consultation is accessed per phone from [the hospital] and the paediatrician arranges for the retrieval team as appropriate. Usually when 'thick' meconium is noted it is recommended that a paediatrician is informed to be present at the birth. The section 88 of the New Zealand Public Health and Disability Act 2000 (section 88) referral guidelines stipulate that in presence of moderate to thick meconium a consultation with a specialist is recommended (Level 2 and Code 5018). However meconium was noted at the time of the head crowning and with [Ms E] being on her own consulting with or calling a paediatrician was probably not considered.

Should [Ms E] have intubated the baby as she had been trained? The paediatric colleagues I work with would prefer practitioners to continue with IPPV (bag and mask) and chest compressions rather than attempt to intubate the baby unless the practitioner [was] competent and [was] maintaining competence in intubation, as you are likely to create more harm than good by intubating the baby. Therefore not intubating the baby is reasonable in this instance.

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Should [Ms E] have given Adrenaline to the baby? The baby was not identified as being stillborn. If there was no change in the heart rate after 30 seconds following IPPV (bag and mask) and chest compressions then [Ms E] should have considered giving Adrenaline as she was resuscitating the baby. Adrenalin is given either intravenously (via umbilical vein) or via the endotracheal tube. As the intubation was not attempted adrenalin would have been given via umbilical vein.

The baby was probably stillborn and this has been ruled by the Coroner so it is likely that calling a paediatrician, a retrieval team or giving adrenaline would have not changed the outcome. However it is important to document the procedure thoroughly. If the baby is not responding and severe asphyxia is diagnosed in presence of thick meconium then relevant practitioners need to be contacted, mouth, nose and pharynx are suctioned under direct visualisation with the use of the laryngoscope and intermittent positive pressure ventilation (IPPV) and chest compressions (if FH <60) continued until help arrives. There should be a reassessment of baby's condition every 30 seconds to assess which aspects of resuscitation needs to continue or which ones can be stopped. For example if the heart rate is above 60 then chest compression can be discontinued and IPPV (bag and mask) continued until respiration is established. The NZCOM Standards of Practice (2005) under '*the fifth decision in labour — the third stage — 'Baby'* state '*obtain additional care for baby if asphyxiated, pulse <100, significant abnormality*'. [Ms E] did try to get additional help by getting [Ms B] to contact the LMC and other [birthing unit] staff but she was unsuccessful for 15–20 minutes. [Ms E] could have considered contacting a paediatrician though it is likely that calling a paediatrician or a retrieval team would have not changed the outcome.

As the baby was given an Apgar score of 1, there was presence of thick meconium and resuscitation was commenced the peers could view this conduct — that is lack of contacting appropriate practitioner such as the paediatrician and not reassessing the baby's condition to continue with appropriate resuscitation with mild to moderate disapproval as the baby was probably stillborn.

4. Was the care provided to [Ms A] by [Ms E] appropriate, according to notes #2? Please explain.

At 1.45am the membranes ruptured spontaneously with the delivery of the head and revealed meconium. [Ms E] suctioned the baby's airway while the head was on the perineum.

At 1.48am [Ms E] has documented cutting the cord, '? FHR <60' with '(NOT HEARD)' added in the text. Resuscitation commenced with CPR but was unsuccessful.

At 2.15am [Ms E] was unable to detect a heart rate.

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[Ms L] was documented as arriving at 2.20am and [Ms D] at 2.30am.

The baby's weight was 3260g with no obvious abnormalities noted.

In Notes #2 the only mention of the management of third stage of labour is that 10IU of syntocinon given in right thigh intramuscularly. It is documented that the cord was cut at 01.48ams so the baby must have been born at that time or just before rather than at 01.55am as stated in Notes #1. Therefore in relation to this documentation there was not much delay between birth of the head and the rest of the body. The baby was born within three minutes of thick meconium being noted in the liquor. There is no mention of presence of pulsation in the cord though cutting of the cord is documented. [Ms E] wasn't sure of whether there was a heart rate of <60 or not so she commenced resuscitation. There is no mention of muscle twitch in these notes. The documentation relating to resuscitation is again brief mentioning CPR and 6 litres of oxygen. There is no mention of suctioning the baby under direct visualisation once baby was transferred to the resuscitaire using a laryngoscope though the baby's airway was suctioned while the head was on the perineum. There is difference in the time stated between the two Notes in relation to heart rate not being detected — in Notes #1 it is documented as 0220 while in Notes #2 as 0215am. Since [Ms E] was unsure of the presence of heart rate at time of birth (<60 or not heard) commencing resuscitation is reasonable. My response made under care provided to [Ms A] and the resuscitation process in relation to Notes #1 is applicable for Notes #2.

5. Was the neonatal care provided to [Baby A] by [Ms E], including the resuscitation, appropriate?

Resuscitation was commenced by [Ms E] as she hadn't identified that the baby was probably stillborn. The last heart rate had been auscultated 20 minutes before the baby was born. The baby was given an Apgar score of 1 in Notes #1 and there was a query of the fetal heart rate being <60 in Notes #2 so commencing resuscitation is reasonable. In an unexpected stillborn not commencing resuscitation could also be perceived as not doing anything.

Suctioning the airway when the head was on the perineum is reasonable. If suctioning is initiated the usual practice is to suction the mouth and then the airways to remove residual meconium. Initiating suctioning when the head remained on the perineum in presence of thick meconium and the baby not being vigorous is a reasonable practice and this management was recommended in Newborn Resuscitation Guidelines in 2004. Using 6 Litres of oxygen, commencing IPPV (Bag and Mask) and chest compressions is also appropriate action in the situation.

However mouth, nose and pharynx were not suctioned under direct visualisation with the use of the laryngoscope when there was thick meconium. [Ms E] had to ask assistance from [Mr C]. It is not appropriate for a support person to assist in

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such an emergency as the support person should be providing support to [Ms A] in this situation. With the resuscitation equipment it appears that there was a neopuff infant resuscitaire (Resuscitation list enclosed in the file). It is unclear why this was not used by [Ms E] as Neopuff infant resuscitaire is more effective and easier to use when you are on your own and have to do chest compressions as well as give oxygen by intermittent positive pressure ventilation (IPPV). The documentation does not reflect reassessment of baby's condition every 30 seconds to assess which aspects of resuscitation needed to continue or which ones could be stopped. No medication such as Adrenaline was considered or given as a part of resuscitation when there was no change in the heart rate. [Ms E] could have considered contacting a paediatrician though it is likely that calling a paediatrician or a retrieval team would have not changed the outcome. The resuscitation was discontinued when bruising near the eyes and face was noted.

There was presence of thick meconium and as resuscitation was commenced the peers in this case could view the conduct of not contacting appropriate practitioner such as the paediatrician and not fully following the process of resuscitation with mild to moderate disapproval as the baby was probably stillborn.

6. Is the procedure of using the telephone contact list to request assistance appropriate in an emergency?

The telephone contact list to request assistance is appropriate when two members of staff are present in the unit in an emergency. However it is not appropriate if you are on your own. Do you contact people or deal with an emergency?

[Ms H] (5th May 2005) under point 7 says that the midwife requests a relative to call from a list secured by the reception phone from top to bottom or if on her own the midwife calls from a cordless phone she carries. In an emergency, when you are on your own neither of these ways of seeking assistance is appropriate. The role of the relative is to support the woman and to ask them to use the contact list to request assistance is inappropriate whether it is an emergency or not. I would think that in an emergency the relatives need to support the woman is even greater than having to help staff with getting assistance.

