Registered Midwife, RM B

A Report by the
Deputy Health and Disability Commissioner

(Case 16HDC01065)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. This investigation focuses on a woman's decisions around the birth of her baby, and the information she received, and understood, when making those decisions.

2. On relocation to another region, at 32 weeks' gestation, Mrs A transferred her care to lead maternity carer (LMC) registered midwife (RM) RM B. Mrs A's birth plan indicated that her ideal birth was a vaginal delivery home birth, but her "Plan B" was a hospital birth or a Caesarean section.

Antenatal care

3. Mrs A told HDC that during her pregnancy, she received a brief record of her visits from RM B when she requested it. Mrs A did not have access to the additional, more detailed antenatal notes or the GROW Chart kept by RM B.

4. On 3 Month3,[1] 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 Mrs A regarding consulting an obstetrician and having a growth scan. Mrs A told HDC that she was not informed that Baby A's growth had slowed, and 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".

5. Mrs A understood from the discussions with RM B 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 that it was more likely than not that Mrs A did not appreciate that the recommendations made were for slow growth.

Labour at home

6. On 5 Month3 at approximately 3pm, Mrs A began experiencing contractions. On 6 Month3 at 5.56am, Mrs A 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. The Deputy Commissioner considered that Mrs A did not understand that the recommendation to transfer to hospital was made because of concerns about her slow progress in labour. At this time, RM B also referred to the on-call obstetrician at the hospital as "Mr Slice and Dice".

7. At approximately midday on 6 Month3, Mrs A was taken to Hospital 1 to consult with obstetrician Dr C. It is unclear whether RM B 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.

8. At the hospital, Dr C examined Mrs A and made a finding of "likely deep transverse arrest[2]" and recommended a Caesarean section. Mrs A declined this and requested an epidural

[1] Relevant months are referred to as Months 1–7 to protect privacy.
[2] Mechanical obstruction of labour in which the fetal head may be unable to rotate from a non-deliverable transverse position to a deliverable position.

and hoped that the baby would turn. There are differing versions of events about whether RM B advised Mrs A to decline a Caesarean section and continued to support Mrs A's decision to decline a Caesarean section despite findings of deep transverse arrest. Given that the accounts of all but RM B indicate that she encouraged Mrs A to request an epidural and Syntocinon,[3] and therefore decline a Caesarean section, the Deputy Commissioner considered it more likely than not that RM B did so encourage Mrs A. The Deputy Commissioner also considered it more likely than not that RM B was still reassuring Mrs A that she could continue to labour following Dr C's finding of deep transverse arrest.

9. Mrs A continued to labour in hospital. At approximately 1.15pm, the first finding of a non-reassuring CTG was noted. However, RM B documented, "CTG really reassuring," and told Mrs A, "[B]aby is ok."

10. The CTG continued to be non-reassuring, and at 2.20pm it was documented that there was meconium[4]-stained liquor. At 2.45pm, Mr A went home for a shower. At 3.05pm, Dr C returned to see Mrs A. He noted that the CTG was very non-reassuring and that there was old meconium-stained liquor. He offered Mrs A a Caesarean section, and documented that she wanted to wait for Mr A to return to make a decision. At 3.15pm, Dr C returned and carried out a vaginal examination. He noted that the CTG trace was pathological, and again advised Mrs A to consider a Caesarean section without further delay. Mr A returned to the hospital at 3.40pm, and Baby A was delivered at 4.31pm by Caesarean section, weighing 2.45kg.

11. At birth, Baby A's Apgar scores[5] were 4 at 1 minute and 9 at 5 minutes. Initially, Baby A was blue and apnoeic,[6] with a heart rate of less than 100 beats per minute, and required significant resuscitation.

Findings

12. The Deputy Commissioner found that RM B failed to provide services to Mrs A with reasonable care and skill, for the following reasons:

- RM B failed to communicate effectively to Mrs A that Baby A's growth had slowed, and failed to follow the actions set out in the *Referral Guidelines* when her recommendations for slowed growth were declined.
- RM B failed to communicate to Mrs A effectively that transfer to hospital was recommended owing to concerns about slow progress in labour, rather than concern as to how Mrs A was coping with pain.

[3] Syntocinon is a hormone that stimulates the muscles of the uterus (womb) to produce rhythmic contractions.
[4] Meconium is the first faeces passed by a newborn, and is green/black in colour. In some circumstances, the baby passes meconium while still inside the uterus. This may be a sign of distress, or can also be a normal process in a post-mature baby.
[5] The APGAR score is a test given to newborn babies soon after birth. The test checks a baby's Appearance (skin colour), Pulse (heart rate), Grimace response (reflexes), Activity (muscle tone), and Respiration (breathing rate and effort).
[6] Lacking respiration.

- RM B referred to Dr C as "Mr Slice and Dice", which created doubts in Mrs A's mind and tainted the interactions she went on to have with him.
- Upon transfer to hospital, RM B failed to ensure that there was clarity around her role and responsibility with respect to Mrs A's care.
- RM B did not communicate clearly that she supported a Caesarean section, and explain the reasons for this.
- RM B documented that the CTG was "really reassuring", and told Mrs A that the baby was "ok", when the CTG was deteriorating.
- RM B failed to provide Mrs A with adequate antenatal notes during her pregnancy.

13. Accordingly, it was found that RM B breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[7]

14. 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 Mrs A about the need for a Caesarean section.

Recommendations

15. The Deputy Commissioner recommended that RM B provide a written letter of apology to Mr and Mrs A for the failings identified in this report.

16. The Deputy Commissioner recommended that the Midwifery Council of New Zealand (a) consider whether any further review of RM B's competence is warranted in light of the findings in this report; and (b) advise HDC when RM B's supervision has concluded, and how she has demonstrated to the Council that its concerns about her competence have been addressed satisfactorily.

17. The Deputy Commissioner recommended that the DHB review its maternity protocol for the Transfer of Clinical Responsibility from Primary to Secondary Care in light of the findings in this report, and advise whether any further improvements can be made.

[7] Right 4(1) provides: "Every consumer has the right to have services provided with reasonable care and skill."

Complaint and investigation

18. The Health and Disability Commissioner (HDC) received a complaint from Mr and Mrs A about the services provided by RM B. The following issue was identified for investigation:

- *Whether RM B provided Mrs A with an appropriate standard of care.*

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

20. The parties directly involved in the investigation were:

Mrs A	Consumer/complainant
Mr A	Complainant
RM B	Provider/registered midwife

21. Further information was received from:

District health board	Provider
Dr C	Obstetrician/gynaecologist (O & G)
RM D	Registered midwife
RM E	Hospital midwife
RM F	Hospital midwife
Ms G	Doula
RM H	Clinical Maternity Manager (CMM)
Dr I	O & G registrar
RM J	Registered midwife

Also mentioned in this report:

RM K	Midwife

22. Independent expert advice was obtained from a registered midwife, Dr Carolyn Young (**Appendix A**), and an obstetrician/gynaecologist, Dr Ian Page (**Appendix B**).

Information gathered during investigation

Introduction

23. This report discusses the care provided to Mrs A by RM B (a registered midwife and lead maternity carer). Mrs A was pregnant with her first child, conceived by in vitro fertilisation (IVF).

24. A number of issues have been raised about the care provided to Mrs A during the antenatal period, while she laboured at home, and when she was transferred to Hospital 1, where her child, Baby A, was delivered by emergency lower segment Caesarean section.

Evidentiary issues

25. There are discrepancies in the computerised maternity notes provided to HDC by Mrs A and RM B. Mrs A alleges that RM B has written the majority of her notes retrospectively after being complained about, and has fabricated points to address specific concerns Mrs A has raised. RM B categorically rejects the assertion that her notes are not a true record, or were created as a result of this complaint.

26. RM B provided HDC with a letter from the maternity clinical notes software provider, which advised that notes cannot be altered more than 24 hours after they have been entered. If changes are required after 24 hours, the content of the note can be copied and added to a new note, with any alterations.

27. An audit was carried out on RM B's computerised notes. Only one entry was found to have a modified date that was different from the date on which it was written (discussed below).

Disputed clinical records

Antenatal Table and GROW[8] Chart

28. There are two copies of the Antenatal Table, which records maternal observations such as maturity, fundal height, blood pressure, fetal heart, and fetal movements. RM B's version, date stamped 29 Month7 [9] (RM B's Antenatal Table), includes fundal height [10] measurements, whereas Mrs A's copy of the Antenatal Table, date stamped 19 Month2 (Mrs A's Antenatal Table), does not.

29. RM B provided HDC with an Antenatal GROW Chart. However, Mrs A advised that she finds it "incredible" that the chart exists, as she was never shown this chart at any point during her pregnancy.

30. RM B explained that her practice was to record fundal height measurements in her diary and then transfer these straight onto the GROW Chart after an appointment. Therefore, when Mrs A requested her antenatal notes after an appointment on 19 Month2, RM B had not entered the fundal heights into the Antenatal Table sent to Mrs A. In addition, RM B said that she also did not realise that she had not included the GROW Chart (which did have the fundal height recordings) when she sent Mrs A her notes in Month2.

31. RM B reported that the GROW Chart is part of the computer program she uses, which automatically generates a chart for each woman, and therefore, from the first

[8] Customised charts delineate the Gestation Related Optimal Weight (GROW) for each baby, by adjusting for characteristics such as maternal height, weight, parity, and ethnic origin, predicting the growth potential by excluding pathological factors such as smoking and diabetes.

[9] Relevant months are referred to as Months 1–7 to protect privacy.

[10] The distance from the pubic bone to the top of the uterus measured in centimetres. Used to assess fetal growth.

appointment, she started a customised GROW Chart. She reported that she carried the GROW Chart with her in her diary.

Fundal height measurement

32. Mrs A told HDC that fundal height was not measured at every visit. On the other hand, RM B stated that she is "a fastidious measurer when it comes to antenatal checks", and she knows that she measured Mrs A at every antenatal visit except one, on 26 Month2, as this was not required.[11] As discussed below, Baby A was born small for a full-term baby (2.45kg).

RM B's additional antenatal notes date stamped 29 Month7

33. Prior to requesting a copy of her full notes in Month7, Mrs A was not aware that additional antenatal notes date stamped 29 Month7 (Additional Antenatal Notes) existed. These notes include detailed commentary of each of RM B's antenatal appointments with Mrs A, as well as a note that RM B headed "Labour and Birth Additional Notes". Mrs A told HDC that "these notes contain half-truths and events which did not occur".

34. The "Labour and Birth Additional Notes" are not together with the other labour and delivery notes, and contain detailed documentation of an important junction during Mrs A's labouring at home.[12] RM B told HDC:

> "The reason these notes are in a different place is because I must have mistakenly at the time of being up all night and tired hit the wrong button when I entered the notes and put them under 'Antenatal' instead of 'Labour and Birth'. I did not notice this until days after the birth."

35. The audit information provided to HDC shows that the notes titled "Labour and Birth Additional Notes" were entered on 6 Month3 but modified on 1 Month7. RM B explained that on 1 Month7, she attempted to move this entry to where the rest of the labour and delivery notes were located. When she did this, this was noted in the audit trail. RM B stated that her action was in good faith and, other than attempting to move the entry, it was not modified in any way.

Labour and Delivery Notes date stamped 6 Month3

36. The DHB, Mrs A, and RM B have provided HDC with the same set of "Labour and Delivery" notes, all date stamped 6 Month3, and this document is not in dispute. The audit trail provided does not indicate that any modifications were made to these notes.

Background

37. On relocating to another region, at 32 weeks' gestation, Mrs A transferred her care to RM B. Mrs A's pregnancy had been uneventful up to this point.

[11] RM B advised that she had visited Mrs A the previous week, and fundal height was measured then.
[12] See section below titled "*6 [Month3], 5.56am — was there a recommendation to go to hospital?*".

Mrs A's birth plan

38. Mrs A told HDC that although she had a preference for natural approaches, she was more than open to necessary medical options. Her birth plan outlined that her ideal birth would be a "vaginal birth at home if possible"; however, it did factor in a "Plan B", which was a hospital birth or Caesarean section. RM B told HDC that Mrs A had "very clear and firm ideas" about having a home water birth.

Antenatal care after 32 weeks

4 Month1 to 26 Month2

39. Between 4 Month1 and 26 Month2 (inclusive), RM B visited Mrs A at her home a total of six times. RM B told HDC that at every visit other than the one on 26 Month2, she measured fundal height. Mrs A disputes that this occurred.

40. RM B also made detailed notes of each visit in her Additional Antenatal Notes. Mrs A disputes most of the documentation in these notes, and advised that "these notes contain half-truths and events which did not occur".

3 Month3 — Recommendation of scan and consultation with specialist at 41 weeks

41. RM B told HDC that at this appointment, Baby A's growth had slowed and had "dropped off" the customised growth chart.

42. As mentioned above, Mrs A's Antenatal Table does not contain any notes for this date, as they were provided to her prior to this visit. RM B's Antenatal Table notes that the fundal height was 36cm, and states:

> "Looks well. Feeling she is ready for baby to come now. [Not] felt like this until now. Discussed natural methods of induction … Offered [a] stretch and sweep.[13] Declined. May want one in the weekend. Discussed [induction of labour] and seeing the O&G. Declined at this stage. Discussed biophysical profile scan,[14] not wanting that at this stage either. To see on Monday if not in the weekend."

43. RM B's Additional Antenatal Notes record:

> "At this visit we had a long discussion about what the plan should be going forward. As per Section 88, I recommended a referral to the obstetrician. This could include a medical induction and CTG[15] monitoring. I strongly recommended a scan for growth, liquor[16] volume and biophysical profile. I was concerned that baby's growth as per GROW chart was dropping off.

[13] Digital separation of the membranes from their cervical attachment, which can escalate the onset of labour.
[14] An ultrasound that tracks the baby's movement and checks the amount of amniotic fluid.
[15] Cardiotocography (CTG) monitoring (the combined monitoring of the baby's heartbeat in utero and the mother's uterine contractions, if any). CTG facilitates interpretation of the fetal heart rate, either alone or in relation to the contractions, and may be used to assist with the identification of fetal well-being and/or distress.
[16] Amniotic fluid — the fluid that surrounds the baby in the uterus.

> …
>
> [Mrs A] at this time, declined all of these recommendations as stated above. I started to feel like my professional opinion wasn't valued or respected …
>
> …
>
> I demanded a scan at 42 weeks if baby wasn't born as I would no longer feel comfortable providing care in what is developing into a high risk birth, therefore I made an appointment at [the radiology service] on 10th [Month3] at 4pm. We agreed to meet again on the 9th [Month3] at 12pm if baby wasn't born to review labour and birth options."

44. RM B said that she explained to Mrs A the risk regarding the finding of slowed growth. RM B told HDC: "I said that the baby's growth could indicate a condition that affect[s] baby's health." Mrs A told HDC:

> "I wasn't keen on unnecessary scans although I would certainly have had one if advised to or if any indication was given to me that anything unusual was going on with the baby's growth."

45. RM B told HDC that as she had not been able to gain Mrs A's consent for the scan, she advised that as a back-up plan, she could in any event have arranged a scan at 42 weeks' gestation at the latest if Baby A had not been born by that time.

46. Mrs A disputes ever being told that Baby A's growth was slowing, or being advised to see an obstetrician or to have a scan because of this. However, Mrs A does state that she was "given the option" to go to another hospital to see an obstetrician and have a scan there. Mrs A told HDC that RM B advised that there was a month-long waiting list to see an obstetrician and receive a scan at Hospital 1, and therefore she would make a booking at another hospital in one week's time, in case Baby A had not been born.

47. Mrs A reported that RM B stated that Baby A would definitely be born by then, and that she was making the booking "to cover [her] ass". Mrs A told HDC that this statement stuck with her, as she remembered being shocked by RM B's attitude. Mrs A reported that whilst she did express displeasure at the idea of having to drive to the other hospital (one hour away) at such a late stage of her pregnancy, she "did not say yes or no" to a scan and seeing an obstetrician, as RM B made it clear that Baby A's birth would be imminent.

48. Mrs A's doula,[17] Ms G, told HDC that after this appointment, Mrs A sent her a text message and advised that a scan had been booked. The message read:

> "I am booked in on Tuesday for a scan [at another hospital] which will provide a scale of health in regards to pregnancy duration, amniotic fluid and baby's health. There is a

[17] A doula is a companion who supports expectant parents in pregnancy, during labour and birth, and postnatally.

> one week wait time to get an appointment, so that is pretty much the main reason it's booked — just as another option as a back up."

49. Doula Ms G recollected:

> "There was absolutely no indication in these messages, or when seeing [Mrs A] the next day, that [RM B] had insisted on booking this scan. Rather, she had booked it to cover all her bases and to buy them a little more time. At no point do I recall [Mrs A] mentioning an issue with size/measurements."

5 and 6 Month3 — Labour at home

First 12 hours

50. On 5 Month3, at approximately 3pm, Mrs A began experiencing contractions. The "Labour and Delivery" notes[18] document that Mrs A contacted RM B at approximately 4pm to advise that she had been having some contractions for the past hour, but that RM B was not yet needed. Between 4.45pm and 5.30pm, Ms G arrived and noted that Mrs A's contractions were not extremely regular at this time. At 8.53pm, RM B received a call from Mrs A, who asked her to attend. RM B arrived at Mrs A's home at approximately 9.10pm. The people present at this time were Mr and Mrs A, Ms G, and RM B.

