Care and information provided to pregnant woman
16HDC01065, 19 June 2019

Midwife ~ Birth plan ~ Transfer of care ~ Complications ~ Right 4(1)

This case concerned a woman's decisions around the birth of her baby, and the information she received, and understood, when making those decisions.

The woman relocated to a new region, and at 32 weeks' gestation, transferred her care to a new lead maternity carer (a registered midwife). The woman's birth plan indicated that ideally she would have a vaginal delivery at home, but her "Plan B" was a hospital birth or a Caesarean section.

During her pregnancy, the woman received a brief record of her visits from the midwife when she requested it. The woman did not have access to the additional, more detailed antenatal notes or the GROW Chart kept by the midwife.

At 41+1 weeks' gestation, the antenatal notes identified the first finding of decreased fetal growth. There are differing versions of events about what was communicated to the woman regarding consulting an obstetrician and having a growth scan. The woman was not informed that the baby's growth had slowed, and she sent a text message to her doula that a scan had been booked to "provide a scale of health in regards to pregnancy duration, amniotic fluid and baby's health".

The woman understood from her discussions with the midwife that there would be a month-long wait time for the obstetric consultation and growth scan, and that the scan booked in a week's time was a formality. The Deputy Commissioner considered it more likely than not that the woman did not appreciate that the recommendations made were for slow growth.

At approximately 3pm, the woman began experiencing contractions. By 5.56am, she had dilated only an additional 1cm since midnight. At this juncture, a discussion about going to the hospital ensued. There are differing versions of events about this discussion and the reason for it. It was considered that the woman did not understand that the recommendation to transfer to hospital was made because of concerns about her slow progress in labour. At this time, the midwife also referred to the on-call obstetrician at the hospital as "Mr Slice and Dice".

At approximately midday, the woman was taken to the public hospital to consult with the obstetrician. It is unclear whether the midwife handed over care to hospital staff upon arrival at the hospital, and the Deputy Commissioner was unable to make a definitive finding about when transfer of care occurred.

At the hospital, the obstetrician's examination revealed a "likely deep transverse arrest", and he recommended a Caesarean section. The woman declined this and requested an epidural in the hope that the baby would turn. There are differing versions of events about whether the midwife advised the woman to decline a Caesarean section, and continued to support the woman's decision to decline a Caesarean section despite the probable deep transverse arrest. Given that the

accounts of all but the midwife indicate that she encouraged the woman to request an epidural and Syntocinon, and therefore decline a Caesarean section, it was considered more likely than not that the midwife did so encourage the woman. It was also considered more likely than not that the midwife was still reassuring the woman that she could continue to labour following the obstetrician's finding of deep transverse arrest.

At approximately 1.15pm, the first finding of a non-reassuring CTG was noted. However, the midwife documented, "CTG really reassuring," and told the woman, "[B]aby is ok."

The CTG continued to be non-reassuring, and at 2.20pm meconium-stained liquor was noted. At 2.45pm, the woman's husband went home for a shower. At 3.05pm, the obstetrician returned to see the woman. He noted that the CTG was very non-reassuring and that there was old meconium-stained liquor. He offered the woman a Caesarean section, and documented that she wanted to wait for her partner to return to make a decision. At 3.15pm, the obstetrician carried out a vaginal examination. He noted that the CTG trace was pathological, and again advised the woman to consider a Caesarean section without further delay. Her husband returned to the hospital at 3.40pm, and the baby was delivered at 4.31pm by Caesarean section, weighing 2.45kg.

At birth, the baby's Apgar scores were 4 at 1 minute and 9 at 5 minutes. Initially, the baby was blue and apnoeic, with a heart rate of less than 100 beats per minute, and required significant resuscitation.

The Midwifery Council of New Zealand carried out a review of the midwife's competence and identified a number of areas of concern. She was required to undertake a period of supervised practice for a minimum of 10 months.

Findings

It was held that the midwife failed to provide services to the woman with reasonable care and skill, for the following reasons:

- The midwife failed to communicate effectively to the woman that the baby's growth had slowed, and failed to follow the actions set out in the *Referral Guidelines* when her recommendations for slowed growth were declined.
- The midwife failed to communicate effectively to the woman that transfer to hospital was recommended owing to concerns about slow progress in labour, rather than concern as to how the woman was coping with pain.
- The midwife referred to the obstetrician as "Mr Slice and Dice", which created doubts in the woman's mind and tainted her interactions with him.
- Upon transfer to hospital, the midwife failed to ensure that there was clarity around her role and responsibility with respect to the woman's care.
- The midwife did not communicate clearly that she supported a Caesarean section, and explain the reasons for this.

- The midwife documented that the CTG was “really reassuring”, and told the woman that the baby was “ok”, when the CTG was deteriorating.
- The midwife failed to provide the woman with adequate antenatal notes during her pregnancy.

Accordingly, it was found that the midwife breached Right 4(1).

Adverse comment was made about the DHB — in particular, the lack of clarity around whether clinical responsibility had transferred to secondary care, and the communication to the woman about the need for a Caesarean section.

Recommendations

It was recommended that the midwife provide a written letter of apology to the family.

It was recommended that the Midwifery Council of New Zealand (a) consider whether further review of the midwife’s competence is warranted; and (b) advise HDC when the midwife’s supervision has concluded, and how she demonstrated to the Council that its concerns about her competence were addressed satisfactorily.

It was recommended that the DHB review its maternity protocol for the Transfer of Clinical Responsibility from Primary to Secondary Care, and advise HDC whether any further improvements can be made.