There has to be two staff present at each shift. How would one staff deal with such an emergency as well as any problem that might occur with a postnatal client who was in the unit? Even if the LMC had been there within 30 minutes both the LMC and [Ms E] would have been involved in caring for [Ms A] and the baby leaving no one to support the postnatal client in the unit if she required assistance or had an emergency herself.

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I feel the [birthing unit] needs to review the reliance on relatives or support person using the telephone contact list to request assistance in an emergency or at any time in provision of woman's care.

7. Was the response by the [birthing unit] staff to [Ms E's] call for assistance appropriate?

From Notes #1 it appears that [Ms E] asked [Ms B] ([Ms A's] sister) to call LMC at 1.38am and [Ms B] was apparently unable to make contact. She then told [Ms B] to ring the manager of the birthing unit '[Ms I]'. [Ms B] informed [Ms E] that she left a message on [Ms I's] phone. [Ms E] then asked [Ms B] to contact [Ms L]. [Ms L] arrived at the birthing unit at 0215am. The LMC was present from 2.30am. At 3.10am [Ms J] arrived.

From Notes #2 it appears that [Ms E] asked [Ms B] to contact the LMC at 1.45am and then asked her to ring [Ms I], [Ms M] and [Ms L]. [Ms L] was present at 2.20am and the LMC at 2.30am.

The LMC, [Ms D's] response is as follows:

At 0201 by her phone she received a call via [Ms A's] phone. The person did not identify themselves but due to caller ID knew it was [Ms A's] phone. The caller hung up when she asked whether everything was ok and no further information was given.

At 0220am the LMC rang the birthing unit and the call was not answered. At 0225– 0230am on arrival to at the birthing unit the LMC phoned [Ms L] while standing at the door and informed her of being outside the entrance. [Ms L] came and alerted the LMC to the news of the baby having died. The retrospective documentation by at 2.30am states 'advised by [Ms L] by phone at door that I was to come immediately — baby of [Ms A] had died'.

The phone call that [Ms E] asked [Ms B] to make to the LMC at 0138am or 0145am is probably received by the LMC at 0201am (by the LMC's phone) and this phone call appears to be from [Ms A's] phone rather than the birthing unit's phone as the caller ID showed [Ms A's] number on the LMC's cell phone. The person did not identify herself and no further information was given. It is interesting that the LMC did not ring back as the time interval between the last call from [Ms A] to this one was nearly an hour. The LMC did ring the birthing unit at 2.20am but there was no answer. The LMC apparently wasn't aware that [Ms E] required assistance, as the [Ms B] had not identified herself and hung up without giving any further information. From documentation it is unclear why the birthing unit phone was not used to contact the LMC. The LMC's response is not appropriate as she knew it was from [Ms A's] phone and [Ms A] had rung her, an hour earlier about making her way to the birthing unit. However the LMC did ring the birthing unit and there was no answer but should have tried [Ms A's] phone too. At the [birthing

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unit] there needs to be further discussion and clarity about the phone that should be used in an emergency and what to do if there is no response either from the staff being contacted or from the birthing unit.

Response by [Ms L] is as follows:

At 2.15am phone call by [Ms B] as requested by [Ms E] needing assistance to help with baby. Advised [Ms B] she would be there immediately. Arrived at 0220am and greeted at the door by [Ms E]. Baby already had died as stated by [Ms E]. Manager [Ms I] contacted by [Ms L]. No response. At 0225am [Ms I's] cell phone was rung and a message service was obtained. At 0226am the LMC was called by [Ms L]. There was no response. At 0235am LMC was in attendance. [Ms J] was phoned for advice. At 0320am [Ms J] was present.

The response by [Ms L] is reasonable. As soon as she was contacted she advised that she would be there and was at the birthing unit within five minutes of receiving the phone call. It appears that the phone call to [Ms L] was not made till 2.15am as the third call was made to a birthing unit LMC domiciled in [the city] (must be [Ms M] documented in Notes #2 by [Ms E]) who advised the relative to ring [Ms L] as she lives the closest to the birthing unit.

Response by Ms I is as follows:

0235am call from [Ms L] from the birthing unit informing of neonatal death. At 0320am arrived at the birthing unit. The rest of the documentation is about events following her arrival at the birthing unit.

In this documentation by [Ms I] there is no mention of the phone call by [Ms B] to [Ms I] as requested by [Ms E] at approximately 01.38am. From this documentation it appears that [Ms L] was the first person to contact [Ms I] at 2.35am. This needs further clarification as [Ms E] has clearly documented in both sets of notes (Notes #1 and #2) of asking [Ms B] to contact [Ms I] when [Ms B] was unable to get LMC [Ms D]. If [Ms B] left the message on [Ms I's] phone at around 1.38 then her response to [Ms E] call for assistance is not reasonable.

8. What standards apply in this case?

For [Ms F] who is a RGON the standards of the nursing profession in relation to RGON apply as well as the requirements in her job specification and the policies and protocols of the [birthing unit] where she is employed in her role as an RGON.

For the midwife, [Ms E], the NZCOM Standards for Practice (2002) and now (2005) as well as the MOH Referral guidelines described by section 88 of the New Zealand Public Health and Disability Act 2000 (section 88) and the policies and

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protocols of the [birthing unit] where she is employed apply for this case. These same standards also apply to the LMC, [Ms D].

The [birthing unit] would also have to follow the facility specifications set by the MOH in section 88 of the New Zealand Public Health and Disability Act 2000 (section 88). I was unable to get a copy of these specifications to see if any information was given to birthing units or facility providers regarding number of staff that should be considered per shift, provisions that should be made to contact staff in time of an emergency and whether using support people or relatives to contact staff in an emergency is appropriate. However [Ms H] would be able to provide a copy of Facility specification or comment on these issues.

9. Was the record keeping adequate?

The record keeping by [Ms F] is adequate however clearly stating that the CTG had not been done [two days before the birth] would have helpful to the LMC, [Ms D].

Including the history, initial assessment of [Ms A] and her baby when she arrived in established labour [on …] as well as documenting ongoing assessment of mother and baby in labour could enhance [Ms E's] record keeping. The resuscitation procedure needed to be fully documented including reassessments if done as well as any discussions and actions regarding a consultation or referral if appropriate.

[Ms E] was involved with birth of [Ms A's] baby as well as resuscitation. There is no mention in her documentation of the baby's skin being meconium stained, which has been documented by [Ms D] at the time of taking samples from the baby.

10. Are there any aspects of the care provided by [Ms F], [Ms E] and the [birthing unit] that you consider warrant additional comment?

[Ms F] should have contacted a staff midwife when she was unable to get LMC, [Ms D] prior to sending [Ms A] home [two days before the birth]. [Ms A] had other children with her and may have just wanted to be reassured but this was the first time in eight years that [Ms F] had come across such a situation as a RGON. It was therefore important that the midwife was contacted to come and review [Ms A] prior to her going home so that the CTG could have been initiated if necessary.

The notes held in a facility are limited in relation to information about the woman and her history as the full set of notes is usually carried by the LMC or the woman. It is therefore important that another midwife rather than a staff nurse assesses the woman as she is better placed to ask relevant questions as well as initiate care such as CTG and interpret them. The RGON's role should be to assist the midwife rather than having to take on the role and the responsibilities of a midwife in such situations.

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[Mr C] mentions that the delivering midwife ([Ms E]) was fresh out of training. This needs further clarification as [Ms H] says the birthing unit had employed [Ms E] since 2003.