51. RM B recorded Baby A's fetal heart rate (FHR) at 9.20pm, 9.55pm, 10.23pm, 10.54pm, 11.09pm, and 11.48pm on the evening of 5 Month3, and at 12.08am, 12.50am, 1.19am, 2.23am, 3.15am, 3.49am, 4.36am, 5.15am, and 5.56am on the morning of 6 Month3. No issues were identified.

52. At 00.31am on 6 Month3, RM B carried out a vaginal examination and noted that the cervix was central, fully effaced, and 6cm dilated. Station was not documented. Spontaneous rupture of the membranes (SROM) occurred at 3.15am, with the liquor being noted as clear.

53. RM B told HDC that her fetal and maternal assessments were not in accordance with her normal practice, owing to Mrs A's direction that assessments be very minimal in labour. RM B reported that the care provided was in keeping with what Mrs A would allow her to perform, but that Mrs A was aware of, and given, the option of more frequent monitoring. In response to the provisional decision, Mrs A told HDC that she had no desire for, nor did she request, less than normal practice at any point in her pregnancy and labour.

6 Month3, 5.56am — was there a recommendation to go to hospital?

54. At 5.56am, RM B documented that she carried out a vaginal examination and noted that the cervix was 7cm dilated and the fetus was in the occiput posterior[19] position. Station was not documented. The notes also state:

[18] These notes are not in dispute.

[19] Occiput posterior (OP) position is when a baby is head down but facing the mother's abdomen. It is a common fetal malposition, and can slow down labour.

> "Discussed with [Mrs A] options of what to do as she is very tired. Phoned hospital and spoke to [RM D] Midwife[20] [regarding] who is on overnight/today. Plan to start homeopathic remedies and try some change of positions."

55. RM D confirmed that she received a call from RM B at this time. She was given a brief update of progress overnight and the findings of the recent vaginal examination. She told HDC that RM B reported that "[Mrs A] had been offered a transfer into the Maternity Unit but had declined, preferring to try positional changes and some homeopathic remedies first". RM B also requested that RM D attend the labour at Mrs A's home after she finished her shift at the hospital.

56. In RM B's "Additional Labour and Birth Notes", typed up at the end of the "Additional Antenatal Notes" and separate from the rest of the labour and delivery notes, the following was also recorded at 5.56am:

> "When I did the second VE, I found despite good strong contractions and SROM since last assessment she had made very little progress, 1cm. The baby was in [an occiput posterior] position and I discussed with [Mrs A] and [Mr A] what that meant, using my Handbook for Labour and Delivery as a reference to explain the position of the baby. [Mrs A] was tired and had had a long night of labour. I advised her that she needed to go to the hospital and have a consultation with an obstetrician as per referral guidelines (5021).
>
> My recommendations were:
>
> - Go to the hospital
> - Obstetric consultation and review due to failure to progress
> - If clinically appropriate, have an epidural (as [Mrs A] was fatigued), so she could get some rest, Syntocinon[21] if required for stronger contractions
> - Hand over to Secondary Care
>
> [Mrs A] declined as she wanted to try change of position and homeopathy. Plan to review situation at 7.30am when [RM D] was there."

57. Ms G's notes differ from RM B's notes. Ms G's notes state:

> "Another [vaginal examination] to assess any change. [RM B] determines [Mrs A] is now 7cms [dilated] and at this point suggests the baby might be posterior. She begins the discussion of what the next options might be, as [Mrs A] appears knackered and is having quite a few tearful moments now. [RM B] suggests that, ideally, an epidural would be good so [Mrs A] could get some rest and might find the strength to carry on. [RM B] rings the hospital and speaks to [RM D]. She asks which [obstetrician] is on.

[20] RM D told HDC that RM B asked her to be Mrs A's second midwife for the home birth. RM D is also a core midwife at Hospital 1.

[21] Syntocinon is a hormone that stimulates the muscles of the uterus (womb) to produce rhythmic contractions.

> [RM B] tells us 'Dr Dice'n'Slice' is on and implies that it's not so likely he'll agree to the epidural and would want to give her a [Caesarean] section straight away. [Mrs A] is pretty insistent she wants to avoid a [Caesarean] section, if possible, and it's decided other options would be tried first. [RM B] starts homeopathic remedies."

58. Ms G told HDC:

> "At no point do I recall [RM B] telling [Mr and Mrs A] there was failure to progress … I do not recall these recommendations of hospital, [obstetric] consult etc., being made at this time …
>
> I believe there was the suggestion of perhaps going to the hospital for an epidural 'depending who is on' … but upon calling the maternity ward and finding out the obstetrician … on duty, [RM B] recommended first trying a change of position and homeopathy."

59. Similarly, Mrs A told HDC:

> "At no point did [RM B] discuss failure to progress with either [Mr A] or myself … [RM B] advised me to go to the hospital to get some pain relief and said I could still attempt a vaginal birth, saying she thought this more likely to happen if I had some pain relief."

60. Mrs A advised that RM B said that the obstetrician coming on duty was "Mr Slice and Dice". Mr A recollected that RM B advised him and Mrs A that the obstetrician on duty was "a slice and dice and would definitely want to do a [Caesarean] section and we had to make a decision now and get to hospital" before the obstetrician came on duty. Mr A expected that they would be leaving following this, but said that RM B "decided it was too late, they would take a wait and see approach". Mr A also told HDC that RM B talked to Mrs A and convinced her that they should try to turn the baby first.

61. RM B confirmed that she advised Mr and Mrs A that the obstetrician coming on duty was known as "Mr Slice and Dice", and accepts that this was inappropriate.

5.56am–11.39am

62. During this time period, RM B monitored the FHR at 6.40am, 7.03am, 7.33am, 8.04am, 8.17am, 8.27am, 8.48am, 9.17am, 9.43am, 10.19am, 10.56am, 11.16am, and 11.39am. No concerns were noted.

63. At approximately 7.30am, at the request of RM B, RM D arrived at Mrs A's home, and carried out a vaginal examination at 7.46am. It was documented that the cervix was fully effaced, well applied, 8 to 9cm dilated, and the station was 0 to –1. During this time, it was noted that Mrs A's liquor was still clear.

64. At 9.54am, RM D carried out another vaginal examination. This time a left anterior lip[22] was noted. No other findings were documented.

6 Month3, 11.55am — final VE at home and transfer[23] to hospital

65. At 11.55am, RM B carried out another vaginal examination. She found that the cervix was 7cm dilated and not well applied. No further detail was recorded regarding this vaginal examination. RM B documented:

> "Decision made to transfer to hospital. Spoke to [on-call obstetric consultant [Dr C] on call O & G]. Plan to go to hospital for epidural and [Syntocinon]. I have advised that most likely she will be advised a [Caesarean] section. Phoned ward to let them know about admission."

66. RM B told HDC that she advised Mrs A that "she needed to ask the obstetrician for information to make an informed choice. If he only offered a caesarean section, she could ask if there were other options she could try first if it was safe." RM B stated that it was not within her scope of practice to make recommendations one way or the other, and she advised Mrs A of this.

67. Ms G's notes at this time document:

> "[RM B] now tells [Mrs A] the decision really needs to be made and they need to head into hospital. She assures [Mrs A] she has spoken to [the obstetrician] and he has agreed to an epidural and possible [Syntocinon]. [RM B] advises that [the obstetrician] will likely insist on a [Caesarean] section, but that it is [Mrs A's] choice and that it's worth trying this other way first."

68. RM B told HDC that she advised Mrs A that if Dr C offered only a Caesarean section, she could ask if there were other options she could try if they would be safe.

69. Mrs A told HDC that RM B coached her on what to say to Dr C, which was to request an epidural and still try for a vaginal birth. Similarly, Mr A reported that as they were getting ready to leave for the hospital, RM B was "coaching [Mrs A] as what to say and what they wanted when we got to the hospital". Ms G recalled that RM B "discussed what procedures [Mrs A] would ask for to ensure she was given a chance to birth naturally".

<u>Communications between RM B and Hospital 1</u>

70. RM B reported that she called Dr C and explained the situation to him. She advised that Mrs A was not making sufficient progress but that Mrs A still desired a natural birth "if possible". RM B suggested to Dr C on the telephone that "an epidural and syntocinon may be an option after a full assessment by himself". She recalled Dr C simply responding, "Bring her in, bring her in."

[22] When the cervix gets caught between the pelvis and the baby's head.
[23] Transfer means the physical transfer of a woman from a primary maternity unit or home to a base hospital, either before, during, or after labour. This may or may not be accompanied by a transfer of care.

71. RM B told HDC that she also telephoned the maternity ward and spoke to the midwife, and advised her of the admission and completed SBARR[24] with her. RM E confirmed that she took a call from RM B at this time, but said that she did not receive any verbal handover. In the DHB's clinical notes, RM E documented: "Phone call received from [RM B]. Has spoken to on call O&G [Dr C] for transfer in from home birth for failure to progress." The notes do not include details of an SBARR discussion.

Transfer of care[25] to secondary care

72. There is a lack of clarity around when Mrs A transferred from LMC care to secondary obstetric care. Based on the information provided to this Office, there are three points in time where transfer of clinical care has been asserted to have occurred — first, upon arrival at the hospital; secondly, after the consultation with Dr C at 12.20pm; and thirdly, at approximately 2pm when the epidural was sited.

73. RM B told HDC that she advised Mrs A before they left her home that once they arrived at the hospital, she would be handed over to secondary care, and RM B would become Mrs A's support person only.

74. Mrs A told HDC:

> "I thought [handover] was meant to happen when we got to the hospital and was part of my confusion at hospital as to who was my primary caregiver, as [RM B] was still there participating actively in my care."

75. Mr A told HDC:

> "[RM B] told us that when we got to the hospital we would be out of her care and in the care of the hospital. This is clearly not what happened. She stayed in control, telling hospital staff what to do and what she wanted."

76. Ms G stated: "I certainly don't recall the mention of handover to secondary care at any point — I don't think this happened at all."

77. RM B reported that Mrs A "begged" her to stay to provide support after she had handed over care, as Mrs A was distressed about going to hospital and what might happen there. RM D also stated that at Mrs A's request, she and RM B remained to support her. Ms G's notes at this time document that Mrs A was "very upset off and on. Crying and afraid." On the other hand, Mrs A told HDC: "I would have been perfectly ok with [RM B] transferring my care to the obstetrician or the hospital at any point." In response to the provisional decision, Mrs A added that "no begging occurred at any point".

[24] Situation, Background, Assessment, Recommendation, Response — a structured method for the communication of critical information.

[25] Transfer of care means transfer of clinical responsibility for decision-making regarding the woman's care from a primary-based LMC to the secondary- or tertiary-based specialist. It may occur during pregnancy, labour, or in the postnatal period.

Midday — arrival at hospital

78. At approximately midday, Mr and Mrs A, RM B, RM D, and Ms G arrived at the maternity unit. Ms G observed that upon arrival at the hospital:

> "[I]t became very obvious to me that there were existing issues at play between [RM B] and [Dr C] as the mood and conversation between them was tense, and at times undermining from both sides."

79. RM E recollected that when RM B entered the room following her discussion with Dr C, she said to Mrs A: "[Dr C wants] to slice and dice you and get your baby out, you have the right to say no." RM E said that she left the room after this. RM B told HDC: "I strongly refute that I said 'Mr Slice and Dice' in the room in front of the staff midwife, this was never raised until after the complaint to HDC."

80. In the Labour and Delivery Notes, RM B wrote at 12.20pm: "[Mrs A] understands that she is now secondary care. Hand over to core midwives and O&G." RM B told HDC that it has been her practice since 2006 to hand over all secondary care upon arrival at the hospital, and Mrs A was fully informed that this would happen once she arrived at the hospital. RM B stated: "I know and believe everyone knew handover had happened as per my documentation." RM D told HDC that it was also her understanding that "the care was handed over on arrival at the maternity unit".

81. Handover is not documented in Mrs A's hospital notes, and the DHB told HDC that RM B's notes were not countersigned by a staff midwife as per the process of agreement at handover from primary to secondary care.

82. The DHB's Maternity Protocol on the Transfer of Clinical Responsibility from Primary to Secondary Care states:

> "Where a Transfer of Clinical Responsibility occurs as per LMC access agreement (LMC has declared they will not manage epidural) Transfer of Clinical responsibility occurs at the time the anaesthetist arrives to site the epidural. The Staff midwife will provide assistance to the anaesthetist for the procedure. The LMC may choose to stay to provide support to the woman."

83. RM B added that the Maternity Manager at the time (RM H) also knew of her intention and her long-standing practice to hand over care at the hospital. RM H told HDC that RM B "had stated [Mrs A] had wanted [RM B] to stay with her", and that the core midwives were working collegially with RM B and assisting her at this point.

84. RM E told HDC: "There was never any verbal handover to myself as the core midwife." She said that she stayed in a support role to RM B until the epidural was sited, as per the DHB protocol.

12.20pm — Dr C's review

85. Dr C told HDC that he examined Mrs A at 12.20pm and had "a three way discussion between specialist, patient and the LMC". Dr C documented the following regarding his discussion with RM B about Mrs A's labour so far:

> "1/ Labour started yesterday afternoon
> 2/ [Cervix] 6cms at 12 midnight
> 3/ [Spontaneous rupture of membranes] at 3am — clear fluid
> 4/ No progress since then in spite of good regular contractions
> 5/ CTG monitoring in progress"

86. Dr C documented the following findings from his vaginal examination:

> "[Cervix] 5–6cm
> Vertex occipital transverse
> Oedema of anterior lip forming[26]
> Small caput +
> Vertex — 2cms
> Likely deep transverse arrest[27]/CPD[28]"

87. Dr C told HDC that he recommended a Caesarean section. However, he stated: "[Mrs A] and her LMC decided to ignore my advice and go for a vaginal birth. They wanted epidural for pain relief." He documented his discussion as follows:

> "In view of the above & being an IVF pregnancy and [Period of Gestation] — [Term] + 11 [days]
> Safest option is to deliver her by [Caesarean] section
> [Caesarean] section offered to patient …
> Patient declined [Caesarean] section
> Wants to have epidural — agreed
> For epidural"

88. Mrs A told HDC that she found Dr C to be abrupt, impatient, and rude. She stated that he did not ask her if she had any questions, and did not stay in the room to allow her to process what he was saying. Mrs A said that he did not explain the risks and benefits of having a Caesarean section or what the procedure involved. Similarly, Mr A stated that he found Dr C to be rude and arrogant.

89. Mrs A told HDC:

> "I was in no fit state to be in charge of such critical decisions by myself after the prolonged and painful labour. I was exhausted and dehydrated. There should have been care and time spent informing me of the gravity of the situation."

[26] Swelling of part of the cervix.
[27] Mechanical obstruction of labour in which the fetal head may be unable to rotate from a non-deliverable transverse position to a deliverable position.
[28] Cephalopelvic disproportion occurs when a baby's head or body is too large to fit through the mother's pelvis.

90. Ms G documented that when Dr C came in to assess Mrs A, "he [seemed] to already be on the defensive and [was] quite abrupt".

91. Mr A said that he noticed that when Dr C entered the room, "there was an instant disdain towards each other with him and [RM B]". Mr A stated:

> "[Dr C] did an examination and he was very direct in what he found. His recommendation to [Mrs A], [RM B] and myself was [that Mrs A] needs a [Caesarean] section as no progress, baby in occiput posterior presentation, fears that baby could move down further and this would make a delivery by [Caesarean] section more difficult. [A Caesarean] section needed now."

92. Mr A added that in response to Dr C's recommendation, Mrs A "recited what [RM B] had told her to say", and declined the Caesarean section. Mr A recalled that Dr C told Mrs A that "it was her decision".

93. Ms G noted that Dr C found the baby to be in a "bad position" and "strongly recommend[ed]" a Caesarean section, but advised that it was Mrs A's choice in the end. Ms G documented: "[Mrs A] declines at this stage, and asks for an epidural."

94. RM B told HDC that Dr C reported that the baby was in deep transverse arrest, which meant that the baby was deeply impacted into the pelvis. He offered Mrs A a Caesarean section with no other alternatives, and he did not explain the risks and benefits of having a Caesarean section versus not having one. Regarding the Caesarean section, RM B documented in her notes: "[Mrs A] declines at this stage and wants an epidural and hope baby will turn."

95. RM D recollected that when Dr C offered Mrs A a Caesarean, she declined right away, stating that she would like an epidural first. RM D reported that Dr C's response was, "as he usually does, something along the lines of 'very well dear, I can only advise, the decision is yours'".

Deep transverse arrest and transfer of care

96. RM B told HDC that Dr C's findings of "a transverse arrest is an automatic case for transfer" of care.

97. The DHB told HDC that handover did not occur following Dr C's consultation because of "[Mrs A] being strongly [averse] to medical intervention and wanting a natural birth, and the supporting influence of the LMC". Mrs A told HDC that she was "not averse to medical intervention", and noted that a Caesarean section was contemplated in her birth preferences.

98. Dr C's documentation at 12.20pm does not outline whether care was handed over. Dr C told HDC: "[I]t is unclear when [LMC] RM B handed over to the secondary care team. This is because … she took an active role and remained in the birthing room throughout."