[Ms H], pertaining to [Ms E], states that one midwife is on duty between the hours of 15.00 and 07.00, one midwife and one health assistant between the hours of 07.00 and 15.00. However [Ms F] comments on often being in sole charge of the premises. [Ms F] is not a midwife therefore a midwife is not on duty at every shift. Some further clarification is required about the staffing of the [birthing unit].

Summary

In this instance there are aspects of care by [Ms F], [Ms E] and the [birthing unit] that are not reasonable. There are also areas such as staffing, contacting staff in an emergency as well as communication and documentation that need further consideration at the [birthing unit]. The LMC, [Ms D] not being able to be contacted [two days before the birth or on the day of the birth] for [Ms A's] care created challenges for both [Ms F] and [Ms E] when providing care to [Ms A]. These could have been minimised or prevented if appropriate steps had been taken by [Ms D] to cover her when she was unavailable.

References:

MOH (2000) *Maternity Services Notice Section 88 of the New Zealand Public Health and Disability Act.* Ministry of Health. July.

NZCOM (2002 & 2005) *The Handbook for Practice*. New Zealand College of Midwives. Christchurch."

On 15 March 2006, Ms Waller gave additional information as follows:

"…

1. What would be the impact on the baby when there is a delay of ten minutes from delivery of the head to the delivery of the body?

Usually the birth of the body follows within 3–5 minutes after the birth of the head. This means that the body usually births with the next contraction. In notes # 1 there appears to be an interval of ten minutes between the birth of the head and the body. The impact this may have on the baby is of birth asphyxia, particularly if the baby is already compromised.

2. What actions, if any should [Ms E] have taken to expedite the delivery?

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The Coroners report states that the midwife confirmed there were no difficulties with the birth so it appears that [Ms E] did not feel there was a delay between the birth of the head and the body. The baby's head was out and there does not appear to be any problems with the birth of the shoulders so there may have been a small delay in the next contraction commencing which can often happen in second stage of labour. The contractions do get spaced out as they are stronger and expulsive at this stage. An episiotomy would be difficult to perform with the baby's head on the perineum. One can encourage the mother to change a position which might stimulate a contraction but this is not guaranteed. Therefore identification of fetal distress earlier is essential for intervention such as an episiotomy to be performed. This was [Ms A's] fourth baby and one would expect her to push the baby out quickly without a need for an episiotomy but [the pregnancy] was with a new partner.

3. Should the presence of meconium and a small amount of liquor, noted at the delivery of the head, have changed the management of delivery? Please explain.

My understanding has always been that where there is presence of meconium and small amount of liquor one should anticipate the outcome may not always be optimal. The small amount of liquor usually indicates moderate to thick meconium and in this instance one would call a paediatrician to be present at the birth. However the paediatrician may not have arrived in time as he/she would be coming from [the hospital]. Therefore it is the midwife's responsibility to commence the appropriate resuscitation if she had felt the baby was asphyxiated.

[Ms E] suctioned the airway when the head was on the perineum which is reasonable. Initiating suctioning when the head remained on the perineum in presence of thick meconium is a reasonable practice and this management was recommended in Newborn Resuscitation Guidelines in 2004. Using 6 litres of oxygen, commencing IPPV (bag and mask) and chest compressions is also appropriate action in the situation. The resuscitation was discontinued when bruising near the eyes and face was noted.

Mouth, nose and pharynx were not suctioned under direct visualisation with the use of the laryngoscope when there was thick meconium. With [the birthing unit] resuscitation equipment it appears that there was a Neopuff infant resuscitaire. It is unclear why this was not used by [Ms E] as Neopuff infant resuscitaire is probably more effective and easier to use when you are on your own and have to do chest compressions as well as give oxygen by intermittent pressure ventilation (IPPV). [[Ms E], in her later statement, said the Neopuff was used]. The documentation does not reflect reassessment of the baby's condition every 30 seconds to assess which aspects of the resuscitation needed to continue or which ones could be stopped. No medications such as Adrenaline was considered or given as part of the resuscitation when there was no change in heart rate. However it appears that none

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of these actions would have changed the outcome for [Baby A] as the baby was stillborn.

Overall [Ms E] continued to give IPPV (bag and mask) and chest compressions until bruising near the eyes and face was noted which is reasonable care. [Ms E] needed to call a paediatrician from [the hospital] when the presence of meconium and small amount of liquor was noted. However the birth of [Baby A] was quick — 40 minutes from the time [Ms A] arrived at the birthing unit. The fast labour would have made it difficult to call the paediatrician as [Ms E] was on her own and trying to get in touch with the LMC. One can understand the dilemma she must have been under about who to contact first as well as assist with the birth of a baby and commence resuscitation. However if you are concerned that the baby is asphyxiated then you need to contact appropriate practitioner which in this case was a paediatrician. In light of [Ms E] being on her own, labour being fast attempts being made to contact LMC and other birthing unit staff not calling the paediatrician could be viewed with mild to moderate sense of disapproval by peers as at this stage the baby was thought to be born alive."

Additional advice

Following [Ms D's] late response and [Ms E's] statement, Ms Waller was asked to provide additional advice on the care provided by [Ms D].

"…

My response to the advice required is as follows:

1. **Did [Ms D] provide appropriate standard of care for the antenatal period?**

[Ms D] was first introduced to [Ms A] on 21st July 2004 by [Ms G] at an antenatal education class with a Maori focus. [Ms D] took over [Ms A's] care as an LMC on 2nd August 2004 at 25 weeks gestation when the previous midwife moved out of the area. This was also the date [Ms D] began work as a case load midwife at the birthing unit. The antenatal checks done by [Ms D] are documented and were done from 17th August to 10th November 2004.

On 17th August at the first antenatal check with [Ms D] at 27 weeks gestation a change in LMC form was signed, a birthing history was briefly discussed and the main concern noted was that [Ms A] had quick births. [Ms D] was able to find out of the second birth being induced but was unsure of the need for induction apart from that [Ms A] had assumed it was for reduced fetal movements. In relation to quick birth [Ms A] was advised to inform [Ms D] early as soon as she had any signs of labour. [Ms A] was given her own antenatal book to write up own notes

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and advised to document fetal movements. A form was also given for antenatal blood screen.

The antenatal check on 24th of August was performed at the [birthing unit] as [Ms D] received a phone call to say that [Ms A] was there due to mix up of appointment dates.

From [Ms D's] response to the Commissioner it appears that on 31st of August [Ms A] was seen by the Manager [Ms J] at the birthing unit as [Ms A] had arrived unannounced thinking she had an appointment that day. This check is not documented on the file with other antenatal checks or included anywhere else.

On 7th September [Ms A] did not come to the birthing unit and was not at home when [Ms D] visited her for a routine antenatal check. [Ms D] contacted [Ms A] the next day by phone and it is documented that [Ms A] had forgotten her appointment and all was well with her. Another appointment for the 12th of September was arranged.

On the 12th September at 31+ weeks gestation [Ms A] was seen by [Ms D] and the scan result and possibility of a change in midwife were discussed with [Ms A] from [Ms D's] response to the Commissioner.

On the 30th September at 33 weeks gestation all was well and no concerns were expressed by [Ms A] to [Ms D].

…

On the 20th October [Ms A] was again not at home when [Ms D] visited her for an antenatal check at 36 weeks gestation. A message was left about a visit for following Thursday.

On 26th October at 37 weeks gestation [Ms A] was apparently well and had no complaints. A form was given for further blood tests and swabs and an MSU. The swab appears to have been taken on the 8th November according to [Ms D's] response to the Commissioner

On the 10th November at 39 weeks all appears well and no mention of any concerns with fetal movements are documented. [Ms A] says that she had raised concerns with [Ms D] about lack of movements and that [Ms D] reassured her that 'it was normal' and did not offer any further advice.

Text message from [Ms A] was received by [Ms D] [a few days later] regarding an antenatal visit. [Ms A] was advised of a visit possibly on Thursday or Friday as [Ms D] was at a birth at [the hospital] on the day of the text. The same day [Ms D] received a voice message from the [birthing unit] nursing staff ([Ms F]) that [Ms A] had come in for antenatal check and expressed concern about decreased fetal

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movements. Check was done and all was well. [Ms D] was unsure of whether a sonic aid was used or a CTG.

During the antenatal period there were regular appointments however there were times when both [Ms D] and [Ms A] missed appointments. It appears that [Ms D] missed appointments when she was busy providing care for another woman. [Ms A] seems to have missed appointments when she had mixed her dates or place of appointments. When appointments were missed by either party [Ms D] made an effort to organise another appointment to follow up [Ms A]. This is reasonable practice. It is unclear from documentation sent whether the date, times and place of appointments were written down for [Ms A] to prevent confusion over the appointments during this pregnancy. When [Ms A] went to the [birthing unit] by mistake she appears to have been seen by other staff including a manager of the facility but documentation of those contacts have not been forwarded by the birthing unit or [Ms D]. This is unfortunate as it may have highlighted any concerns raised by [Ms A] at these visits.

At the first antenatal visit by [Ms D] an attempt was made to get a brief history from [Ms A]. There was lack of clarity regarding why [Ms A] was induced for her second birth in 1999. [Ms A] was unsure but had assumed it was due to reduced fetal movements. [Ms D] in her response to the Commissioners states: *'I had not been privy to any of her previous birth notes so relied on information that [Ms A] shared with me.'* [Ms A's] third baby had birthed at the [birthing unit] in 2002 without any complications. [Ms D] states: *'At a later stage, I discussed [Ms A's] birthing history with [Ms J] as she had been one of the midwives for [Ms A] at her last pregnancy and birth. She confirmed that she could see no reason why [Ms A] should be birthing anywhere else other than the [birthing unit] due to her last normal birth.'*

Discussing [Ms A's] birth history with [Ms J] is reasonable as [Ms D] was a new employee of the [birthing unit] and [Ms J] was involved in [Ms A's] third pregnancy and birth. However in this third pregnancy in 2002 there was concern about reduced amniotic fluid as the amniotic fluid index is reported as reduced at 32 weeks gestation. Reduced amount of amniotic fluid however seems to have resolved and normal liquor was noted with good Doppler results by the time [Ms A's] third pregnancy was coming to an end. [Ms A's] second baby was less than 2.5kg again indicating some issue with growth. The records in the file sent of this pregnancy show that the second pregnancy was induced for IUGR/SFD — that is there was concern of the baby being small. In view of this history it would have been ideal for [Ms D] to have accessed previous clinical records to get a detailed history of [Ms A's] obstetric history rather than relying on [Ms A] or colleagues to complete the picture. Being a new employee it would have been beneficial for [Ms D] to have asked [Ms J] (Manager) how to access the notes that she had not

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been privy to in the past so that she could provide and plan appropriate care for [Ms A]. The Standard Three of the New Zealand College of Midwives (NZCOM, 2005) states: *'The midwife collects information using all sources in consultation with the woman.'* It is therefore expected for practitioners to access previous birth notes from women or facility so appropriate plan of care for existing pregnancy is made. However there are still practitioners who rely on women and colleagues for such information. Midwifery care in New Zealand is based on partnership however not all women remember their births in detail and are able to articulate the risks identified in their previous pregnancies. For [Ms D] to have not accessed previous notes could be viewed with mild to moderate disapproval by her peers.

[Two days before the birth] [Ms D] received a voice message from the [birthing unit] nursing staff that [Ms A] had come in for antenatal check and expressed concern about decreased fetal movements. She was informed that a check was done and all was well. [Ms D] was unsure of whether a sonic aid was used or a CTG. In this instance [Ms D] needed to contact the [birthing unit] to clarify whether a CTG had been done as she was unsure. It appears that at the time of the phone call from nursing staff about [Ms A's] concern for reduced fetal movements [Ms D] was with a client who needed a lot of support as she was being induced for post dates. However [Ms D] needed to either clarify about a CTG herself or use a team midwife or the [birthing unit] midwife to do that for her while she was busy with the client for two days. She needed to respond to the message [Ms F] had left on her cellphone regarding [Ms A's] concern of lack of fetal movements though the fetal heart rate at the time of auscultation was satisfactory (137bpm). As [Ms F] was a staff nurse and probably not the authorised person as described by section 88 of the New Zealand Public Health and Disability Act 2000 (section 88) not following up on her phone call to ensure all was well with [Ms A] could be viewed with moderate disapproval by her peers. It needs to be noted that the relationship between [Ms D] and the [birthing unit] was tense at this stage due to redundancy and review of services at the [birthing unit] so it is difficult to know how easy [Ms D] would have found getting a team midwife or a [birthing unit] staff to follow up on a CTG being done but she needed to make an attempt to do so.

Antenatal checks done by [Ms D] documented from 17th August to 10th November 2004 all have fetal heart rate documented however only once on the 30th September has fetal movements been documented. [Ms A] was asked to document fetal movements in her notes. It is unclear from [Ms D's] documentation whether [Ms A] was asked of this information at each visit. Midwives at each visit do routinely ask women they see at antenatal checks about fetal movements so it is important that they document this information so that both practitioners and women/families know that all is well with the baby at that time.

2. **Please review the information [Ms D] provided to [Ms A] during the antenatal period. In particular concerning the on-call service, appointments and reduced fetal movements.**

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[Ms D] in her response to the Commissioner mentions that these discussions of on call service, appointments and reduced fetal movements occurred however they are not documented in clinical records. The documentation at each antenatal check highlights care provided and action taken but does not reflect the wider discussions that may have occurred regarding on call services, appointments and the adequacy of the fetal movements. When it is not documented it is difficult to say that it was done. My understanding has always been that if it is not documented then in legal sense it has not happened. The Standard Seven of the New Zealand College of Midwives states '*the midwife clearly documents her decisions and professional actions*' (NZCOM, 2002 and 2005). The documentation is therefore inadequate in relation to discussions that may have occurred between [Ms D] and [Ms A].

3. Did [Ms D] apply an appropriate standard of risk identification and management?

In relation to identification of bacterial vaginosis and its treatment [Ms D's] risk identification and management was appropriate. The information about [Ms A's] quick births was obtained and plan put in place for this pregnancy which is reasonable.

When [Ms D] took over the care of [Ms A] as LMC on 2nd August 2004 there appears to be only a brief history taken from [Ms A] regarding her risks in this pregnancy. In the first question it is highlighted that [Ms D] was not privy to any of [Ms A's] previous birth notes however the notes from both the second and the third pregnancies (1999 and 2002) are enclosed in the file so they must be available at the [birthing unit] for staff to peruse. The Midwifery Care Plan started in this pregnancy must have been available for [Ms D] when she became the LMC to [Ms A]. [Ms D] would therefore have seen that [Ms A's] previous three babies were small. This could have alerted her to a possible reason for induction in previous pregnancy and a potential risk of a small baby in this pregnancy. However it is not clear from this care plan how tall or of what weight [Ms A] was as this could also have an influence on previous baby's birth weight.