99. RM H told HDC that she was concerned about the diagnosis made by Dr C and the decision made by Mrs A to decline a Caesarean section. RM H recalled talking to Dr C and asking if there was anything else that could be done, but said that she was advised that consent was required.

100. RM H reported that there was no other senior midwife on site, and therefore she sought advice from the midwifery leader at another hospital. RM H briefed the midwifery leader on the situation — "long labour at home, failure to progress, diagnosis of deep transverse arrest and [Mrs A's] decision to decline a [Caesarean section]". RM H queried whether there was anything else that could be done, as she had not been in such a position previously. The midwifery leader also advised RM H that it was the woman's choice.

101. RM H told HDC that she recollects asking RM B whether she could speak to Mrs A about her decision, but that RM B advised that there was no need for this. RM H reported that RM B "did not indicate in any way that she was concerned with [Mrs A's] decision".

102. Mrs A stated that "at no point did [RM B] suggest or encourage the caesarean". Mr A told HDC:

> "[RM B] reassured [Mrs A] that even if she does need a [Caesarean] section in the end, Plan A epidural and syntocinon would not get in the way of her having to eventually go to Plan B, a [Caesarean] section."

103. Similarly, Ms G recollects that RM B reassured Mrs A that even if she did need a Caesarean section in the end, the epidural "won't get in the way — that she can go from Plan A–B but not from Plan B back to Plan A".

104. RM B disagrees that she did not support the decision for a Caesarean section.

Labour at Hospital 1

Epidural and deterioration of CTG

105. RM B told HDC that following Dr C's assessment at 12.20pm, she left the room for approximately 30 minutes to prepare her notes. When she returned to the room, "the staff midwife who had taken over care" was present. RM B noted that the anaesthetist had not arrived to site the epidural, so she called to follow up, noting that the staff midwife was busy caring for Mrs A. As mentioned previously, RM E disputes that care had been handed over. She stated that she stayed in a support role to RM B until the time of the anaesthetist arriving to site the epidural.

106. RM B recollects that Dr C entered the office where RM B was preparing her notes, and stated that Mrs A's baby was large for her, and she probably would not get it out normally. RM B said that he advised that Mrs A had a "20% chance" of the baby turning and being born vaginally, but he felt that Mrs A would need a Caesarean section at some stage.

107. RM B reported that she spoke to Mr A and explained to him what Dr C had said about the chances of the baby being born normally. They both returned to the room, and RM B

explained the same message to Mrs A. RM B told HDC that Mrs A "just stated 'I still have a chance of a normal birth'".

108. At 1pm, RM E documented that CTG monitoring was in progress, and that RM D and RM B were present in the room "supporting" Mrs A. Mr A and Ms G were also present. RM E also documented that there was "some loss of contact", and that the baseline FHR was 150bpm with periods of reduced variability and no accelerations and one deceleration. RM E noted that the CTG trace was "non-reassuring".

109. RM B told HDC that she returned to the room at approximately 1.10pm. She stated that RM E was very busy, so she offered to site the IV luer, and the staff midwife was happy for her to do this. On the other hand, RM E stated:

> "[O]n the ward at the time … there were two low acuity patients and I was not busy … [and] as the woman was still under primary midwifery care, I asked [RM B] to insert a luer and take bloods [and RM B said] she was too busy typing up her notes."

110. RM E said that in light of this, she went to Mrs A's room to site the luer herself. However, as she was about to site the luer, RM B re-entered the room and stated that she was good at siting a luer. RM E therefore gave the luer to RM B to site.

111. At 1.15pm, RM B and RM E both documented that RM B tried to site the luer twice but missed. Regarding the CTG trace, RM B documented: "CTG really reassuring … Explained baby is ok at this stage but must understand that she probably will go to theatre for [Caesarean] section." On the other hand, RM E documented that the CTG was non-reassuring with reduced variability, no accelerations, and decelerations down to 80bpm that recovered to the baseline.

112. RM B told HDC:

> "[U]pon reflection …, I should never have written anything about the fetal heart at this stage because I did not review the CTG myself. I had asked [RM E] 'was the baby ok'. She stated yes."

113. However, RM E told HDC that she "never said to [RM B] that the trace was reassuring". Rather, RM E reported that she noted that the CTG was non-reassuring after 15 minutes of being in progress. In response to this, RM D advised her that the CTG was fine, as the decelerations were from loss of contact and the maternal pulse. In RM E's opinion, having two senior midwives in the room dismissing her concerns about the CTG made her feel that her opinion was undervalued. RM E reported the non-reassuring CTG to RM H.

114. At 1.40pm, RM E documented that the IV luer had been sited by the consultant anaesthetist. RM E recorded her interpretation of the CTG as "baseline 150bpm, variability [greater than] 5bpm, [nil] accelerations, decelerations, variable [decreasing to] 100bpm with contractions".

115. Some loss of contact was noted again at 1.50pm whilst the epidural was being sited. At 2pm, RM E documented: "[D]ifficulty inserting epidural. FHR difficult to trace. Baseline 150bpm." At 2.05pm, RM E documented that the epidural was sited and that Mrs A consented to a fetal scalp electrode (FSE) [29] for the baby.

116. RM E stated that once the epidural had been sited, she explained to Mrs A that she would be taking over the midwifery care under the direction of the obstetrician, as RM B did not provide care to women with an epidural. Despite the DHB advising HDC that handover occurred at this time, a handover sticker identifying that clinical care was now the responsibility of the DHB was not placed in Mrs A's notes.

117. At 2.20pm, RM E documented the CTG trace as: "Baseline 145bpm, variability [less than] 5pm, [nil] accelerations, decelerations [decreasing to] 60–80bpm taking [approximately] 90 [seconds] to return to baseline." At 2.25pm, RM E carried out a vaginal examination and applied the fetal scalp electrode. Her findings from this examination were:

> "Dilatation: 5cm
> Effacement: 90%
> Station: –2
> Position: OT
> Membranes: ++ mec[onium] [30] [stained] liquor
> Plan: FSE and continuous CTG"

118. RM E added that during this time, RM B remained in the room and questioned her actions and findings. RM E stated: "[T]he way in which she asked me made me feel like she was judging all my actions and making out to [Mrs A] that she was supervising me." RM E recalled that Mrs A asked her what she thought about her case, and RM E advised Mrs A that due to the meconium, the obvious fetal distress displayed on the CTG, and because she had not progressed since midnight, she needed a Caesarean section.

119. RM E recollects that after this discussion, another midwife, RM J, who had provided Mrs A with antenatal classes, visited Mrs A and told her that everything would be all right, as she had had a woman in a similar clinical situation some weeks previously, and it had gone well for that woman. RM J confirmed that she visited Mrs A to give her some encouraging words and mentioned that she had cared for a woman where her labour had stalled and needed intervention to help, and she continued on to have a normal birth. RM J stated: "I can't remember exactly what I said but something along the line of 'don't give up you can do it'."

[29] Internal fetal heart rate monitoring uses an electronic transducer connected directly to the fetal skin. A wire electrode is attached to the fetal scalp or other body part through the cervical opening, and is connected to the monitor.

[30] Meconium is the first faeces passed by a newborn, and is green/black in colour. In some circumstances, the baby passes meconium while still inside the uterus. This may be a sign of distress, or can also be a normal process in a post-mature baby.

120. RM E commented: "[T]his constant reassurance given to [Mrs A] … made me feel that [she] would probably discredit the information I was giving her."

121. RM B told HDC that at around this time, she had been gone from the room for a period and, when she came back, she observed RM E trying to apply a fetal scalp clip, as at this time meconium-stained liquor was present. RM B understood that up until this point, the liquor had been clear.

122. RM B told HDC that she then left the room again and, when she returned, she observed that there was no staff midwife present. The fetal scalp clip was also not picking up the heart rate very well, as it was sitting in the vagina, and not attached to the baby. RM B reported that she noticed a very big deceleration and immediately advised Mrs A that the "baby really wasn't happy anymore and needed to be born. [The CTG] was showing baby was in fetal distress and that was not good for [the baby]." RM E reported that she returned to the room at this point, and was present when RM B recommenced external CTG monitoring. At 2.36pm, RM E noted that the fetal scalp electrode had fallen off and that external CTG monitoring was recommenced.

123. Mr A told HDC that at approximately 2.45pm, he went home for a shower and a change of clothes.

124. At 2.45pm, RM E documented that the CTG was non-reassuring: "Baseline 145bpm, variability [less than] 5bpm, nil acceleration, latest deceleration [decreasing to] 70bpm [taking] 120 seconds to return to baseline." RM E further documented that Dr C had been informed and would come to review Mrs A. RM E ended her shift and handed over to hospital midwife RM F.

125. RM F told HDC that she went to see Mrs A at 2.55pm:

> "I explained to [Mrs A] my concern for the health of her baby. [I] explained [that the] baby is in distress and if she would consent to an emergency LSCS as had already been recommended to her by the on call obstetrician. [Mrs A] declined stating she would like to wait for her husband to return before a decision was made … I responded by informing [Mrs A] that I would be calling the on call obstetrician to come immediately and review the CTG, she understood."

126. In relation to the above, RM F documented:

> "FHR baseline 145bpm, variability is becoming decreased. There are late decelerations present. Mum adamant she does not want a [Caesarean section] at present. Phone call to on call obstetrician, [Dr C], he will come and review. Discussed with [Mrs A], she will wait."

127. Ms G reported that around this time, RM B noted that "the baby was not looking too good [and] she started acting a little more nervous". Ms G recollected Mrs A asking questions about "whether it was going to be a [Caesarean section or not], and how to know when to call it". Ms G added:

> "At one point [Mrs A] was asking and not really getting a clear answer, she looked at me and I gave her the only real answer I could within my professional role — that I felt like she chose her midwife because she trusted her, so it was best to be asking [RM B] … To this [RM B] replied 'I'm not the only midwife in this room. [RM E] is a midwife, [RM D] is a midwife, why don't you ask their opinions?'"

3.05pm — Second recommendation for Caesarean section

128. At 3.05pm, Dr C returned to see Mrs A. He documented the following:

> "CTG showing prolonged deep decelerations
> Old meconium stained liquor.
> [Caesarean] section offered. [Patient] wants to wait for her husband to come to make a decision."

129. Mrs A stated:

> "[H]ad it been made clear to me how serious the situation during birth had become, I would not have hesitated to do anything I could to have a positive outcome including caesarean as soon as possible."

130. Mrs A said that "not once during the labour did [RM B] recommend a caesarean as the best or safest option".

131. Ms G recollected that around this time, "[RM B] made the suggestion that a [Caesarean] section was inevitable and might as well be done now."

132. RM B was present during this time, and recalled that a Caesarean section was offered, but that Dr C "did not indicate there was any urgency", and was not in the room for very long. RM B also stated that Mrs A asked Dr C if she could wait until Mr A returned before having a Caesarean. RM B recollects that Mrs A appeared "really scared" at the prospect of facing a Caesarean section without the support of her husband. RM B told HDC that she asked Ms G to call Mr A and ask him to return to the hospital as soon as possible. RM D concurred with RM B's recollection above, and told HDC that at this point, she left the hospital as she was on a morning shift the next day.

133. Ms G told HDC that she called Mr A at 3.12pm and asked him to return to the hospital. Mr A stated that he received a call from Ms G advising that "[RM B] had decided that a [Caesarean] section seemed to be inevitable so why not now". Mr A recollected that Ms G stated that Mrs A did not want to make the decision to have a Caesarean section without him. However, he said that he spoke to Mrs A and told her to "go ahead, it was the right decision, to sign the papers and get things moving".

134. RM B reported that Mrs A "didn't say that [Mr A] had said go ahead without him, nor did the doula". RM B recollected that during this time, no staff were in the room, and the CTG continued to be non-reassuring. RM B stated that she felt very concerned, so she went to the maternity office, where all staff were sitting and writing Mrs A's notes. RM B asked why no one was preparing Mrs A for a Caesarean section, and communicated to the staff

that Mrs A "was not saying she would not have a caesarean, she was saying she had questions and wanted support from her husband". RM B was told that nothing would be done until Mr A returned, but that Dr C would carry out another vaginal examination to see if there was any progress.

135. O & G registrar Dr I said that she received a call from the hospital midwifery team asking that she go to the maternity ward to organise theatre for an emergency Caesarean section. Dr I told HDC the following:

> "My memory of this case is so detailed in part because of the poor outcome and also because of the (in my opinion) dubious decision making that took place … both prior to arrival to the hospital and once on the maternity ward. My recollection of events is as follows.
>
> …
>
> I arrived at the maternity suite to find [Dr C] there along with the hospital midwives. They informed me that [Mrs A] required an emergency caesarean section. It was then relayed to me that [Mrs A] was refusing to sign the patient consent form until her husband had returned to the hospital … The urgency of the situation was stressed to the patient by both [Dr C] and the hospital midwife on duty in an attempt to hurry along the process. Despite this the consent was not obtained in a timely fashion. I proceeded to call the theatre team including the anaesthetist to advise them that we had a patient who required an emergency caesarean section but she was not ready to come at that point in time because the consent had not been signed."

136. At 3.15pm, Dr C returned and noted that the CTG trace was "pathological". Dr C documented that whilst waiting for Mr A he carried out another vaginal examination and "again advised the patient to consider [Caesarean] section without further delay. Fetal compromise is a possibility."

137. Mrs A told HDC: "[A]t no point was the gravity of the situation explained to me. Nobody said what a 'distressed' baby meant. I had no idea that 'distressed' could mean brain damage, blindness or anything like that."

138. Ms G recollected that during this time, Dr C and Mrs A discussed "[w]hat would happen with the epidural and how things would look during the procedure". Ms G stated:

> "[Mrs A] discussed some special requests — including that the placenta be left attached if possible, and that there would be skin-to-skin. [Dr C] explained ... it would be difficult to get the baby out of the pelvis, so these things would be done if time and circumstances allowed."

139. RM B reported that at 3.40pm she asked for Mr A to be telephoned again. Ms G confirmed that RM B asked her to call Mr A and tell him that he was needed "right now". Just as Ms G began dialling, Mr A walked through the door. Mrs A told Mr A that "a [Caesarean] section was happening" and recalled Mr A's response being, "about time". Mr A told HDC that

when he arrived back at the hospital, "nothing had happened even the forms had not been signed".

140. Dr I commented that Dr C relayed to her the urgency of the situation and the need to remain on the maternity ward with the patient because of the acuity of the situation, and also to ensure that the consent did eventually get signed. Dr I recalled that Dr C was already dressed and prepared to go to theatre as they both waited on the delivery suite until Mrs A was ready for theatre.

141. At 3.40pm, RM F documented: "[H]usband has arrived discussing [lower section Caesarean section] with [Dr C] at present." At 3.45pm, Dr C documented: "Husband arrived. Now both agree for [Caesarean] section." In response to the provisional decision, Mrs A commented that she signed the consent documents without delay when they were offered to her.

142. At 3.45pm, RM F documented that Mrs A had been "prepped for emergency [lower segment Caesarean section]" and "to [open theatre]" with RM B, Mr A, and Ms G. By 4.03pm, Mrs A was in theatre.

143. Baby A was delivered at 4.31pm by Dr C with assistance from Dr I. Baby A's weight was 2.45kg. Dr C commented that Baby A was small for a post-date baby, and that this had not been diagnosed during the antenatal period.

144. At birth, Baby A's Apgar scores[31] were 4 at 1 minute and 9 at 5 minutes. Initially Baby A was blue and apnoeic[32] with a heart rate of less than 100 beats per minute, and required significant resuscitation.

Subsequent events

145. Baby A required ongoing neonatal management, including therapeutic neonatal cooling and transfer to the Hospital 2 neonatal unit. Baby A was diagnosed with birth asphyxia and hypoxic ischaemic encephalopathy, which has resulted in long-term adverse consequences.

DHB maternity protocol*:* Transfer of Clinical Responsibility from Primary to Secondary Care

146. This protocol outlines the processes to be followed where a primary care provider (LMC) transfers clinical responsibility to the DHB obstetric, medical, or paediatric services. The protocol states that the standards to be met are as follows:

[31] The APGAR score is a test given to newborn babies soon after birth. The test checks a baby's Appearance (skin colour), Pulse (heart rate), Grimace response (reflexes), Activity (muscle tone), and Respiration (breathing rate and effort).
[32] Lacking respiration.

STEP	ACTION
1	• LMC liaises with obstetric services to discuss a transfer of clinical responsibility. • This may be in the form of a written referral, or phone referral following the woman being assessed by the LMC and then telephone consult with on call obstetrician.
2	• Following referral, the LMC will ensure all relevant clinical and administrative documentation and information is available to the receiving specialist service in a timely manner.
3	• Where a woman is transferred into [DHB] secondary care facility, the LMC will contact delivery suite to communicate the urgency of the woman's condition. • The secondary service shall fully complete the SBARR telephone record to capture the information given by the referrer in order to enable prioritisation and a timely review/assessment and place a copy of this in the woman's clinical notes.
4	• The LMC will be notified as soon as practicable/reasonable of the outcome of an assessment and ongoing care, including discharge advice where appropriate.
5	• The provision of midwifery care, once agreed between the woman, LMC, obstetric service and midwifery shift leader (as per Referral Guidelines) shall be documented in woman's notes. • The handover sticker is to be completed and placed in the patient's health record.
6	• Where an LMC identifies a transfer of clinical responsibility is appropriate, this will occur in a timely manner and communicate intention with the Clinical Coordinator or the Shift Leader.
7	• Where it is agreed the LMC is going to provide the midwifery component of care, the LMC will hold the required certification to so do. • The LMC will continue to provide midwifery care on delivery suite until two hours post normal 3rd stage.
…	
10	• **<u>Epidural management</u>** Where a Transfer of Clinical Responsibility occurs as per LMC access agreement (LMC has declared they will not manage epidural) Transfer of Clinical responsibility occurs at the time the anaesthetist arrives to site the epidural. The Staff midwife will provide assistance to the anaesthetist for the procedure. The LMC may choose to stay to provide support to the woman.

Further information

147. The Midwifery Council of New Zealand carried out a review of RM B's competence. The Council identified concerns in the following areas:

- Assessment and monitoring skills.
- Understanding of professional responsibilities, including documentation.
- Intrapartum assessment of fetal and maternal well-being.
- Knowledge and interpretation of cardiotocographs.
- Risk assessment and usual referral processes.
- Processes for informed decision-making.

148. As a result, RM B was required to undertake a period of supervised practice consisting of meeting with a Council-approved supervisor for a minimum of 10 months on a monthly basis, for the purpose of reviewing matters relating to:

- The role and scope of midwifery practice in the provision of primary care, including prescribing and the use of complementary therapies.
- Risk assessment, changing risk profiles, and adapting care accordingly.
- Communication and inter-professional relationships.
- Conflict resolution.
- Accurate documentation of care provided and decisions made with women.

149. At the time of writing to HDC, the Council advised that RM B remained subject to the above supervision, and that this would continue until the Council received the necessary assurances from RM B's supervisor that the Council's concerns regarding her competence had been addressed satisfactorily.

Response to provisional decision

Mr and Mrs A

150. Mr and Mrs A were provided with an opportunity to comment on the "information gathered during investigation" section of the provisional decision. Where relevant, their comments have been incorporated into this report.

RM B

151. RM B was provided with an opportunity to comment on the relevant sections of the provisional decision. She advised HDC that she accepted the provisional opinion and recommendations.

DHB

152. The DHB was provided with an opportunity to comment on the relevant sections of the provisional decision. Dr C's comment has been incorporated into this report. The DHB advised that it had no further comments.

Relevant standards

Referral Guidelines

153. The *Guidelines for Consultation with Obstetric and Medical Related Services (Referral Guidelines)* provide guidelines for circumstances in which an LMC must recommend a consultation with a specialist, or the transfer of clinical responsibility to a specialist.

154. The *Referral Guidelines* require that the woman must be informed that the responsibility for her care be transferred to a specialist in certain circumstances. Under "Transfer", the guidelines state:

> "The LMC must recommend to the woman (or parent(s) in the case of the baby) that the responsibility for her care be transferred to a specialist given that her pregnancy, labour, birth or puerperium (or the baby) is or may be affected by the condition. The decision regarding ongoing clinical roles/responsibilities must involve three-way conversation between the specialist, the LMC and the woman. The specialist will assume ongoing clinical responsibility and the role of the LMC from that point on will be agreed between those involved. This should include discussion about timing of transfer of clinical responsibility back to the LMC when the condition improves. Decisions on transfer should be documented in the woman's records."

155. The *Referral Guidelines* require that the woman must be informed that a consultation is warranted in certain circumstances. Under "Consultation", the guidelines state:

> "The LMC must recommend to the woman (or parent(s) in the case of the baby) that a consultation with a specialist is warranted given that her pregnancy, labour, birth or puerperium (or the baby) is or may be affected by the condition. Where a consultation occurs, the decision regarding ongoing care, advice to the LMC on management, and any recommendation to subsequently transfer care must involve three-way conversation between the specialist, the LMC and the woman. This should include discussion of any need for and timing of specialist review. The specialist will not automatically assume responsibility for ongoing care. This responsibility will vary with the clinical situation and the wishes of the woman. A consultation may result in a transfer of clinical responsibility. In this event, the consulting specialist formally notifies the LMC of the transfer and documents it in the woman's records."

156. With regard to a woman declining a referral, the *Referral Guidelines* state:

> "In the event that a woman declines a referral, consultation or transfer of clinical responsibility, the LMC should:
>
> - advise the woman of the recommended care, including the evidence for that care
> - explain to the woman the LMC's need to consider discussing her case with at least one of the following (ensuring that the woman's right to privacy is maintained at all times):
>
> — another midwife, GPO or GP

— an appropriate specialist

— an experienced colleague/mentor

- share the outcomes of the discussion and any resulting advice with the woman
- document in the care plan the process, the discussions, recommendations given and decisions made, and the woman's response.

If, after this process, resolution satisfactory to the LMC and the woman has not been reached, the LMC must decide whether to continue or to discontinue care. If the LMC decides to continue care, she or he should:

- continue making recommendations to the woman for safe maternity care, including further attempts at referral
- engage other practitioners as appropriate for professional support (eg, secondary obstetric service, other midwives)
- continue to document all discussions and decisions."

157. The *Referral Guidelines* also set out the process for transfer of clinical responsibility for care. Under "Communication", the guidelines state:

> "The critical part of this process is documenting the point at which responsibility for coordination and provision of maternity care is formally transferred from the LMC to the specialist. This requires:
>
> - a three-way conversation between the LMC, the woman and the specialist to determine that the transfer of care is appropriate and acceptable
> - the LMC to provide all relevant information, including any relevant maternity notes, test results, and histories, to the specialist
> - a discussion and documented decision about the nature of the ongoing role of the LMC or whether all care, including midwifery care, is transferred to the specialist and the DHB midwifery team.
>
> Transfer of clinical responsibility requires timely and full communication from the LMC to the specialist; and then from the specialist back to the LMC. All other practitioners involved in the process (eg, GP or other primary care practitioner) should be informed of the decisions made."

158. Under the conditions and referral categories, code 4011 of the category "Consultation" refers to intrauterine growth restriction (IUGR) or small for gestational age (SGA), and defines this as being:

> "Estimated fetal weight (EFW) < 10th percentile on customised growth chart, or abdominal circumference (AC) < 5th percentile on ultrasound, or discordancy of AC with other growth parameters, normal liquor."

159. Code 5021 of the category "Consultation" refers to a prolonged first stage of labour, and defines this as being:

> "< 2 cm [dilatation of the cervix] in 4 hours for nullipara and primipara. Slowing in the progress of labour for second and subsequent labours. Take into consideration descent and rotation of fetal head, and changes in strength, duration and frequency of contractions."

160. The *Referral Guidelines* state that deep transverse arrest (Code 5008) and obstructed labour (5020) both fall under the "Transfer" category. An epidural (Code 5009) falls under the "Consultation" category.

Opinion: RM B — breach

Introduction

161. This investigation focuses on a woman's decisions around the birth of her baby, and the information she received, and understood, when making those decisions. It is essential that women receive full and balanced information about risks and care options.

162. The *Referral Guidelines* require the LMC in certain situations to recommend to the woman (or parent(s) in the case of the baby) that a consultation with a specialist is warranted given that her pregnancy, labour, birth, or puerperium (or the baby) is or may be affected by the condition. Where a consultation occurs, the decision regarding ongoing care, advice to the LMC on management, and any recommendation to subsequently transfer care must involve three-way conversation between the obstetrician, the LMC, and the woman, and the agreed care plan must be documented carefully.

163. By setting out when specialist services should be accessed to discuss care options and when care should be transferred, the *Referral Guidelines* provide an essential safety-net for pregnant women and their babies. The *Referral Guidelines* also support and guide midwives. Used consistently, the *Referral Guidelines* ensure that every woman receives specialist input when necessary, and the information she requires to make an informed choice, give informed consent, and be a partner in her own care.

164. Women, of course, have the right to decline a consultation or a transfer of care. However, before a woman declines, it is essential that she is given full information on which to base that decision. The information must include why it is recommended that there is a consultation with other health professionals, and that the consultation will involve a three-way conversation so that the woman can make an informed decision after hearing the views of the obstetric/neonatal team. In addition, the actions required when the midwife believes that a woman has declined a recommendation for a consultation or transfer are clearly set out in the *Referral Guidelines*; this process offers a further safety-net to women and to midwives.

165. I have a number of concerns about the care and communication provided to Mrs A by RM B during Mrs A's pregnancy and labour.

Decreased fetal growth

166. At 41+1 weeks' gestation, RM B's Antenatal Notes identified the first finding of decreased fetal growth. There are differing versions of events about what was communicated to Mrs A regarding consulting an obstetrician and having a growth scan on this date.

167. RM B documented in separate notes not available to Mrs A, and told HDC, that she was concerned that Baby A's growth "as per GROW chart" was dropping off, and "as per Section 88, [RM B] recommended a referral to an obstetrician" and "strongly recommended a scan for growth, liquor volume and biophysical profile". RM B noted that Mrs A "declined all of these recommendations". On the other hand, Mrs A told HDC that she was never shown the GROW Chart or informed that Baby A's growth was slowing. Mrs A said that she finds it "incredible" that the GROW Chart exists, as she was never shown it during her pregnancy. Mrs A's doula also said that "at no point" does she recall Mrs A mentioning an issue with Baby A's size or measurements. In a text message sent to Ms G, Mrs A wrote that her understanding of the scan was to "provide a scale of health in regards to pregnancy duration, amniotic fluid and baby's health".

168. Regarding a consultation with an obstetrician and a growth scan, Mrs A recollects RM B advising her that there was a month-long waiting list to see an obstetrician and receive a scan at Hospital 1. As such, a scan was booked in a week's time at another hospital as a back-up.

169. Code 4011 of the *Referral Guidelines* states that an LMC must recommend a consultation with an obstetrician if IUGR or SGA is present, and defines this as:

> "Estimated fetal weight (EFW) < 10th percentile on customised growth chart, or abdominal circumference (AC) < 5th percentile on ultrasound, or discordancy of AC with other growth parameters, normal liquor."

170. My midwifery expert, Dr Carolyn Young, advised that more exact information regarding the above can be ascertained only by an ultrasound growth scan. Therefore, Dr Young advised that where fetal growth has "declined markedly (as in [Mrs A's] situation)", the woman should be offered a referral for ultrasound assessment. Dr Young added that given that this was also an IVF pregnancy and now post dates, a growth scan was indicated even more. Dr Young commented that "consultation could then be offered to provide an obstetrician's opinion in jointly developing a plan with the woman and midwife for ongoing care".

171. Dr Young noted that "strong recommendation" is an emotive phrase and subject to interpretation. She added:

> "It must be asked that if the grow chart was carried by [RM B] in her diary … why this information was not shared with [Mrs A] when advocating for her to consent to a scan and consultation because of the clearly declining graphing of fetal growth?"

172. Dr Young considers that for future practice, all decision-making by a woman that does not reflect recommended practice should be documented clearly, with concerns stated plainly, and the woman should be asked to countersign the documentation indicating that she understands the seriousness or potential seriousness of her decision.

173. In addition, the *Referral Guidelines* state that when a woman declines a referral, the LMC should explain to the woman the LMC's requirement to consider discussing her case with another midwife, GPO or GP, an appropriate specialist, or an experienced colleague/mentor. The LMC should then share with the woman the outcome of the discussion and any resulting advice.

My assessment

174. I note RM B's documentation that she strongly recommended a growth scan to Mrs A. In view of the audit provided by RM B, I accept this documentation as a contemporaneous record, but I am critical that this record was not available to Mrs A at the time the advice was given. Furthermore, given that Mrs A understood from the discussions with RM B 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, I consider it more likely than not that Mrs A did not appreciate that the recommendations made were for slowed growth. Mrs A told HDC that if she had known this, she would "certainly have had one if … any indication was given to [her] that anything unusual was going on with the baby's growth". Clearly, RM B's recommendation was not communicated effectively.

175. In my view, RM B had two opportunities to communicate clearly to Mrs A that Baby A's growth had slowed. First, when RM B recommended an obstetric consultation and growth scan, she could have showed Mrs A the GROW Chart, which clearly showed a marked decline in growth. Secondly, the actions required when the midwife believes that a woman has declined a recommendation to consult or transfer are clearly set out in the *Referral Guidelines*; this process offers a further safety-net to women and to midwives. When RM B understood that Mrs A had declined her recommendations, as per the *Referral Guidelines*, RM B should have shared this information with Mrs A, and explained the need to discuss her case further with a colleague.

Conclusion

176. Given that this was a key decision-making point in Mrs A's pregnancy, I am critical of RM B for not following the actions set out in the *Referral Guidelines*, and for not communicating effectively to ensure that Mrs A understood the information being provided to her.

Care at 5.56am, 6 Month3

177. By 5.56am on 6 Month3, Mrs A had been having contractions for approximately 12 hours, and had dilated only an additional 1cm since approximately 12.30am. 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.

178. RM B told HDC that she recommended that Mrs A go to the hospital for an obstetric consultation owing to failure to progress, and that this was declined. There are two entries

for the care provided at this time. The first entry is with the rest of the Delivery and Birth Notes, and does not specifically mention "failure to progress". Rather, it states that RM B "discussed … options of what to do as [Mrs A was] very tired", and that the plan was to commence homeopathic remedies and try a change of position. Mr and Mrs A's and Ms G's accounts to this Office are consistent with this entry. RM D told HDC that she recalls RM B advising that a hospital transfer was "offered" to Mrs A.

179. The second entry for this time was documented in RM B's Additional Antenatal Notes under the heading "Additional Labour and Birth Notes". These notes are separate from the rest of RM B's Labour and Delivery Notes. This entry discusses in detail the recommendations made — in particular: "I advised [Mrs A] that she needed to go to hospital and have a consultation with an obstetrician as per referral guidelines (5021) … due to failure to progress."

180. Ms G's notes at this time conflict with this entry. Specifically, Ms G documented: "[RM B] suggests that, ideally, an epidural would be good so [Mrs A] could get some rest and might find the strength to carry on." Ms G does not recall RM B advising that there was a failure to progress, or recommending an obstetric consultation. Similarly, Mrs A told HDC that "at no point" did RM B discuss failure to progress. Mrs A said that she was advised to go to the hospital for some pain relief.

181. At this point in time, RM B also called the on-call obstetrician at Hospital 1. She referred to him as "Mr Slice and Dice", indicating that he had a low threshold for recommending a Caesarean section. This is not disputed. Ultimately, Mrs A did not go to hospital at this time.

My assessment

182. The key fact in dispute is whether Mrs A understood that an obstetric consultation was being recommended owing to her failure to progress. Whilst RM B may have documented that she recommended that Mrs A go to hospital to consult with an obstetrician owing to her failure to progress, this was not understood by anyone else present at the time.

183. Although there is consensus that a discussion about going to the hospital took place, everyone but RM B recollects that this was in the context of receiving pain relief. Ms G and Mrs A have advised that at no point did RM B discuss that there was a failure to progress.

184. Again, I note RM B's documentation that she recommended a consultation to Mrs A for her failure to progress. In view of the audit provided by RM B, I accept this documentation as a contemporaneous record. However, RM B's recommendation was not communicated effectively, as it appears that no one in the room understood the reason for the recommendation. I also find it concerning that, on the one hand, RM B recommended a consultation with an obstetrician, yet, on the other hand, she undermined that recommendation by referring to the obstetrician as "Mr Slice and Dice".

Conclusion

185. Mrs A did not understand that the recommendation to transfer to hospital was made because of concerns about her slow progress in labour, rather than because of how she

was coping with the pain. This was essential information, and I am critical that RM B did not communicate that information to Mrs A and her support people effectively.

186. To aggravate the matter, at this juncture, RM B labelled the on-call obstetrician "Mr Slice and Dice". Dr Young advised that this discussion was "inappropriate" and "unbecoming to a professional". She added that "by demeaning the obstetric professional integrity of the consultant … the professional opinion is demeaned before it is even given". I agree. I am critical of RM B for calling Dr C "Mr Slice and Dice". I consider that this unprofessional and derogatory comment created doubts in Mrs A's mind about Dr C, and tainted the interactions she would then go on to have with him.

Transfer to secondary care

187. At approximately midday, Mrs A was taken to Hospital 1 to consult with obstetrician Dr C.

188. RM B documented in her Labour and Delivery Notes that Mrs A understood that she was now with secondary care, and that RM B had handed over to the hospital midwives and obstetrician upon arrival at the hospital. RM D's recollection also supports this. However, Mrs A, Mr A, Ms G, Dr C, RM E, RM H, and the DHB all have a less clear understanding of when care was handed over:

- Mrs A told HDC that she thought that RM B was meant to be transferring her care to the obstetrician or the hospital, but because RM B continued to participate actively in her care, Mrs A became confused as to who her primary caregiver was.
- Mr A does recall being told that when they got to hospital they would be out of RM B's care and in the care of the hospital; however, he stated: "[T]his is clearly not what happened. She stayed in control, telling hospital staff what to so and what she wanted."
- Dr C told HDC that it is unclear when RM B handed over to the secondary care team, because she took an "active role" and "remained in the birthing room throughout".
- Ms G stated that she does not recall the mention of handover to secondary care at any point. She added: "I don't think this happened at all."
- RM E told HDC that she stayed in a support role to RM B until the epidural was sited, as per the DHB protocol.
- RM H told HDC that RM B had stated that Mrs A wanted RM B to stay with her, and the core midwives were assisting RM B.
- The DHB told HDC that handover did not occur at this point because Mrs A was strongly averse to medical intervention and wanted a natural birth, and because of the supporting influence of the LMC.