[Ms D] was aware of [Ms A] smoking and that she was thinking of a quit smoking programme. The growth of the baby in this pregnancy was certainly not of concern during any of the antenatal visits and the baby weighed 3260gms at birth which is of a reasonable size.

[Ms D] states in her report to the Commissioner that this was a pregnancy with a different partner and she got to know of this … on the 12th October 2004 when [Ms A] was 36 weeks pregnant. This information of a new partner is not in the Midwifery Care Plan. Relying on [Ms A] to provide such information to a new LMC may not be ideal as she may have already given the information to the previous practitioner hoping that it would be passed on. This highlights the

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importance of going over the history in detail each time when taking over the care of a woman from another practitioner even though the information may have been gathered before.

[Ms D] in her response to the Commissioner says that there was a history of excessive alcohol use by [Ms A] before pregnancy and that there were rumours among staff and the community that [Ms A] had attended her GP for matters relating to alcohol and domestic violence. On the 26th July 2004 [Ms A] had come into the [birthing unit] with a bruised eye, requesting a scan form when [Ms D] was orientating as a new staff. There is no documentation to suggest whether these risks were identified and managed when [Ms D] took over [Ms A's] care as an LMC on the 2nd August.

4. Was the scan dated 27th August appropriate?

The scan form was given for a fetal anatomy when the scan was really for an accidental blow to her stomach. Ideally one wanted to know if there was any sign of abruption to the placenta and that the growth was satisfactory rather than an anatomy. ([Ms D] said that this was a blow to the stomach. However, [Ms A] later confirmed that she had a black eye, and there was no suggestion of injury to her stomach.) However the result of the scan was within normal limits with no comments relating to possibility of placental abruption or growth being unsatisfactory. There was probably no anatomy scan done previously due to cost so it was appropriate to request anatomy but needed to add specifically to note for placental abruption due to accidental blow to [Ms A's] stomach.

5. Did [Ms D] provide an appropriate standard of care to [Ms A] during the intra partum period?

[Ms A] began a spontaneous labour at 11pm on […] and contacted [Ms D] at approximately 1am [the next day] and arranged to meet her at the [birthing unit]. [Ms D] explained that she had just returned home from [the hospital] after a 24-hour period of caring for another woman. [Ms D] said that she required a change of clothes and petrol, and advised that her home address is 40–50 minutes from the [birthing unit]. On this occasion she arrived at the [birthing unit] at 2.30am. On her arrival, [Ms D] took over the care of [Ms A] to complete the third stage. This is not reasonable as [Ms D] needed to be at the [birthing unit] within 30 minutes as her contract stated or arrange for another midwife to cover her while she made her way to the [birthing unit]. As [Ms D] was not going to be at the [birthing unit] in 30 minutes she at least needed to phone the [birthing unit] staff and inform her of late arrival and of [Ms A's] impending arrival. From clinical notes [Ms D] did not contact the [birthing unit] till 2.20am which is an hour and twenty minutes after [Ms A] contacted her at 1am. [Ms D] had been awake for 24 hours so arranging another team midwife to cover her for [Ms A's] intrapartum care would have been appropriate. However none of these arrangements were put in place leaving [Ms E] to manage a challenging birth on her own. Apart from your contractual

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arrangements as an employee you have a contractual arrangement with the Ministry under Section 88 (MOH 2002) to be at the facility within 20 minutes or make appropriate arrangements and inform the facility. Lack of provision of appropriate standard of care or making arrangements for [Ms A's] care can be viewed with moderate disapproval by her peers.

6. Did the [birthing unit] provide adequate systems, services and facilities for the provision of maternity care?

Having one midwife on duty that had returned to practice after maternity leave and had minimal intra partum experience was probably not appropriate. Ideally the LMC would have been there within 30 minutes as per her contract however in this instance the LMC was unable to be there in that time frame leaving the midwife with little experience to deal with a challenging situation.

To discontinue the use of cellphone and mileage claims of an LMC midwife who is still continuing to provide care for women booked with the [birthing unit] appears unreasonable however [Ms H] may be able to clarify why such action was necessary in this instance with [Ms D].

The telephone system put in place to contact staff in an emergency needs reviewing as it is not appropriate for support person to help the midwife to phone other staff members in an emergency or open doors for staff or family coming in when they should be supporting the woman who is birthing. From [Ms B's] [information] it appears that she had to leave the room and go to reception to find the list of staff to contact and this was not according to her an easily seen list but one she had to search in the reception area. I feel the [birthing unit] needs to review the reliance on relatives or support person using the telephone contact list to request assistance in an emergency or at any time in provision of woman's care.

7. What standards apply in this case?

For the LMC, [Ms D], the NZCOM Standards for Practice (2002) and now (2005) as well as the MOH Referral guidelines described by section 88 of the New Zealand Public Health and Disability Act 2000 (section 88) and the policies and protocols of the [birthing unit] where she is employed apply for this case.

The [birthing unit] would also have to follow the facility specifications set by the MOH in section 88 of the New Zealand Public Health and Disability Act 2000 (section 88). I was unable to get a copy of these specifications to see if any information was given to birthing units or facility providers regarding number of staff that should be considered per shift, provisions that should be made to contact staff in time of an emergency and whether using support people or relatives to

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contact staff in an emergency is appropriate. However [Ms H] would be able to provide a copy of Facility specification or comment on these issues.

8. Was the record keeping adequate?

The documentation relating to [Ms A] when seen by other than her LMC during antenatal period is not included in the file as neither the birthing unit or [Ms D] were able to provide these to the Commissioner.

The documentation by the LMC at each antenatal visit highlights the care at the time but lacks the discussions that may have occurred regarding her role as LMC, the use of back up midwife when she was unavailable, the plan made for previous quick labours and the risks identified and their management. [Ms D] in her response to the Commissioner mentions that these discussions occurred however they need to be documented in clinical records so that there is clarity for all involved of the care planned. There is no evidence of a birth plan formulated with [Ms A] by [Ms D].

9. Are there any aspects of the care provided by [Ms D] and the [birthing unit] that you consider warrant additional comment?

Policy re stillbirth
It appears that there was no policy that could be easily accessed by staff regarding a baby that is stillborn. However the Manager [Ms J] was able to get one from clinical folder straight away on her arrival. This highlights the need for all staff to be updated regularly of policies that may be required on rare occasions and where they could be found. The placenta was not sent [to] histology with the baby for post-mortem. The [birthing unit] needs to review that there is appropriate policy regarding what is sent to get maximum information in this situation.

[Ms A's] clinical records
[Ms H] in her response says that the LMC carries the client's notes and on booking with the facility lodges the front sheet, which includes a brief history, EDD and current laboratory and scan result. [Ms E] in her interview states she went to find [Ms A's] notes but they were not there and that she was unaware of [Ms A] coming in with reduced fetal movements until after the event. It appears that there needs to be clear information for staff at the [birthing unit] of which part of notes are available to them and which ones are carried by LMC midwives.

Orientation, disciplinary actions, redundancy, review of services
It appears from the information in the file that from the commencement of [Ms D's] employment at the [birthing unit] there were issues relating to above which would have created a tense environment for ongoing relationships. It needs to be noted that these possibly may had some impact on good communications between LMC and the facility.

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Incentive & Bonus Scheme

It is noted that number of facilities have such schemes where the LMC has to ensure that majority of births occur in the facility they are employed by. However when such schemes are linked to financial gain there may be a potential to book woman to birth in a facility when it may not be the appropriate place to birth or have large number of cases that may be difficult to provide adequate care to specially if number of midwives in the team are reduced. [Ms H] may be able to comment on strategies that have been put in place to ensure that staff do not overstress with inappropriate workload.