189. Further factors that contributed to a lack of clarity were:

- There was no summary of the labour care provided by RM B prior to admission in the hospital notes at admission, and a sticker was not placed in Mrs A's notes indicating that handover had occurred, as per DHB protocol.
- RM B's notes were not countersigned by a staff midwife, as per the process of agreement at handover from primary to secondary care; and staff midwife RM E was not given a verbal handover of care.
- Hospital staff such as RM H and Dr C communicated to Mrs A through RM B, rather than to Mrs A directly. After Dr C's first assessment of Mrs A, RM H asked RM B whether she could speak to Mrs A about her decision to decline the recommended Caesarean section, and was advised that there was no need for this. RM B told HDC that around this time, Dr C advised her that there was a "20% chance" of a vaginal birth.
- RM B continued to provide clinical services, such as following up on the epidural; attempting to site the IV luer twice; reapplying the fetal scalp clip; and documenting that the CTG was reassuring.

My assessment

190. The key fact in dispute is the point at which transfer of clinical responsibility from primary to secondary care occurred. Given the conflicting accounts above, and with no clear handover processes being observed, I cannot make a definitive finding about when transfer of care occurred. I note, however, that RM B has argued strongly that she handed over care upon arrival at the hospital, and that this had been her practice since 2006.

Conclusion

191. When transfer of care takes place, the *Referral Guidelines* require three-way communication between the woman, the specialist, and the LMC regarding the diagnosis, treatment, and care plan, with the ongoing role of the LMC being discussed and clearly documented. I am concerned that this did not occur at any time.

192. Dr Young advised that there was lack of clarity in RM B's role, with her continuing to provide advice and hands-on care beyond the point at which she stated she regarded herself as having handed over care. Dr Young further advised: "[T]his creates a very confusing picture as to who is responsible for care and at what mutually understood point this occurred." She stated that this is "a situation well recognised as being one in which errors happen". In Dr Young's opinion, RM B's ongoing involvement was "detrimental to the clarity of the handover of her role as LMC and the assumption of responsibility by the facility staff midwives". Dr Young advised that when RM B assumed the role of a support person, there was "a blurring of boundaries", and that "this was inappropriate".

193. Dr Young concluded that "handover of care appears to have been poorly done" and "adequate handover did not occur"; Dr Young found this to be a moderate departure from acceptable midwifery care. I agree. As Mrs A's LMC, RM B was ultimately responsible for ensuring clarity regarding handover. As identified by my expert, this did not occur, and I

am critical of RM B for failing to ensure clarity of her role and responsibility with respect to Mrs A's care at the hospital.

Communications around Caesarean section

194. Prior to going to the hospital, RM B documented in her notes that the plan was to go to hospital for an epidural and Syntocinon, if safe. She told HDC that she advised Mrs A that it is not within her scope of practice to make recommendations one way or another, but that if Dr C offered only a Caesarean section, Mrs A could ask if there were other options she could try first.

195. Mr and Mrs A and Ms G's recollections differ. Ms G documented that RM B "assured" Mrs A that Dr C agreed to an epidural and possible Syntocinon, and that although he would likely insist on a Caesarean section, this was Mrs A's choice, and it was "worth trying this other way first". Mr A recollected RM B "coaching" Mrs A on what to say to Dr C. RM E told HDC that prior to Dr C's examination, she witnessed RM B stating that Dr C wanted to "slice and dice" Mrs A, and that she had the right to say no. This is disputed by RM B.

196. Dr C's examination showed that Baby A was likely in deep transverse arrest, with swelling of the fetal scalp and cervical oedema causing regression of dilatation. Mr A said that Dr C was direct, and told them that he feared that the baby could move down further, and that this would make a delivery by Caesarean section more difficult. Dr C recommended a Caesarean section, but Mrs A declined this. She requested an epidural and hoped that the baby would turn.

197. Statements from DHB staff indicate that RM B supported Mrs A's decision to decline a Caesarean section. Dr C told HDC that RM B decided to ignore his advice, and RM H told HDC that RM B did not appear to be concerned about Mrs A's decision. However, RM B disagrees, and told HDC that she communicated to Mrs A that a Caesarean section was the likely outcome.

198. Mrs A told HDC that RM B reassured her that even if she did need a Caesarean section in the end, "Plan A" (an epidural and Syntocinon) would not get in the way of her eventually going to "Plan B" (a Caesarean section). Ms G's recollection is consistent with Mrs A's.

199. At approximately 1.15pm, RM B documented: "CTG really reassuring … Explained baby is ok at this stage but must understand that she probably will go to theatre for [a Caesarean] section." RM B advised that she regrets documenting this, as she did not interpret the CTG at this time. It is also noted that around this time RM B communicated to Mr and Mrs A that there was an "80% chance" of Mrs A having a Caesarean section.

200. From approximately 2.30pm, RM B noted fetal distress on Mrs A's CTG, and it was at this point that RM B reported that she advised Mrs A that the "baby really wasn't happy anymore and needed to be born". Mrs A told HDC that "not once during the labour did [RM B] recommend a caesarean section as the best or safest option". Ms G recollects that RM B suggested that a Caesarean section was "inevitable and might as well be done now".

201. Ms G also told HDC that at this time Mrs A began asking about whether delivery would be by Caesarean section, and "how to know when to call it". Ms G recollects RM B replying, "I'm not the only midwife in this room," and suggesting that Mrs A ask the other midwives in the room for their opinion.

202. Mr A was not present during this time, as he had left to go home to shower and eat. Following Dr C's second recommendation for a Caesarean section — this time due to a pathological CTG — Mrs A asked to wait for Mr A to return to the hospital before consenting.

Staying as a support person

203. As a preliminary note, Dr Young has advised that as a support person, RM B is not responsible for the provision of clinical care, and is not open to professional critique of the non-professional care that she provided. Whilst I acknowledge Dr Young's opinion, previously the Midwifery Council has advised me that in the event that a midwife acts as a support person, the midwife "must act if she sees a deteriorating situation and cannot say 'I am here as a support person only'. The midwife is not able to remove [herself] from a detrimental situation, but must act as a midwife."[33] The following discussion is based on this position.

My assessment

204. The key facts in dispute are:

- Whether prior to Mrs A's arrival at the hospital, RM B advised Mrs A to decline a Caesarean section and request an epidural and Syntocinon.
- Whether RM B continued to support Mrs A's decision to decline a Caesarean section despite findings of deep transverse arrest and fetal distress.

205. Given that the accounts of all but RM B indicate that RM B encouraged Mrs A to request an epidural and Syntocinon, and therefore decline a Caesarean section, I consider it more likely than not that RM B did so encourage Mrs A.

206. Given Mrs A's and Ms G's recollections, as well as RM B's note at 1.15pm, I consider it more likely than not that RM B was still reassuring Mrs A that she could continue to labour following Dr C's finding of a deep transverse arrest at 12.20pm.

207. RM B advised HDC that when fetal distress was evident, she told Mrs A that the baby was not doing well and needed to be born. However, it is concerning that other recollections indicate that RM B discussed the Caesarean section as being "inevitable" rather than urgent, and Mrs A does not recall being advised at any point that a Caesarean section was the best or safest option. I also note that around the time the CTG deteriorated, Mr A left to go home, and so was clearly not aware of the seriousness of the situation. However, given the lack of documentation to corroborate one version over the other, I am unable to

[33] 15HDC01534 (issued 21 June 2018).

make a factual finding regarding RM B's communication to Mrs A after the CTG deteriorated.

Conclusion

208. Dr Young has advised that the advice RM B gave to Mrs A prior to the hospital admission is, by itself, not inappropriate, as the baby was not showing signs of distress upon arrival at the hospital.

209. However, Dr Young advised that when the finding of likely deep transverse arrest was made by Dr C, although the decision to perform a Caesarean section is an obstetrician's one, by this stage, "the clinical findings had become clearer that a caesarean birth needed serious consideration". Therefore, "[a]s the person who had continued to advocate for [Mrs A's] right to decline a caesarean birth, [RM B] had an obligation to re-discuss this in light of the clinical information now available". In Dr Young's view, this was the case even if RM B considered that she had assumed the role of a support person, as this advice was given in her role as the LMC.

210. Dr Young considered it to be a mild departure from accepted practice that RM B did not revisit her advice around Mrs A's right to decline a Caesarean section following Dr C's examination.

211. I am critical that RM B did not balance her previous advice about Mrs A being able to decline a Caesarean section with the possible outcomes of progressing labour in the presence of a deep transverse arrest. Given that RM B had devalued Dr C's opinion by referring to him as "Mr Slice and Dice", it was crucial that RM B communicate clearly that she also supported a Caesarean section, and the reasons for this, after Dr C's finding of a deep transverse arrest. In my view, comments such as "she probably will go to theatre for a [Caesarean] section" or an "80% chance of a caesarean section" did not adequately convey the support RM B states that she had for the Caesarean section.

212. In addition, RM B documented that the CTG was "really reassuring", and told Mrs A that "the baby was ok" when the CTG was deteriorating. Furthermore, RM B advised that she provided this information without interpreting the CTG herself. As a midwife in the room, RM B ought to have been aware of the CTG. If she was not, she should not have advised Mrs A about it. This advice was provided at a critical time in Mrs A's labour, when the need for a Caesarean section was becoming even more necessary. I am very critical of this.

Lack of duplicate notes

213. Mrs A told HDC that during her pregnancy, she received a brief record (an Antenatal Table) of her visits from RM B when she requested it. In Mrs A's Antenatal Table, fundal height is documented only once, and the information in it is abridged. Furthermore, Mrs A did not have access to additional, more detailed antenatal notes as well as a GROW Chart.

214. Dr Young advised that it is the expectation that women hold a duplicate copy of their antenatal records. Standard Four of the NZCOM Handbook for Practice/Standards of Midwifery Practice states: "The midwife maintains purposeful, on-going updated records

and makes them available to the woman." Dr Young advised that the criteria includes that the midwife "makes records accessible and available at all times to the woman".

215. Further, Dr Young cited Standard One of the NZCOM Handbook for Practice/Standards of Midwifery Practice, which states that the midwife works in partnership with the woman, including sharing relevant information within the partnership.

216. Dr Young commented that the lack of duplicate notes meant that Mrs A had no immediate record of advice and information given to her by RM B. Mrs A was therefore unable to refer to this information or question it at the time. Dr Young added that the lack of immediately available hand-held notes created a situation where the accuracy of the documentation is now subject to question.

217. I agree with Dr Young's advice. I am critical of RM B for failing to provide Mrs A with adequate antenatal notes during her pregnancy. That Mrs A had to request these rather than be provided with them as a matter of course is poor. Further, when she was provided with her notes, they were incomplete, and therefore of little value. I do not consider this to be in line with the midwifery partnership model of care.

Conclusion

218. As set out above, I have numerous concerns about the care provided to Mrs A by RM B. I consider that RM B failed to provide services to Mrs A with reasonable care and skill, for the following reasons:

- At 41+1 weeks' gestation, RM B failed to communicate effectively to Mrs A that Baby A's growth had slowed, and to follow the actions set out in the *Referral Guidelines* when her recommendations for slowed growth were declined.
- At 5.56am on 6 Month3, RM B failed to communicate to Mrs A effectively that transfer to hospital was recommended owing to concerns about slow progress in labour, rather than concern as to how Mrs A was coping with the pain.
- RM B referred to Dr C as "Mr Slice and Dice". This unprofessional and derogatory comment created doubts in Mrs A's mind, and tainted the interactions she went on to have with him.
- Upon transfer to hospital, RM B failed to ensure that there was clarity around her role and responsibility with respect to Mrs A's care.
- Following Dr C's assessment of Mrs A at 12.20pm on 6 Month3, RM B did not communicate clearly that she supported a Caesarean section, and explain the reasons for this.
- RM B documented that the CTG was "really reassuring", and told Mrs A that the baby was "ok", when the CTG was deteriorating. Furthermore, RM B advised that she provided this information without interpreting the CTG herself. As a midwife in the room, RM B ought to have been aware of the CTG and, if not, she should not have advised Mrs A about it.
- RM B failed to provide Mrs A with adequate antenatal notes during her pregnancy. That Mrs A had to request these rather than be provided with them as a matter of

course is poor. Further, when she was provided with her notes, they were incomplete and therefore of little value. This is not in line with the midwifery partnership model of care.

219. Accordingly, I find that RM B breached Right 4(1) of the Code.[34]

Opinion: DHB — adverse comment

220. Several DHB staff were involved in the care provided to Mrs A on 6 Month3. This included consultant obstetrician Dr C, RM E and RM F, and RM H.

221. My midwifery expert, Dr Carolyn Young, considers that the midwifery care provided to Mrs A by hospital staff was appropriate in the circumstances. My obstetrics expert, Dr Ian Page, has also advised that he considers Dr C's care to have been reasonable in the circumstances.

222. While overall I accept Dr Young's and Dr Page's advice, I am nonetheless concerned about the lack of clarity around whether clinical responsibility had transferred to secondary care, and the communication to Mrs A about the need for a Caesarean section.

Transfer to secondary care

223. RM B told HDC that she handed Mrs A's care over to secondary care upon arrival at the hospital. However, the DHB advised that this was not the case, as Mrs A declined a Caesarean section and opted for an epidural. The DHB further advised HDC that transfer of care occurred when the epidural was sited, two hours after admission, as per its Maternity Protocol. The DHB acknowledged that a handover sticker should have been added to Mrs A's maternity notes at this point, and that this did not occur. In addition, no other documentation in Mrs A's hospital notes indicates when transfer of care occurred.

224. Dr Young advised:

> "In my opinion handover of care to secondary services should have occurred on admission … In my opinion, under the circumstances of having provided prolonged care with an increasing need for vigilance of care, this would have been the optimal time for handover to have occurred."

225. I agree. Whilst Mrs A may have declined the Caesarean section offered to her, it does not necessarily mean that she also declined transfer of care to secondary care. The two are not mutually exclusive. The clinical documentation is silent on whether this discussion occurred, and I consider that this contributed to the confusion about who was responsible for Mrs A's care.

[34] Right 4(1) provides: "Every consumer has the right to have services provided with reasonable care and skill."

226. Further, the *Referral Guidelines* require that transfer of care occurs following a three-way conversation with the specialist, the LMC, and the woman. However, Dr Young noted that the handover process set out in the DHB protocol does not require a three-way conversation with the woman.

227. I am concerned that the DHB's Maternity Transfer Protocol is not consistent with the *Referral Guidelines*, and I have recommended that it review its protocol in light of this report.

228. In addition, I am critical that the DHB process for documenting the transfer of care and any ongoing role of the LMC, and the application of a handover sticker to the clinical notes, was not followed. Adherence to that policy would have provided important clarity as to when handover of care occurred.

Communication about Caesarean section

229. Mrs A told HDC the following:

- "[H]ad it been made clear to me how serious the situation during birth had become, I would not have hesitated to do anything I could to have a positive outcome including caesarean as soon as possible."
- "[A]t no point was the gravity of the situation explained to me. Nobody said what a 'distressed' baby meant. I had no idea that 'distressed' could mean brain damage, blindness or anything like that."

230. After fetal distress was evident on the CTG, at approximately 2.45pm, Mr A left the hospital to go home to shower and change.

231. I note that Dr C, RM E, and RM F all submit that they advised Mrs A that a Caesarean section was required at different points during her labour at the hospital. Dr C documented at two points during the labour that he advised both Mrs A and RM B of the risk of delaying decision-making, and that a Caesarean section was needed without further delay. RM H also stated that she telephoned another hospital to obtain advice. Whilst evidence was submitted from numerous DHB staff that they understood the concerning situation for Mrs A, I am thoughtful about why this did not appear to be understood by Mr and Mrs A.

232. I appreciate that staff found themselves in a difficult position during Mrs A's labour, and that it appears that Mrs A's LMC had a strong influencing presence. However, nonetheless I remind staff at the DHB to act as an advocate for the patient, and ensure that communication is effective in these circumstances.

Recommendations

233. I recommend that RM B provide a written letter of apology to Mr and Mrs A for the failings identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding for the family.

234. I recommend that the Midwifery Council of New Zealand:

a) Consider whether any further review of RM B's competence is warranted in light of the findings in this report, and advise HDC of the outcome of its consideration, within four months of the date of this report.

b) Advise HDC when RM B's supervision has concluded, and how she has demonstrated to the Council that its concerns about her competence have been addressed satisfactorily.

235. I recommend that the DHB review its maternity protocol for the Transfer of Clinical Responsibility from Primary to Secondary Care in light of the findings in this report, and advise whether any further improvements can be made to the protocol. The DHB is to report back to HDC on the review of its protocol, within six months of the date of this report.

Follow-up actions

236. A copy of this report with details identifying the parties removed, except the experts who advised on this case, will be sent to the Midwifery Council of New Zealand, and it will be advised of RM B's name.

237. A copy of this report with details identifying the parties removed, except the experts who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent midwifery advice to the Commissioner

The following expert advice was obtained from Dr Carolyn Young:

"Re Complaint: [Mrs A] and [Baby A]: Your Reference 16HDC01065

My name is Carolyn Young. I have been a practising midwife since 1970.

My academic qualifications are as listed:

- 1960 School Certificate.
- 1961 University Entrance & Endorsed School Certificate
- 1967 Palmerston North Hospital School of Nursing: General and Maternity Nurse Registration
- 1970 St Helen's Hospital, Auckland: Midwifery Registration
- 1972 Massey University Palmerston North, Bachelor of Arts: English Stage I
- 1972 Auckland University Certificate of Social Studies
- 1973 Auckland University, Bachelor of Arts: Social and Physical Anthropology I, Psychology I, Sociology I and English II
- 2002 Auckland University of Technology: Master of Health Science Knowledge for Midwifery Practice
- 2003 Auckland University of Technology Master of Health Science, Science for Midwifery Practice and Health Research Paper
- 2004 Auckland University of Technology, Master of Health Science, Specialist Practice for Midwifery
- 2005 Auckland University of Technology, Master of Health Science Qualitative Research Methods
- 2011 Auckland University of Technology, Doctor of Philosophy.

Positions held relevant to midwifery are those of a Midwifery Standards Reviewer, mentor for graduate midwives first year of practice, midwife representative on the NZ College of Midwives resolutions committee, competency reviewer and expert adviser for the NZ Midwifery Council.

My professional experience after qualifying as a midwife is that of working in the birthing unit at Waitakere Hospital (1970–1972); working within the community providing home birth care in collegial practice with G.P.s (1972–1990); working within the community providing autonomous midwifery care for home births (1990–1996); working as a case loading LMC midwife providing care for women planning both home births or hospital births (1996–2017). My midwifery experience extends over forty-eight years of practice. From 2012 I have additionally held a position as a part time lecturer within the Auckland University of Technology undergraduate midwifery programme and working within the post graduate Health Sciences programme.

I currently work as a case loading LMC midwife providing care to women planning both home and hospital births in the West Auckland area and hold a position of part

time lecturer predominantly within the Midwifery Bachelor of Health Science degree course offered by the Auckland University of Technology.

I confirm that, in preparing this statement of evidence, I have read the Code of Conduct for Expert Witnesses and agree to comply with it. I also confirm that I have not omitted to consider any material facts known to me that might alter or detract from the opinions expressed in my evidence, and that the issues I address are within my area of expertise. I have no professional or personal conflicting interests in this case.

Response:

I have been engaged by the Health and Disability Commissioner to re-visit the previous advice I provided […] after reviewing additional information relating to this case that has now been made available. In the light of this new information I have been asked to then consider if it would alter my original advice. I have been instructed to focus my comments on [RM B] only. I have sought verbal clarification that the original instructions to confine myself to commenting on midwifery care only still stand and that this therefore excludes being influenced by the new statement from the attending obstetrician. The new information provided consists of a written response from [RM B] to [HDC] […]; copies of diary entries by [RM B], responses sent to [HDC] from midwives [RM D], [RM H], [Mrs A's] first LMC and [the DHB]. [RM B's] diary entries were previously made available to me and were commented on and considered in my original advice, therefore this documentation does not provide any new information to me that would influence the prior advice. For ease of accessing my current advice in response to reviewing the new information this has been written in italics and underlined after the original response has been restated.

I have been asked to reconsider all the questions relating to [RM B] that were previously posed and to advise in each instance:

- What is the standard of care/accepted practice?
- If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?
- How would it be viewed by your peers?
- Recommendations for improvement that may help to prevent a similar occurrence in future.
- Where there are different versions of events in the information provided to provide advice in the alternative.

Questions previously answered where the focus is on [RM B's] care.

Make particular comment in the first instant on:

1. [RM B] Antenatal care: a. monitoring of fetal growth and adequacy of actions taken in response to growth restriction (alternative versions), b. adequacy of information provided to [Mrs A] including ii. vaccinations (alternative versions) iii. The power point presentation and the adequacy of information shared

about fetal distress c. adequacy of actions in response to possible breech position

2. Labour care at home: a. adequacy of fetal and maternal assessments during this time b. appropriateness of homeopathic remedies and the documentation around provision of these c. adequacy of [RM B's] care in respect of transferral advice at around 6 am. (alternative versions) [RM B] accepts she referred to [Dr C] as 'Mr Slice and Dice' d. timeliness of transfer to hospital which occurred at approximately midday e. appropriateness of the alleged advice to [Mrs A] that she should tell the obstetrician she wants an epidural and hopes the baby turns
3. Labour care at hospital: a. at what point, if any, should handover to secondary care have occurred? b. adequacy of handover (if any) (alternative versions) c. adequacy of care if [RM B] was remaining as a 'support person' d. Adequacy of care if [RM B] had not handed to hospital staff e. communication regarding the possible need for Caesarean section (alternative versions) f. fetal assessments and monitoring, including but not limited to CTG interpretation
4. **Original advice** on the provision of care by LMC [RM B] as detailed above was:

Antenatal care: 1.a. monitoring of fetal growth and adequacy of actions taken in response to growth restriction

Question 1.a: Compromised fetal growth has long been associated with IVF pregnancy. A controlled comparative Dutch study citing twice the incident of small for gestational age pregnancies in IVF singleton pregnancies than in spontaneously conceived pregnancies was published as far back as 2000, (Kouds anl, Braat, Bruinset, Naaktgeboren, Vermeiden & Visser, 2000). There is no record of any preliminary discussion with [Mrs A] by [the fertility clinic] or with [the first LMC] engaged by [Mrs A], around the increased need for monitoring of fetal growth. [Mrs A] further states that 'nobody had told me that this pregnancy needed to be monitored closely — not [RM B], not [the fertility clinic].'

In [the first LMC's] documentation she has commented that [Mrs A] had made an 'informed decision to decline a scan via [the fertility clinic]', had agreed to a Nuchal translucency scan and declined an Anatomy scan at the appropriate gestational ages. Growth scans are not usually considered until the gestational age of 24+ weeks.

[Mrs A] transferred her care at 30+2 weeks from [the first LMC] to [RM B]. [The first LMC] recorded satisfactory fetal growth at her final antenatal check prior to transferring [Mrs A's] care.

In [RM B's] response (scenario 1 a) she states that at her preliminary meeting with [Mrs A] she 'explained to [Mrs A] at that time that an IVF pregnancy can have some risk for example IUGR (intra uterine growth retardation) and eclampsia'. This information was offered in response to [Mrs A's] expressed preference to approaching her pregnancy and birth care as normal and without the need for undue specialist input. In the birth plan provided by [Mrs A] her focus is on the birth of her child and

not antenatal or postnatal care so there is therefore a reliance on undocumented conversation around antenatal care, of which there are differing accounts. As [RM B] had not formally begun to provide [Mrs A] with care at the time of this conversation, there are no formal antenatal records of this initial point of contact or of any conversation that took place.

The NZCOM Handbook for Practice/Standards of Midwifery Practice Standard three states: The midwife collates and documents comprehensive assessments of the woman and/or baby's health and wellbeing. Part of the Criteria of which is that the midwife

- Collects and compiles information from the first visit for antenatal care or at the first formal contact with the woman

[RM B] first met with [Mrs A] in [month]. While this was the first point of contact, it was an informal meeting to ascertain whether [Mrs A] wished to engage [RM B] as her LMC after relocating. [The first LMC] was still the current LMC; it would have been professionally inappropriate for [RM B] to take over the LMC role including documentation until [Mrs A] had formerly transferred her care to her. The process of transfer of care from one LMC to another differs from that of meeting with a woman who has no current LMC to initiate care. There are professional boundaries over not providing care for a woman registered with another LMC. In [RM B's] account she does, however, maintain that this knowledge around risk factors for IVF pregnancies was given to [Mrs A] at their first meeting before she became legally responsible for her care. A summary of what had been discussed prior to [RM B] undertaking the formal provision of midwifery care within the documentation after [RM B] had assumed the LMC role would have upheld that this discussion had occurred.

During [Mrs A's] antenatal care with [RM B], [RM B] has used a customised growth chart, as is becoming usual practice, a copy of which she has submitted. She has provided a computer-generated record derived from more casual notes made in her diary around the time that the antenatal visits took place and also submitted copies of the preliminary diary notes. Visits were at [Mrs A's] home not an antenatal clinic and there did not seem to be an ability/preference to enter the antenatal visits and clinical assessments directly into [Mrs A's] computerised records at the time of the visits. The preliminary diary notes are very minimal but cover basic findings which are then enlarged upon with the inclusion of any discussion that took place in the computerised antenatal data entries.

From [RM B's] records, fetal growth is plotted on the customised growth chart to be above the 50th centile with consistent growth until the final antenatal visit pre-labour onset. At this visit a significant drop in fundal height is recorded but with the growth still plotting above the 10th centile as per palpatory findings. However, where there is static growth or, as in [Mrs A's] situation, where fetal growth declines markedly the woman should be offered a referral for ultrasound assessment (NZCOM consensus statement, 2012). Palpation is an approximal skill and at times findings may be at

variance with actual fetal size. Ultrasound assessment is also presented with the same difficulty, hence allowing for a deviance of 500 grams on EFW (estimated fetal weight) prediction. I note that [Mrs A] has a BMI of 22.1 which allows palpation to be more accurate, but it is still not an exact clinical skill even when the practitioner is very experienced. At 37 weeks' gestation [RM J], a second experienced midwife, did a palpation with [Mrs A's] consent at [RM B's] request to confirm that the presentation was cephalic. [RM J's] clinical findings were also that fundal height was appropriate for gestational age at this visit.

At 41+1 weeks' gestation, the first finding of decreased fetal growth was made on palpation. Given that this was also an IVF and now postdates pregnancy, a growth scan was further indicated in addition to the reasons already stated. The Maternity Guidelines recommend that LMCs must recommend that a consultation with a specialist is warranted where the fetal abdominal circumference is below the 5th centile if the liquor volume is normal and to recommend that the responsibility for care is transferred to a specialist if the liquor volume and cord dopplers are additionally abnormal (Maternity Services 2000). This more exact information can only be ascertained by an ultrasound growth scan. Consultation is then offered to provide an obstetrician's opinion in jointly developing a plan with the woman and the midwife for ongoing care. [RM B] states in her notes that she believed these steps were the appropriate actions that needed to be taken in response to the clinical decline in fetal growth. She recounts that she 'strongly recommended' a scan to determine fetal wellbeing and growth with a view to consultation but that this was declined by [Mrs A].

The NZCOM Handbook for Practice/Standards of Midwifery Practice Standard Two states: The midwife upholds each woman's right to free and informed choice and consent throughout the childbirth experience. The criteria include that the midwife

- Facilitates the decision-making process without coercion
- Respects the informed decisions made by the woman, even when these decisions are contrary to her own beliefs
- Respects the woman's right to decline treatments or procedures

The Ministry of Health Guidelines for Consultation with Obstetric and Related Medical Services (5) states: The right to informed consent, including the right to refuse medical treatment, is enshrined in law and in the Code of Health and Disability Services Consumers' Rights in New Zealand. This means that a woman can choose to decline treatment, referral to another practitioner, or transfer of clinical responsibility.

Fetal activity is also used to assess the baby's wellbeing with absence, reduction or significant change in the normal pattern of movements needing to be responded to. Fetal movements have been assessed at each antenatal visit by [RM B] and recorded as being 10+. While evaluation of fetal movements is now more focussed on the consistency of the pattern of fetal activity rather than the number of fetal movements, counting of the movements still ascertains a consistency of fetal activity

(Royal College of Obstetricians and Gynaecologists, 2012). Documentation of fetal movements indicates that [RM B] appropriately sought further evaluation of the baby's wellbeing through this means.

Based on [RM B's] account of events, scenario a, information was shared appropriately, fetal growth and movements were monitored, collegial findings of an appropriate fundal height supported [RM B's] own assessments at 37 weeks' gestation and a referral for an ultrasound scan with a view to obstetric consultation was offered when a reduction in fetal growth was first noted. My opinion therefore is that the care, if provided in accordance with this account, was acceptable midwifery care.

17/09/18: *My advice after reviewing the new information remains unchanged; that in my opinion the care, if provided in accordance with this account, was acceptable midwifery care.* ***ADVICE UNCHANGED.***

Antenatal care: 1.a. monitoring of fetal growth and adequacy of actions taken in response to growth restriction

Original Advice:

[Mrs A] disputes that she was informed by anyone of the need to monitor her pregnancy more closely for fetal growth and/or signs of eclampsia. This contrasts with [RM B's] statement that this was discussed at their first meeting prior to her formally taking over the LMC role for the provision of midwifery care. As there is no formal record of this conversation the two versions of this discussion that are in dispute are difficult to prove or disprove.

The NZCOM Handbook for Practice/Standards of Midwifery Practice Standard three has been referred to in that the midwife collates and documents comprehensive assessments of the woman and/or baby's health and wellbeing. The criteria include that the midwife collects and compiles information from the first visit for antenatal care or at the first formal contact with the woman.

As previously commented, it is apparent that while [RM B's] preliminary meeting with [Mrs A] in [month] was the first point of contact, this was an informal meeting for [Mrs A] to decide whether to engage [RM B] as her LMC after moving to her new location. [The first LMC] was still registered as [Mrs A's] LMC and providing her with ongoing care, so it would have been inappropriate for [RM B] to begin documentation as her LMC at this point.

[Mrs A] expresses her concerns around the monitoring of the fetal growth during the third trimester while in [RM B's] care. She comments that she has been told by doctors at [Hospital 2] that throughout this time [Baby A] had not grown. In my opinion this is erroneous information. Static fetal weight gain over a period of ten plus weeks in the last trimester of pregnancy is not compatible with ongoing reassuring fetal activity. Based on her customised fetal growth chart if [Baby A] had survived static growth over such a prolonged period [the baby] would have been born weighing

a maximum of 2 kilos. I feel the information she has been given needs correcting as it has undoubtedly added to her distress.

It is the expectation that women hold a duplicate copy of their antenatal records. The NZCOM Handbook for Practice/Standards of Midwifery Practice Standard Four states that: The midwife maintains purposeful, on-going updated records and makes them available to the woman and other relevant persons. The criteria include that the midwife

- Makes records accessible and available at all times to the woman and other relevant and appropriate persons with the woman's knowledge and consent

[Mrs A] comments that during her pregnancy care she received a brief record of her visits from [RM B] only when she requested it and she has submitted this record. Fundal height in this record has, as [Mrs A] describes, only been documented as being measured once and the information in it is abridged. [RM B] explains this as having occurred because she plotted the fundal height directly on [Mrs A's] customised growth chart and had not added the measurements into the original computerised antenatal record because of oversight. She also acknowledged that she had neglected to include the growth chart when she first emailed [Mrs A's] records to her. However, regardless of this explanation, [Mrs A] further states that fundal height was not routinely physically measured at all antenatal visits despite it being documented as it having been done.

I understand that when using a computerised record when providing antenatal care in a home visiting situation there may be a difficulty in providing an ongoing current record of care for the woman. The lack of duplicate notes however meant [Mrs A] had no immediate record of advice and information given that she could refer to or question at the time if she believed care was inaccurately documented. [RM B] states she has now addressed this situation. The lack of hand held notes immediately available to [Mrs A] creates a situation where the accuracy of documentation is subject to question.

[Mrs A] also states that she was unaware that a customised growth chart was being used to monitor her baby's growth and that she was not shown this. She believes it did not exist and was only created in response to her complaint. [RM B] disputes this allegation by way of stating that the Grow Chart is part of her computer programme and automatically created for each woman. That it exists however does not confirm that it was used. She further states that she carried [Mrs A's] chart with her in her diary in which she entered the preliminary details of her antenatal checks. It is usual to discuss the palpatory findings including fetal growth with the woman as part of her antenatal check. It must be asked that if the grow chart was carried by [RM B] in her diary where she entered the preliminary findings of antenatal visits, why this information was not shared with [Mrs A] when advocating for her to consent to a scan and consultation because of the clearly declining graphing of fetal growth?

The NZCOM Handbook for Practice/Standards of Midwifery Practice Standard one states that the midwife works in partnership with the woman, the criteria include that:

- Facilitates open interactive communication and negotiates shared decision making
- Shares relevant information within the partnership

The lack of transparency in documentation has led to [Mrs A's] opinion that the antenatal record produced by [RM B] in response to [Mrs A's] request for her full and unabridged information is in fact inaccurate. She further speculates that the information has been added to in retrospect to present a stronger case for the quality of the antenatal care that was provided by [RM B]. [RM B] confirms that at the time of providing [Mrs A's] care it was not 'unusual for me to write notes soon after a visit and certainly on the same day' but categorically rejects the assertion that the notes are not a true record or created in response to the complaint. She further states that the computerised software she uses does not allow the information to be edited after a lapse of 24 hours. This has been confirmed by an independent letter from the software distributor. However, the fact remains that [Mrs A's] antenatal records were unavailable to her during her antenatal care with [RM B]. It is unclear when the initial record was provided to her, but as it is incomplete it is of limited value.