10. Review the previous advice in light of the additional information provided concerning [Ms E] and the [birthing unit].

The interview transcript has been useful in clarifying the role of [Ms E] when [Ms A] arrived at the [birthing unit] in labour on […]. In light of this information [Ms E's] care to [Ms A] and the baby is reasonable. The actions she had taken were the only actions she could take in the situation when birth is rapid and there is little information of the possible risks.

This was [Ms E's] first birth since graduating and it is unfortunate that she was on her own at this time. Such situations are rare but highlight the need for presence of two staff at birth so adequate care and support is provided for all involved in the situation, ie, practitioners, woman and family/whanau.

Summary

In this instance there are aspects of care by [Ms D] and the [birthing unit] that are not reasonable. There are areas such as dealing with staff employment, communication and documentation that need further consideration by [Ms D] and the [birthing unit]. The LMC, [Ms D] not being able to be contacted [two days before the birth or on the day of the birth] for [Ms A's] care created challenges for both [Ms F] and [Ms E] when providing care to [Ms A]. These could have been minimised or prevented if appropriate steps had been taken by [Ms D] to cover her when she was unavailable."

On 26 May 2006 Ms Waller added further comment by telephone. She said that because the resuscitation drugs were locked away outside the birthing room they were not available to the midwife, as she could not leave the baby. Resuscitation drugs need to be accessible at all times owing to the possibility of delivering a compromised baby alone. The acceptable standard is that the right equipment will be available.

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Additional advice received by Ms Nimisha Waller on 9 November 2006

"…

My response to the advice required is as follows:

1. ***Section 88 4.4.2 and 4.4.3 ask for a second authorised practitioner to be available to attend the birth. What do you consider 'available' means? Is that someone at the delivery, on site but not required in the room, or within ? minutes from attending.***

   In an ideal situation I would consider being 'available' to mean a second practitioner being present at birth. However this is not always feasible even in a tertiary facility. The midwife or the LMC may ring the bell for the second authorised person to be present but if the facility is busy then the second practitioner may not arrive in time for the birth so 'available' often means within minutes from attending. Practitioners may consider that the person being on site but not required in the room is still being available. I have spoken to staff at number of primary birthing units within [a city] Region which are situated within the city area, semi rural and rural in relation to this specification. They all said that the LMC should contact the second authorised practitioner to attend the birth. This second authorised practitioner could be the midwife working a shift in the primary birthing unit or a back up midwife that the LMC works with. If the primary birthing unit midwife is busy then she will often suggest to the LMC to contact the back up midwife to be the second authorised practitioner. The second authorised practitioner (midwife) may be present for the birth or may arrive just after the birth but is available (present) at some stage during labour and birth. The New Zealand College of Midwives say that the presence of the second authorised practitioner (midwife) may not be possible in rural and remote areas as it may take up to 40–45 minutes just for the LMC to arrive and therefore the LMC may be the only authorised person present at birth which is better than no midwife being present. Particularly with the workforce issues in some parts of the country it may not always be possible to have the second authorised person available at birth.

2. ***National Specs 5.2.2 'Labour and Birth' ask for the facility to have a midwife available 24/7. Do you interpret that to mean a midwife should be on site to receive the woman in labour prior to the LMC arrival. I note that 5.2.3 refers to in-patient postnatal care which can be provided by a nurse with a midwife on call. What is the normal practice for birthing units?***

   The primary birthing units in [a city] Region that I spoke to all address the issue of midwife availability in a variety of ways. Some have a midwife on site to receive the woman as she and her colleagues work a rostered shift covering the unit over 24 hours seven days a week. My understanding from discussion with these units is that the minimum requirement for staffing the units over 24 hours

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are one midwife per shift. However, most units have changed to having two midwives per shift when it is possible to reduce risk related to clinical issues. Other primary units have nurses in the unit when there is inpatient postnatal care and the LMC midwives are available on the phone 24/7. If the LMC is having time off then the back up midwife is available 24/7 and this is arranged by the LMC to ensure cover while she is away. Some birthing units are only open when there is a woman in labour or there is an inpatient postnatal care. In such units apart from LMC being available 24/7 there is sometimes an on-call midwife who is also available so that she can be called as a second authorised person to be present at labour and birth and when the nurses need to call a midwife while caring for inpatient postnatal women. The primary units that do not have midwives on rostered shift have a system where the women contact the LMC first and only go to the birthing unit once they have spoken to the LMC and a decision has been made to meet there. The LMCs often arrive before, with or just after the woman's arrival.

3. ***The [birthing unit] have said their manager is on call for all responses outside of hours. Is this reasonable to expect one person to be on call for this extended period. Also, is the home telephone adequate as the only mode of emergency contact without any other method of communication. What is the normal practice for on call health providers.***

   It is reasonable for one person to be on call for the extended period particularly when the person is not the LMC. In one of the rural primary units an LMC midwife is on call for the primary unit all the time. It depends on how busy the unit is and the support for that on call midwife and the ability to arrange a back up if the on-call person wants time out. Such arrangements one hopes have been discussed with an employer if the on call person is employed or with local community if the unit is in a rural setting.

   The home telephone number is not always adequate as the only mode of emergency contact. There needs to be a call diversion on the home telephone number so that if the person does not answer the home phone then the call is diverted to the cellphone rather than a message being left on the home phone number in an emergency. This is particularly important when one person is on call for all responses outside of hours for extended period of time. One would not expect that person to be at home all the time. Call diversion would also be dependent on whether there is a signal for cellphone in the area the person resides in. Health care providers that are on call have a responsibility to ensure that they are contactable and that there is a back up person that can be contacted in case there is a problem to get in touch with them in an emergency.

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4. ***Please provide some comment about the [birthing unit's] response concerning the availability of drugs.***

The [birthing unit's] response concerning the availability of drugs was as follows:

Emergency drugs are managed according to the standard. The policy reflects these requirements and I draw your attention to Standard 3, Storage of Medicines in the policy (enclosed). We are at loss to see how a facility can meet the requirement of both the Standard which requires controlled drugs to be locked away from unauthorised persons and the Code, in relation to this type of incident. Had the LMC been present accessing the drugs it would not have been an issue.

The drugs used in neonatal resuscitation are Adrenaline, Naloxone and Sodium Bicarbonate. These are not controlled drugs. All the primary birthing units that I spoke to apart from one have these drugs near the resuscitation table or trolley and are not locked away. One primary unit has the drugs locked in a cupboard when the unit is not open and these are taken out when the LMC arrives with the woman in labour. In tertiary facilities these drugs are on the resuscitation table/ trolleys or cupboards that are not locked in the birthing rooms.

Midwives on rare occasions may use Adrenaline and in very rare instances Sodium Bicarbonate. This is often following a consultation with a paediatrician and intubation of the baby as my understanding is that giving Adrenaline intramuscularly is not as useful as giving it via an endotracheal tube or an umbilical vein. The main role for the midwife is to continue with Intermittent Positive Pressure Ventilation (IPPV or bag and mask) and when heart rate is 60 or below to commence chest compressions. However, drugs need to be available in case the heart rate fails to increase following chest compressions and IPPV.

Naloxone is used where the infant exhibits respiratory depression and mother has received opioid analgesia such as pethidine."