The recommendation for a growth scan and consultation is again at variance within the two scenarios. Strong recommendation is an emotive phrase and subject to interpretation. [Mrs A] and [RM B] hold differing views of how clearly the need for a growth scan was advocated for. [RM B] details that she discussed the serious implications of this finding of lack of fetal growth and the reasons for her recommendation for a growth scan and consultation with [Mrs A] and this was declined by her. [Mrs A] does not believe she was given adequate information to understand the significance of the drop in fetal growth and would have readily agreed to a scan had she known. She felt that she was led to believe that a scan was probably unnecessary and more of a postdates formality to demonstrate that recommended midwifery care had been followed in case she did not come into spontaneous labour. Given the distance she would have to travel to facilitate a scan and a consultation she was undecided. A scan was subsequently booked for the 10th [Month3] when [Mrs A] would have been 42.1 [weeks'] gestation. The Ministry of Health Guidelines for Consultation with Obstetric and Related Medical Services Code 4024 Prolonged pregnancy recommends consultation and describes the need to 'refer in a timely manner for planned induction by 42 weeks.'

Based on [Mrs A's] account (scenario b) her antenatal records were unavailable to her, when made available she deemed them to be inaccurate, clinical checks did not always include monitoring of fundal height as was stated in her clinical records, information was not shared adequately to alert her to the extra need for vigilant fetal monitoring, the urgency of the need for an ultrasound scan for fetal growth compromise was not made clear to enable her decision to decline an ultrasound scan

to be informed. My opinion therefore is that if care was provided in accordance with this account there has been a moderate departure from acceptable midwifery care.

17/09/18: *In the additional response from [RM B], [Mrs A's] account is disputed in that she rejected advice from [RM B] making it challenging to provide her midwifery care. She asserts that appropriate information was provided and recommendations around a growth scan and obstetric consultation were made but declined by [Mrs A]. That these recommendations were made by [RM B] is not in dispute, however [Mrs A] asserts that the implications of the findings and the seriousness of the situation were never made clear to her; that if the level of concern had been made clear to her she would have decision made differently.*

That a consultation and scan were offered is confirmed and that these were offered does indicate that there was concern over fetal wellbeing on [RM B's] part. The right for any care to be declined by the consumer is upheld within the Code of Health and Disability Services Consumers' Rights but this has to be balanced against the further right for you to be told things in a way that you understand. My opinion remains that if care was provided in accordance with [Mrs A's] account and she was not provided with enough information to understand the gravity of the reasoning behind the need for a growth scan and obstetric consultation and therefore declined these this is a moderate departure from acceptable midwifery care. ***ADVICE UNCHANGED***

My recommendation for future practice as requested is that all decision making by women that does not reflect recommended practice is clearly documented, concerns plainly stated and the woman asked to countersign the documentation indicating that she understands the seriousness or potential seriousness of her decision and continues to elect to decline recommended care.

In response to the opinion sought on the provision of Antenatal Care by [RM B]
ii. adequacy of information provided to [Mrs A] including ii. vaccinations (alternative versions)

The NZCOM Handbook for Practice/Standards of Midwifery Practice Standard One states:

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

The criteria for this includes that the woman understands the implications of her choice. It needs to be clarified that Vitamin K is not a vaccination as it has been referred to. It is a prophylactic preventative against Vitamin K Deficiency Bleeding administered at birth requiring parental consent. Vaccination is the administration of antigenic material to stimulate an individual's immune system to develop adaptive immunity to a pathogen. Other than when a baby is at risk of exposure to tuberculosis or Hepatitis B, vaccinations are administered by the woman's General Practitioner or their Practice Nurse under GP instruction with parental consent at the infant's six-week check. Advice as to when vaccinations will be offered and further basic

information about the vaccination programme by way of leaflets, websites etc. upon parental request would be an expectation of the midwifery role, but the professional who is administering the vaccination is responsible for ensuring that an informed consent process has occurred. [Mrs A] comments in her complaint that having asked for [RM B's] opinion on vaccinations she ascertained that she was opposed to them therefore she didn't pursue the conversation.

Her focus was on Vitamin K. It is the expectation that the consent or decline of the administration of Vitamin K will form part of a woman's birth plan so she and her partner can make an informed decision. [Mrs A] states she had elected to go with the option of oral administration but if the birth was traumatic she would choose intramuscular administration. This is in accordance to the standard recommendation made to parents who elect oral administration as their preferred option.

[RM B's] response (Scenario A) as pertaining to information around Vitamin K and vaccination:

[RM B] disputes aspects of the discussion around vaccination, but in [Mrs A's] account she was invited by her to share her opinion, an opinion being a personally held belief. Within her power point information there is reference to the giving of Vitamin K to the baby with parental consent and [Mrs A] had discussed her preferences around its administration with her.

My opinion based on scenario A is that this was acceptable midwifery care.

[Mrs A's] response (scenario B) as pertaining to information around Vitamin K and vaccination:

[Mrs A] sought an opinion from [RM B] as to her thoughts on vaccination and having established they had a different point of view she did not pursue this any further. As stated, informed consent is a process that is undertaken with the person administering the vaccine which differs from an opinion. She was clearly well informed around the giving of Vitamin K, had decided the preferred method of administration and stated the circumstances that would lead her to change her original decision. [RM B] had indicated to her in written material she had provided this was a process of informed consent and had had this discussion with her.

My opinion based on scenario B is that this was acceptable midwifery care.

17/09/18: *There has been no new information provided in relation to this question and my opinion therefore remains unchanged.* ***ADVICE UNCHANGED***

In response to the opinion sought on the provision of antenatal care by [RM B]
iii. The power point presentation and the adequacy of information shared about fetal distress.

The power point submitted by [RM B] covers basic information with a focus on normal birth, therefore fetal distress is not specifically covered in this. While [RM B] states in

her response that her power point includes information about caesarean birth, breast feeding and the first few days of birth this material is not present in the power point that has been submitted. She similarly states that information regarding pain relief is also included but it is offered as additional documentation.

Antenatal visits by [RM B] extended up to two hours, whereas the time allocation for a routine antenatal check is approximately half an hour. This implies that a lot of discussion took place over and above the clinical care, although [Mrs A] contests that much of this was irrelevant. [RM B] felt that [Mrs A] was a well-informed woman from their first point of contact. She comments that [Mrs A] had a folder of information, she had personally researched pregnancy and birth topics and had developed her own birth plan. After completing a twelve-week antenatal class [RM B] comments further that [Mrs A] had felt that she had learned nothing new as she had already researched topics including fetal distress. [Mrs A's] birth plan also considers the care she would accept if transferred to hospital or needing a caesarean birth.

Midwives are professionally aligned to normal birth but expected to have the ability to detect and take appropriate actions when birth deviates from normal. The monitoring of both mother and baby in labour is a well-known midwifery responsibility to ensure the wellbeing of both. Through this means indications are picked up on if there is a need for an increased level of surveillance such as cardiotocography and/or obstetric intervention. It is implicit in this standard midwifery care that the fetus is monitored closely for fetal distress.

The NZCOM Handbook for Practice/Standards of Midwifery Practice Standard One states: The midwife works in partnership with women while Standard Two states: The midwife upholds each woman's right to free and informed choice and consent throughout the childbirth experience. The criteria for both standards include the expectation that the midwife

- Shares relevant information.

In a clinically well woman experiencing an uncomplicated pregnancy and with an existing awareness evident in her care plan that maternal or fetal distress would require transfer to hospital and/or caesarean birth, I do not think extended discussion around fetal distress is relevant. Nor does this align with the midwifery philosophy captured in the NZCOM Handbook for Practice under competency Three: 'Midwifery is a primary health service in that it recognises childbirth as a significant and normal life event'. Within this context discussing obstetric emergencies and intrapartum abnormalities in the less than likely event that they may occur would be undermining the perception of birth as a normal life event. It is well established that fear impacts adversely on the normal progression of labour.

My opinion on the adequacy of information shared about fetal distress is that it meets acceptable midwifery care.

17/09/18: *There has been no new information provided in relation to this question and my opinion therefore remains unchanged* ***ADVICE UNCHANGED***

In response to the opinion sought on the adequacy of actions in response to the possible breech presentation, C:

Diagnosis of a breech presentation can be difficult in a primigravid woman who has firm abdominal muscles. Further difficulty presents in that the suboccipito-bregmatic diameter (head circumference) and bi-parietal diameter (distance between the two parietal skull bones) is only half a centimetre different from the birochanteric diameter (bottom). It is for this reason that on occasions breech presentations are not diagnosed until labour is established with sufficient cervical dilatation to confirm the presenting part and a decision is then made with the woman whether she wishes to continue with a vaginal birth or to proceed to a caesarean delivery.

Under the referral guidelines (Ministry of Health, 2012) breech presentation does not require consultation and is within the scope of Midwifery practice. Current midwifery training includes the management of the birth of a baby in breech presentation. Vaginal delivery is an option where the fetus presents as a frank breech (feet up by their head), but caesarean birth is recommended where the baby is a footling or a complete breech with its feet presenting because of the increased chance of cord prolapse. Caesarean is shown to be a safer option than vaginal breech birth but some women do choose to have a vaginal birth. It is suggested that if that is their choice there should be immediate access to an obstetrician and a setting where a caesarean can be performed, but some women again elect to continue with their home birth preference if they are supported.

Per [RM B's] account, she shared her uncertainty as to presentation with [Mrs A] at the time and suggested an ultrasound scan to determine the presentation. When this was declined by [Mrs A], she arranged for a second opinion from an experienced colleague [RM J] in 4 days' time to coincide with [Mrs A's] proposed visiting [RM J] for an antenatal session. [Mrs A] agreed to have a scan if a breech was suspected at the next consultation however a cephalic presentation was confirmed by [RM J]. In the antenatal notes provided, the antenatal check on the 31st [Month1] was the only time when presentation was in doubt.

Per [Mrs A's] account a scan was not offered. She felt [RM B] took a flippant approach to the baby being in a breech presentation while indicating it would not influence her decision to assist [Mrs A] to birth at home. She states that [RM B], however, did discuss options for turning the baby should it be breech.

To summarise, breech presentation was only suspected but not confirmed at 36+3 weeks' gestation and a second opinion was sought and put in place by 37 weeks' gestation. If women wish to attempt an external cephalic version to correct a breech presentation it is not offered until after 37 weeks because of the tendency for the baby to revert back to a breech presentation. The second opinion obtained 4 days later confirmed a cephalic presentation. Because the baby was not in a breech

presentation further conversation about birthing a breech baby at home and the risks associated with vaginal breech birth were no longer relevant.

My response to the opinion sought on the adequacy of actions in response to the possible breech presentation is that it meets acceptable midwifery care.

17/09/18: *There has been no new information provided in relation to this question and my opinion therefore remains unchanged.* ***ADVICE UNCHANGED***

In response to the opinion sought on Question 2) Labour care at home a. Adequacy of fetal and maternal assessments during this time.

Documentation provided by [RM B] as to the care given in labour is in the form of clinical notes; a labour partogram which graphs progress on time lines has not been used. This is optional in a homebirth situation and I note that in [Mrs A's] birth plan she states that she did not wish a time line to be applied to her labour that 'if we are both doing well then let the birth run its natural course.' In using a partogram there is a clear tracking of progress, or lack of progress in relation to timeframes and stability or instability of maternal and fetal recordings that makes such information readily identifiable and assessable. This may not have been in keeping with [Mrs A's] preference to labour without time constraints if she and her baby were not distressed. As the care plan created by [Mrs A] has influenced midwifery care offered I will discuss this further.

The NZCOM Handbook for Practice/Standards of Midwifery Practice third decision point in labour states: the birth plan is referred to and followed in consultation with the woman and her partner/supporters as/if appropriate. The birth plan was presented to [RM B] by [Mrs A] at their initial meeting as a condition of her being engaged to provide midwifery care. There had been a lack of joint consultation, information sharing and a process of partnership between the woman and the midwife in its development. Therefore, where [RM B] felt that there was conflict between what was being requested and what, in her professional judgement, compromised best care, further discussion should have been entered into. The need for this may not have been immediately apparent as the degree to which [Mrs A] planned to adhere to her birth plan under altering circumstances may have taken further knowledge of her to evaluate. [RM B] had indeed gone on to express concerns as to how rigid [Mrs A] might be around any need for interventions and/or transfer prior to giving labour care. This reinforces that further open dialogue around these concerns was essential in the antenatal period to clarify boundaries around safe care. Despite [Mrs A] having extensively researched labour and birth there was a need to ensure that she did have the appropriate information to make her decisions with. [Mrs A] also commented as to her growing dislike of [RM B] and expressed the hope that she would not be providing labour care despite having been offered the option by [RM B] of using an alternative midwife. Again, this was not raised by [Mrs A] directly with [RM B]. In my opinion the midwifery partnership was fallible before the commencement of labour care making it a less effective relationship.

Evaluating the documentation that was submitted upon [Mrs A's] transfer to hospital summarising the labour care that had been provided, I note that there is an absence of any maternal recordings of temperature, pulse and blood pressure. It is usual practice to establish a maternal baseline at the commencement of established labour, the change in subsequent recordings can then be evaluated as an indicator of whether there is any maternal distress and/or pyrexia developing. There is no indication in [Mrs A's] actual birth plan that she was specifically not open to this monitoring. In [RM B's] extended notes she has added in the comment around her commencement of labour care that 'Normally at this point in my midwifery care, it would be my standard practice to carry out a full assessment and internal examination including palpation, observations, V/E etc. This was not done at this point because of [Mrs A's] express wishes for limited intervention in labour as per her very extensive birth plan. I had no concerns at this point.'

The NZCOM Handbook for Practice/Standards of Midwifery Practice Standard Six states that:

- Midwifery Actions are prioritized and implemented appropriately with no midwifery act or omission placing the woman at risk.

The NZCOM Handbook for Practice/Standards of Midwifery Practice third decision point in labour states:

- Continue regular assessment of the woman and baby and progress of labour.

Maternal recordings were not done at any point, even when there was sufficient concern by [RM B] to advocate for transfer from home to hospital. Because it is not documented that a full assessment was offered and declined, it is unclear whether it is an assumption on [RM B's] part that [Mrs A's] desire for limited intervention in labour included maternal assessments or a specific requirement. The care plan is a guide to care preference and therefore subject to revisiting per the events that occur.

Abdominal palpatory findings as to the lie and descent of the baby are not recorded; these assessments can be help[ful] in detecting mal presentation and poor progress through the lie of the baby and lack of descent by the fetus through the maternal pelvis. Again, [RM B] in her extended notes has commented that this was not done guided by her understanding of [Mrs A's] care plan.

The initial vaginal examination at 00.31 did not include information as to the presentation, position, presence or non-presence of caput or moulding of the fetal head and the station of the fetus, just the dilatation, position of the cervix and the degree of effacement.

The presentation of the fetus confirms the leading part of the baby while the position signifies how it is aligned within the maternal pelvis; identification of this enables determination of a mal presentation. Caput succedaneum occurs in prolonged or obstructed labour when the area in immediate contact with the cervix becomes oedematous. Oblong moulding of the fetal head may also occur with prolonged

pressure as the fetal head tries to adapt to the birth canal to pass through it. An increasing degree of developing caput and/or molding can be diagnostic of obstructed labour. The station at which the presenting part is assessed at gives an indication as to how far it has descended through the maternal pelvis, Station 0 being the point at which the widest diameter of the fetus is at the narrowest dimension of the pelvis. This also helps to inform whether the labour is obstructed. These evaluations are a routine part of vaginal assessments to ascertain progress; where a woman is reluctant to consent to such examinations there is an additional need for those for which consent has been given to then be very thorough. These findings may have been determined by [RM B] as part of her assessment, but there is no documented evidence of this.

Examinations are ordinarily done at four hourly intervals where labour and progress are normal. A follow up earlier examination may be indicated if progress is poor so that appropriate action can then be put in place earlier, as [RM B] did do, the last 3 examinations being performed at approximately 2 hourly intervals. The second examination occurred $5^1/_2$ hours after the first which is acceptable as [Mrs A] was using the pool for relief and appeared to be making normal progress. At the second examination at 00.56 documentation again did not include evaluation as to the presence or non-presence of caput or moulding, or the station. Dilatation, condition of the cervix is commented on and the position was also stated to be thought to be OP (occiput posterior), a position that can frequently be problematic for primigravid women.

The third examination done by [RM D] includes documented information of the station the fetus has descended to, assessment of the cervix and dilatation, but no comment as to whether there is any caput or molding. The fourth examination only offers documented information as to cervical dilatation while the fifth and final examination prior to transfer offers documented information as to cervical application and dilatation. The timing of the examinations is appropriate but while my assumption is that all criteria of a vaginal examination would have been met to maximise information to inform decision making, the documentation does not support this and my opinion must be based on the documented evidence. There are no recordings of the maternal base lines of temperature, blood pressure and pulse. Liquor has been noted to be clear, which is reassuring as to fetal wellbeing as the presence of meconium in the liquor is indicative of a degree of fetal distress. The monitoring of the fetal heart rate is appropriate. All care must be viewed in the context of this being a postdates infant with compromised fetal growth, hence [RM B's] recommendation for a growth scan and consultation late pregnancy.

My opinion therefore as to the adequacy of the fetal and maternal assessments during labour care at home as per the documentation provided is that this is a mild departure from acceptable midwifery care.