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Appendix 2 — Independent advice to Commissioner

The following expert advice was obtained from Ms Terryll Muir:

"My name is Terryll Muir; I am a registered midwife and have been working as a midwife for 22 years. For 16 years I worked as a Self-Employed Midwife caring for women in a variety of settings: Home births, Primary Facilities and at the Secondary Base Hospital. Following that I spent two years employed as a core midwife at the Secondary Base Hospital, then two years as a Midwifery Lecturer. For the past eighteen months I have been employed as the Clinical Midwife Leader at our Secondary Base Hospital. This position is a combined management and clinical role. During this time I have continued to provide LMC care for a small number of women in the Home birth setting.

I have been asked to give advice to the Health and Disability Commissioner on the appropriateness and adequacy of the antenatal services provided to [Ms A] by the [birthing unit] in November 2004. The appropriateness and adequacy of the labour and delivery services provided by the [birthing unit] to [Ms A] in November 2004 and the appropriateness and adequacy of the neonatal care services provided by the [birthing unit] to [Baby A] in November 2004.

…

1. **In your professional opinion, was the care given by the [birthing unit] appropriate and adequate?**

   In answering this question I would like to separate the care given by the [birthing unit] into seven sections:

   a) Antenatal services in the absence of the LMC.

   b) Antenatal care by the LMC.

   c) Labour care in the absence of the LMC.

   d) Labour care by the LMC.

   e) Supplying sufficient qualified staff to ensure a safe experience for the mother and baby.

   f) The presence of emergency equipment.

   g) The resuscitation of [Baby A].

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a) Antenatal services in the absence of the LMC

The National Service Specifications for Primary Maternity Facilities, for antenatal care, does not specify any expectation of the facility to provide antenatal care to the woman and her baby when that woman has an LMC. Antenatal care is the responsibility of the LMC; in this case that was [Ms D]. The antenatal care given to [Ms A] by [Ms F] was of a reasonable standard. [Ms F] was not the LMC; any CTG taken would need to be interpreted by the LMC. [Ms F] informed the LMC that [Ms A] had attended, that she had heard a strong and regular fetal heart and that [Ms A] had expressed a concern about reduced movements. Any further care was the responsibility of the LMC to either perform herself or arrange another midwife to do this on her behalf.

b) Antenatal care by the LMC

[Ms A] had a history of small babies and reduced fetal movements in both previous pregnancies. During the current pregnancy, [Ms A] reported reduced fetal movements on the 9th November and again [a few days later]. Reduced fetal movements are known to be associated with unexpected stillbirth and because of this should always be investigated. Investigations that would include a CTG and commencing a kick chart and may have included an ultrasound scan and a discussion over where was the safest place to birth. [Ms D] states that there was no discussion about reduced movements at the antenatal check on the 9th November. She acknowledges receiving the message [a few days later] but chose to do nothing further as ‘all seemed well’. The NZ College of Midwives Standards for Practice states that if [Ms D] could not attend herself, she is responsible for ensuring another midwife does. The antenatal care given to [Ms A] by [Ms D] falls below acceptable standards.

c) Labour care in the absence of the LMC

The National Service Specifications for Primary Maternity Facilities, for labour and birth care, states that the facility will ‘provide care according to the woman’s needs until the LMC arrives’. [Ms E] was the facility midwife on duty that evening. For a woman in advanced labour, as [Ms E] correctly assessed [Ms A] to be, it was her responsibility to provide full labour care to [Ms A] until [Ms D] arrived. Full labour care may include:

- Assessing the woman’s wellbeing,
- Checking her blood pressure and pulse,
- Discussing the need for a vaginal examination,
- Assessment of the contractions, lie, presentation and descent of the baby,
- Assessment of the baby’s wellbeing, including the heart rate,
- And continuing regular assessment of the woman and baby and progress of labour.

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[Ms A] arrived at the [birthing unit] at 0115 hours. At 0120 [Ms A] felt like pushing. At 0130 the FHR was checked, the presenting part was visible. At 0145 the head was born. At 0148 the baby was born. [Ms E] has not listened to the FHR frequently enough, she did not continue to do regular assessments of the baby between 0130 and 0145. It is usual for the fetal heart rate to be assessed every 5 minutes during the second stage of labour. This would have meant [Ms E] listening to the fetal heart at approximately 0135 and 0140. However, as [Ms E] had no warning that [Ms A] was coming, she was also responsible for finding the notes, preparing the birthing room and settling [Ms A] between 0115 and 0130. At 0130 [Ms E] saw the advancing head and the bag of membranes which was full of thick meconium, she would have realised then the need to have the resuscitaire warmed and ready. The baby's head was born at 0145, [Ms E] immediately suctioned the baby's nose and mouth. The FHR would have been difficult to locate from 0130 as the baby's head was on the perineum. I believe that the care given is below normal expectations but reasonable under the circumstances when [Ms E] was own her own and had only a short time to prepare the environment.

d) Labour care by the LMC

There is no requirement in either the National Service Specifications for Primary Maternity Facilities or Section 88 for the LMC to notify the Maternity Facility that a woman is coming. The National Service Specifications for Primary Maternity Facilities state that it is the responsibility of the facility to notify the LMC of the woman's arrival. Section 88 states that there is a requirement for the LMC to make every effort to attend the woman within, on average, twenty minutes of the woman's arrival at the Maternity Facility. In the circumstances where [Ms D] had just returned from another birth and needed to change her clothes and get petrol, it would be reasonable for her to take longer than usual. However, in these circumstances, it would be reasonable to expect that [Ms D] would notify the Maternity Facility of her expected late arrival and pass on the information of [Ms A's] previous quick labours and any other relevant information, e.g the history of reduced fetal movements. The care given by [Ms D] is below expected standards.

e) Supplying sufficient qualified staff to ensure a safe experience for the mother and baby

The National Service Specifications for Primary Maternity Facilities states that the facility is to ensure a midwife is available 24 hours/day, 7 days/week to provide support to the LMC during labour and birth. And to provide a mix of midwives or nurses, with a midwife on call, to supply 24 hour/day, 7 days/week postnatal care.

It would appear that the [birthing unit] relies on the presence of the LMC to ensure that this requirement is met. From the information available to me it is unclear as to

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whether the employed case loading LMC midwives also provide 24-hour cover to support the facility staff for emergency care, unforeseen circumstances or as a second midwife to non employed LMC's. If they do, then the [birthing unit] does provide sufficient qualified staff to ensure a safe experience for the mother and baby. However, if the employed case loading LMC midwives are only on call for their own women and provide on call cover for each other but not for emergencies, unforeseen circumstances, or for non employed LMC midwives, then the [birthing unit] does not appear to be meeting the requirements set in the service specifications.

In this case the rostered staff member was a midwife ([Ms E]) so at the time in question the requirements of the service specifications were being met. However, [Ms E] did not appear prepared for the role she was suddenly faced with and she did not appear to know who to phone for assistance. Without employed LMC's also being on call for emergency care, unforeseen circumstances or as a second midwife to non employed LMC's, then the [birthing unit] would not meet the requirements set in the service specifications when the rostered facility shift was covered with a registered nurse.

f) The presence of emergency equipment

The National Service Specifications for Primary Maternity Facilities states that the facility is to have adequate equipment for emergency resuscitation. It is a reasonable expectation that the resuscitaire in the birthing room will contain all the necessary equipment. It is below acceptable standards to have the emergency drugs located in another room.

g) The resuscitation of [Baby A]

It appears that [Ms E] provided a competent effort to resuscitate [Baby A] under extremely difficult circumstances. [Ms E] suctioned the baby at the perineum; she dried the baby, opened the airway, and commenced breathing and cardiac compressions. According to the Coroner's report, it is likely that [Baby A] was stillborn. To have even the smallest chance of survival, this baby needed an experienced team to attempt resuscitation. [Ms E] was not experienced; however inexperience does not mean a lack of competence. The NZ Resuscitation Council does not see the use of a laryngoscope and the ability to intubate as basic skills of a midwife. The resuscitation efforts by [Ms E] were of a reasonable standard.

2. What standards apply in this case?

a) National Service Specifications for Primary Maternity Facilities
b) New Zealand College of Midwives Standards for practice
c) Nursing Council Standards for Practice
d) Section 88
e) Health & Disability Sector Standards

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f) New Zealand Resuscitation guidelines

3. Were those standards complied with?

a) National Service Specifications for Primary Maternity Facilities
- Antenatal services in the absence of the LMC (Yes, see answer 1a)
- Labour care in the absence of the LMC (Yes, see answer 1c)
- Supplying sufficient qualified staff to ensure a safe experience for the mother and baby. (Yes, see answer 1e)
- The presence of emergency equipment (No, see answer 1f)

b) New Zealand College of Midwives Standards for practice.
- Antenatal care by the LMC (No, see answer 1b)
- The resuscitation of [Baby A] (Yes, see answer 1g)

c) Nursing Council Standards for Practice
- Antenatal services in the absence of the LMC (Yes, see answer 1a)

d) Section 88
- Labour care by the LMC (No, see answer 1d)

e) Health & Disability Sector Standards
Yes. The [birthing unit] gained accreditation for the Health & Disability Sector Standards. This accreditation was given by Quality Health New Zealand on 24/12/2004, and is valid for a period of 3 years. I see no reason to have any concern over this accreditation.

f) New Zealand Resuscitation guidelines (No, see answer 1f; Yes, see answer 1g)

4. Whether the [birthing unit] facility is appropriately accredited and licensed.

Yes. See answer 3e.

5. Whether the facility is adequately staffed at all times.

No, answered above in 1e

6. Please comment on the appropriateness and adequacy of the obstetric nurse in this case.

The antenatal care given to [Ms A] by [Ms F] was of a reasonable standard. See answer in 1a.

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7. **Was the withdrawal of the telephone and petrol allowance from the LMC appropriate?**

   I think that this is best answered by someone experienced in employment contracts. However, it seems unreasonable to withdraw these allowances prior to the cessation of employment.

8. **Please comment on adequacy of the emergency contact system for staff to call for assistance.**

   The system in place at the time of this incident did not ensure that an extra staff member could be raised quickly and easily. This should be an area of concern for all staff and management employed at the [birthing unit] as an emergency could occur in a mother or baby postnatally, and the staff member may find herself on her own. The system in place should be reviewed.

9. **Whether it is appropriate to have paediatric resuscitation drugs located in another room.**

   No, see answer 1f.

10. **Whether appropriate actions were taken following the event to review and assess any potential risk factors.**

    Following the incident, the [birthing unit] completed an incident review. This is an appropriate way in which to deal with a sentinel event, which should enable the [birthing unit] to review and assess any potential risk factors."

Reference list:

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

Nursing Council of New Zealand, (2004). *Standards for Practice.* Wellington, Nursing Council of New Zealand.

Ministry of Health, (2003). *National Service Specifications for Primary Maternity Facilities.* Ministry of Health website: www.moh.govt.nz

Ministry of Health, (2002). *Maternity services notice pursuant to section 88 of the New Zealand Public Health and Disability act.* Retrieved March 30 2004, from the Ministry of Health website: www.moh.govt.nz

New Zealand Resuscitation Council (2004). *Newborn Resuscitation for Health Professionals.*

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Additional advice provided by Ms Terryll Muir on 9 November 2006

"I have been asked to further comment on the following questions.

Section 88 4.4.2 and 4.4.3 ask for a second authorised practitioner to be available to attend the birth.

1. **What do you consider 'available' means?**
   Available means 'named on call', it means that either a roster is drawn or a named person is available. The named person does not have to be present in the room but must be available. The best availability would be on site but at home within 20 minutes from the facility would be reasonable.

National Specs 5.2.2 'Labour and Birth' ask for the facility to have a midwife available 24/7.

2. **Do you interpret that to mean a midwife should be on site to receive the woman in labour prior to the LMC arrival?**
   No, but the midwife must be available to provide support to the LMC during labour and birth. Therefore the LMC should be able to call the available midwife if she needs to. If a registered nurse was on site, she too should be able to call the available midwife if she needs to. The available midwife should be named and easy to get hold of.

I note that 5.2.3 refers to in-patient postnatal care which can be provided by a nurse with a midwife on call.

3. **What is the normal practice for birthing units?**
   The normal practice for birthing units is to have registered nurses on site providing postnatal care to women and to have an on call midwife available at all times.

The birthing unit have said their manager is on call for all responses outside of hours.

4. **Is this reasonable to expect one person to be on call for this extended period?**
   Yes, this is reasonable. Most birthing units will have one midwife who is on call for most of the week, she will be on call 24/7 and only off if she has cover arranged.

5. **Also, is the home telephone adequate as the only mode of emergency contact without any other method of communication?**
   Yes, this is reasonable. The midwife would be expected to have a pager/cellphone for when she was not at home. However, an alternative contact source at home is a good back up to ensure contact can be made if someone is on the phone or Internet at home.

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6. **What is the normal practice for on call health providers?**
   Normal practice is for health care providers to use the home telephone when they are at home and to use a pager/cellphone for when they are out.

7. **Please provide some comment about the availability of drugs.**
   It is not common practice to have the emergency drugs located in another room, however it would be acceptable practice if they can be accessed easily if requested. The drugs present on the resuscitaire are not classed as 'controlled drugs' and do not have to be locked away.

Reference list:

Ministry of Health, (2003). *National Service Specifications for Primary Maternity Facilities.* Ministry of Health website: www.moh.govt.nz

Ministry of Health, (2002). *Maternity services notice pursuant to section 88 of the New Zealand Public Health and Disability act.* Retrieved March 30 2004, from the Ministry of Health website: www.moh.govt.nz"

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Appendix 3 — Record of Settlement as supplied by Birthing unit

-2 OCT 2006
HDC AKLD

RECORD OF SETTLEMENT

BETWEEN

Employer

AND

Employee

Dated this Day 1st October 2004.

We, the undersign agree that the following Terms of Settlement have been agreed between us with regard to a employment relationship problem in which case these Terms of Settlement shall be final and binding upon us.

Terms Of Settlement

1. The Employer agrees that the Employee will be employed in a .5 position as of the 4th October 2004 at until the 31st January 2005.
2. The Employer will continue to pay the car lease of to the Employee until the 31st January 2005.
3. The Employer will continue to pay the monthly Midwifery College fee of the Employee until the 31st January 2005.
4. That the Employer will ensure that the Employee will have full use and reasonable access to the facilities of
5. The Employer will pay the costs of $1,500.00 to within 7 days of receipt of an invoice.
6. The Employer will be entitled to full reimbursement of fees under S88 of the Health and Disability Act of clients that are presently under the care of the Employee until the 31st January 2005.
7. The Employee will not make any claims or have the use of the cellphone from the 4th October 2004.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

8. The Employer will pay any outstanding entitlements, as per the Employment Agreement of the Employee by the 4th October 2004.

9. The Employee will not claim any travel reimbursements from the 4th October 2004.

10. These Terms of Settlement and all matters discussed shall remain confidential to the parties.

Signed .... Employee

Signed .... Employer

Dated this Day 1st October 2004.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.