17/09/18: *In the additional response from [RM B] she has referred to the restrictions placed on her practice by [Mrs A] as to what monitoring in labour would be accepted*

causing her to not adhere to her usual standard of practice. There is a lack of clarity within the birth plan documentation as to exactly what care and/or monitoring was declined; there is a generalized expectation for letting the birth run its natural course providing both mother and baby were doing well. [Mrs A's] care plan states that 'if a medical emergency does arise, I am open to considering alternatives to these as long as I have been provided with all the information I need to give informed consent'. She also lists her preferences should she require hospitalisation or a caesarean section indicating that she has considered and accepted these as possible birth outcomes.

While the birth plan was independently devised by [Mrs A], in her original response [RM B] comments on discussing this with her as part of her responsibility as the incoming midwife who would be providing care from that point on. This would have provided an opportunity to clarify what was acceptable and what wasn't and the documenting of what was agreed to accordingly.

There is no evidencing of [Mrs A] declining of monitoring in the statements made by [Ms G] (Doula) who was present throughout labour or by [RM D] who was present in the later part of labour.

The vaginal examinations were consented to but the documentation around findings were minimal. This new statement by [RM B] recreates the on-going dilemma of what is the true account of events? If [Mrs A] did in fact decline usual monitoring when it was offered, then [RM B] is correct in stating that she was restricted by the need for informed consent to carry out any procedures and without this she could not provide her usual care. While the vaginal examinations were poorly documented it is expected that an experienced midwife would automatically do a full assessment, but even if findings were limited to dilatation only the obstructed labour would still declare itself. There is beginning to be a move away from the adage of if it hasn't been documented it hasn't happened (NZCOM Expert Witness Workshop, 2017). There is recognition that documentation in a planned anticipated low risk homebirth may not have been as robust when no external scrutiny of notes was anticipated.

In the light of the further comment by [RM B] if it is established that [Mrs A] did in fact decline routine examinations preventing [RM B] from undertaking these, then my revised advice would be that the adequacy of the fetal and maternal assessments during labour care at home is acceptable care as the woman has the right to control what care she accepts. However, the documentation that is currently offered does not support this and there is an absence of any confirmation that [Mrs A] did decline routine care by the other two birth attendants. If [RM B's] further statement is not upheld, then the original opinion that this is a mild departure from acceptable midwifery care still stands. ***ADVICE CHANGED IF [RM B'S] STATEMENT IS UPHELD.***

My recommendation for future practice is that the documentation must reflect what occurs regardless of where that care is taking place and that the expected standard of documentation is always adhered to. Should a woman decline routine monitoring this needs to be clearly documented as must her continued choice of declining of such cares

during labour and birth if the need for these are indicated. Where this occurs, the midwife's increasing concerns and the subsequent advice given to the woman must be plainly stated within the documentation. It should be evident what the midwife's concerns were, that the woman understands them and the possible adverse outcomes so that the thinking around decision making points is transparent. Ideally the woman, or her partner on her behalf if she is unable to self sign, should countersign those entries.

In response to the opinion sought b. appropriateness of homeopathic remedies and the documentation around provision of these:

The New Zealand College of Midwives recognises that complementary therapies may have beneficial effects (NZCOM Consensus Statement, 2000). They advise that midwives using them have either undertaken a recognised education programme in their use or refer clients to an appropriately qualified practitioner. There was discussion between [RM B] and [Mrs A] during the antenatal period about the use of homeopathic remedies if the need seemed indicated during labour and this was agreed to by [Mrs A]. [RM B] made it clear that she was not qualified to suggest remedies herself but had access to a qualified practitioner who was willing to recommend remedies in response to the labour scenario if need be. [Mrs A] accepted this offer. While [RM B] facilitated the subsequent telephone consultation, she was not acting as a homeopath and there was a clear understanding of this and it was external to midwifery labour care.

My opinion as to the appropriateness of homeopathic remedies and the documentation around provision of these is that this was acceptable midwifery care.

17/09/18: *There has been no new information provided in relation to this question and my opinion therefore remains unchanged* ***ADVICE UNCHANGED***

In response to the opinion sought c. adequacy of [RM B's] care in respect of transferral advice at around 6 am (alternative versions)

[RM B's] version i: At this juncture [RM B] had assessed [Mrs A's] progress with a consented to vaginal examination and determined that there was a mal presentation of a posterior position. Progress in terms of dilatation was sub optimal with only 1 cm of dilatation occurring over 5½ hours — the expectation is that primigravid women progress at the rate of 0.5–1cm of dilatation each hour. Descent, a further indication of progress is unknown from the documentation as is the presence or absence of any degree of caput and/or molding which are further indicators of obstructed labour. [RM B] then states that in the light of her findings she recommended that [Mrs A] transfer to hospital for consultation with an obstetrician as per referral guidelines for slow progress (Maternity Services, 2000). This was then followed by a phone call to the hospital by [RM B] to ascertain which obstetrician was on call — her opinion was then offered to [Mrs A] and her partner that the current obstetrician on would be more amenable to supporting her to continue labouring while the incoming obstetrician at 8am would most likely advocate for an immediate caesarean and she

admittedly referred to him as 'Mr Slice and Dice.' I concur with her reflection that this was inappropriate particularly when [RM B] already had an awareness that the decision to transfer to hospital from home would be a fraught one for [Mrs A].

The NZCOM Handbook for Practice/Standards of Midwifery Practice third decision point in labour includes under Assessment and plan of care that:

- Consider whether additional care may be required and discuss with the woman

In my opinion such discussion should be unemotive while acknowledging that it represents a difficult decision for a woman who had had such a strong preference for a home birth with minimal intervention. The transfer is being recommended to access a specialist level of obstetric input and access to a facility able to provide a greater level of care than that which is available at home. Who is the provider of that care under such circumstances is of lesser consequence; it is the secondary level skills and facility access that the transfer is making available to the woman that is the priority. Even where there are philosophical differences between practitioners, the reality is with the obstetrician beginning at least a 12-hour shift at 8 am they would be providing the secondary care for [Mrs A] should it be deemed necessary. While the intent in establishing that the current on call obstetrician would be more empathetic to continue with a trial of labour, the most likely scenario would have been that they would be off duty before [Mrs A] had her baby and the incoming obstetrician would be involved if his expertise was necessary. Creating doubts around an obstetrician's clinical judgement who will be engaging in her care in a woman already very opposed to intervention is, in my opinion, not doing that woman a service regardless of whether those comments were offered with good intent.

The NZCOM Handbook for Practice/Standards of Midwifery Practice Standard Six states that: Midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk. The criteria include:

- Identifies deviations from the normal, and after discussion with the woman, consults and refers as appropriate
- Works collaboratively with other health professionals and community groups as necessary

[RM B] states that she advocated for transfer and outlined a proposed likely plan of care on hospital admission, but this was strongly declined by [Mrs A].

My opinion in response to the adequacy of [RM B's] care in respect of transferral advice at around 6 am, version i, takes into account that information from her assessment was shared with her client and that there was no current evidence of fetal distress with clear liquor draining and reassuring fetal heart rate recordings. While there was discussion unbecoming to a professional around the obstetrician coming on call, the need for transfer was advocated for, therefore the care provided was acceptable midwifery care.

17/09/18 *My advice in this version of events remains unchanged, that this was acceptable midwifery care.* ***ADVICE UNCHANGED***

[Mrs A] (version ii):

[Mrs A] has no recollection of the implications of a posterior presentation and 'failure to progress' being discussed with her by [RM B] after this examination. Her understanding was that admission to [Hospital 1] was only being advocated for so she could get some pain relief. She states that she did not decline admission and the option to transfer was not discussed after it was learnt who the incoming obstetrician would be. She does not state clearly that with additional information she would have been open to transfer, but the implication is that she would have been. Her support people offer slightly differing versions of events. [Mr A] states that his wife was convinced to try alternatives to rotate the baby from its posterior position. He adds saying that 'as long as the baby was ok he was ok with it, but as soon as the baby showed any signs of distress "all bets were off and its straight to the hospital".' This suggests that some discussion did take place around transferring to hospital and a decision was made to continue labouring at home providing the baby remained in good condition. [Ms G's] recollection is that [RM B] tried to explain the position of the baby to [Mr A], but she has no recollection of any recommendation of transfer and obstetric consultation being made by [RM B].

There are further comments around whether a phone call was in fact made to the hospital at that time, but for [RM B] to have acquired an awareness of the on-call obstetrician's roster on that day a phone call must have made to the unit. There is also a statement from [RM E], a midwife on duty on that day, that confirms that this phone call had been received by the nightshift.

There are further concerns for [Mrs A] that she was encouraged by [RM B] to feel a vaginal birth 'was more likely to happen' with adequate pain relief and that caesarean delivery was not suggested or encouraged. The findings of this vaginal examination did not necessarily mean that the baby's birth needed to be by caesarean section although it would be easier to further ascertain the likelihood of this if full information including descent, and the presence of caput/molding had been documented. With appropriate analgesia and augmentation of labour using syntocinon infusion to create stronger more effective contractions the fetus can rotate to the more favourable position of occipito anterior (O/A) or alternatively with improved descent and dilatation the fetus can be born vaginally in the occipito posterior (O/P) position. The presence of clear liquor and reassuring fetal cardiac rates was reassuring. [Mrs A] was still feeling physically able to cope with labour in the absence of any maternal recordings to show if this was inappropriate from the aspect of maternal wellbeing. While this was a decision-making point, it was technically a non-urgent one. It was however an appropriate time to advocate for transfer from the home situation to hospital in view of the mal presentation and slow progress.

The NZCOM Handbook for Practice/Standards of Midwifery Practice Standard Six states that: Midwifery actions are prioritised and implemented appropriately with no

midwifery action or omission placing the woman at risk. The criteria, in addition to what has been cited in version i includes:

- Ensures assessment is on-going and modifies the midwifery plan accordingly.

While Standard Two states that the midwife upholds each woman's right to free and informed choice and consent throughout the childbirth experience, the criteria includes

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

My opinion in response to the adequacy of [RM B's] care in respect of transferral advice at around 6 am version ii considers that there was no indication at this time of any fetal compromise. A choice could have been made by [Mrs A] to continue to labour at home therefore but if any information was withheld from her of the findings of her examination and the implications of these then informed consent did not take place in full. It is [Mrs A's] assertion that this was the case and therefore the care provided was a mild departure from acceptable midwifery care.

17/09/18 *In the new information provided [RM B] disputes that [Mrs A] was given inadequate information with which to make her decision as to whether to transfer into hospital from home; she states of informing her that 'she had not made very much progress and really should be going to the hospital now.' It was only because of [Mrs A's] preference detailed in her birth plan to not have a time line imposed on her labour and in the absence of fetal distress that [RM B] remained willing to continue to care for her at home 'for as long as possible'. [Ms G] (Doula) states in her original account '[RM B] now tells [Mrs A] that the decision really needs to be made and they need to head into hospital' but that it is '[Mrs A's] choice'. In her original statement [RM D] recollects this event as '[RM B] commented that [Mrs A] was tired but insistent she wanted to avoid a caesarean section and was therefore reluctant to transfer.' Both [Ms G] and [RM D] refer to the baby's posterior position and the implications of this being commented on although [Mrs A] has stated that she has no recollection of this.*

[Mrs A] also expressed doubts that the phone call to the hospital at this time was in fact made, however it was confirmed by the night staff midwife [RM E] that it was. [Mr A's] comments also support that transfer had been discussed. It is very unfortunate at the time of this decision point that the on-call obstetrician was referred to by [RM B] as 'Mr Slice and Dice' to a woman who was hoping to avoid a caesarean birth, a point which [RM B] has since fully acknowledged.

In the light of [RM B's] new response that adequate information was given around the need to transfer and the original statements by [Ms G], [RM D] and [Mr A], it would now appear that the accurate version of events is more likely to be that transfer was advocated for by [RM B] but declined. Accordingly, my advice is now revised to this being acceptable midwifery care. ***ADVICE CHANGED***

Recommendation for future practice, as is now accepted by [RM B], that professionalism in all interaction concerning and with other health personnel is upheld. Where reaching a decision-making point in care thorough documentation reflecting what took place is particularly important.

In response to the opinion sought etc. Timeliness of transfer to hospital which occurred at approximately midday:

The primary decision-making point for transfer had occurred at around 6 am. There are differing versions as to the information that was shared to inform [Mrs A's] decision to continue to labour at home. There is dispute over whether she in fact even made a conscious decision whether to transfer in to hospital or to continue to labour at home as opposed to [RM B's] version of advocating transfer to hospital and this being strongly declined by [Mrs A].

The next decision point came at midday when the mal presentation and failure to progress indisputably declared itself. Again, the station indicating level of descent and the presence or absence of caput and/or molding of the fetal head is unknown, but the posterior presentation is again confirmed, poor application of the presenting part to the cervix is noted which typically occurs in a mal presentation and cervical dilatation is estimated at 7cms.

On the previous two assessments at 07.46 findings had been station 0 to –1 (widest diameter of fetal skull still above the narrowest part of the maternal pelvis), cervix well applied to the presenting part and dilatation 7–9 cms with some rotation of the head towards anterior presentation; on the second assessment prior to transfer at 0954 the station is not commented on, there is no further rotation of the fetal head, cervical dilatation is almost complete with just an anterior rim of cervix left to dilate. This represents acceptable progress of 3.5 centimetres over 6 hours, expected primigravida process being of 0.5 to 1 cm over an hour, fetal heart rate monitoring continued to be reassuring and amniotic liquor remained clear. The regression in dilatation occurs when the cervix becomes oedematous and swollen in obstructed labour, or when the fetus may rotate back to a less optimal position and the pressure and application to the cervix is decreased causing the cervical dilatation to reduce again indicating obstruction; in the examination prior to transfer it is noted that there is now poor cervical application of the presenting part to the cervix.

In my opinion regarding the timeliness of transfer to hospital at midday is acceptable midwifery care.

17/09/18: *There has been no new information provided in relation to this question and my opinion therefore remains unchanged.* ***ADVICE UNCHANGED***

In response to the opinion sought e. appropriateness of the alleged advice to [Mrs A] that she should tell the obstetrician she wants an epidural and hopes the baby turns

The NZCOM Handbook for Practice/Standards of Midwifery Practice Standard Two states that: the midwife upholds each woman's right to free and informed choice and consent throughout the childbirth experience. The criteria for which includes:

- Shares relevant information, including birth options and is satisfied that the woman understands the implications of her choices
- Facilitates the decision-making process without coercion

If [RM B] believed with epidural analgesia allowing [Mrs A] to rest the fetus might still rotate and enable [Mrs A] to achieve a vaginal birth, then she had an obligation to share this information with [Mrs A]. At the time of this discussion there was no clinical evidence of fetal distress. As previously commented information as to whether there were physical indicators of maternal distress over and above physical and emotional tiredness is unknown because of the absence of any documented maternal recordings. In the extended notes provided by [RM B] she writes 'I stated at that point that she needed to ask the obstetrician for information to make an informed choice. If he only offered a caesarean section she could ask if there were other options she could try first if it was safe. It was not within my scope of practice to make a recommendation one way or the other. I advised [Mrs A] it was a matter for the specialist and her.'

[Mrs A] however talks of being coached on what to say, 'which was to request an epidural and still try for a vaginal birth. I was still being led to believe by her that this could happen.' [Mr A] refers to the discussion around this as '[RM B] was coaching [Mrs A] what to say and what they wanted when we got to hospital.' [Ms G's] account is that [RM B] advised them that 'she has spoken to the obstetrician and he has agreed to an epidural and possible synto. ... that he will likely insist on a C-section, but that it is [Mrs A's] choice and that it is worth trying this other way first.'

This discussion must be seen in the context of the on-call obstetrician having been referred to by [RM B] as 'Mr Slice and Dice' and presented to [Mrs A] and her husband as an obstetrician with a reputation of being more likely to advocate for and perform a caesarean delivery than to support an ongoing trial of labour. It does not appear that there was an understanding of the possible outcomes of continuing with the labour or obstructed labour being further confirmed and/or the development of maternal and/or fetal distress and the implications of this for [Mrs A] and her baby. For these reasons, from a midwifery perspective I do not feel adequate information was provided to enable [Mrs A] to make an informed decision nor was it free from coercion. However, the decision whether or not to perform a caesarean delivery is an obstetric led decision and not a midwifery led one. At the time that this alleged advice was given there was also no clinical evidence of fetal distress.

In my opinion regarding the appropriateness of the alleged advice to [Mrs A] that she should tell the obstetrician she wants an epidural and hopes the baby turns, this was acceptable midwifery practice.

17/09/18: *There has been no new information provided in relation to this question and my opinion therefore remains unchanged.* ***ADVICE UNCHANGED***

Labour care at hospital

a. At what point, if any, should handover to secondary care have occurred?

By the time [Mrs A] was admitted to [Hospital 1] which is recorded in her hospital records as her assessment on arrival being performed at 12.20, [RM B] had been in attendance for approximately 15 hours. Labour care had commenced mid evening so there is an assumption that [RM B] had already completed a day's work before undertaking care. The second midwife, [RM D], had completed a nightshift at the hospital before becoming involved with [Mrs A's] care at home. She had originally indicated that she would be able to attend until midday, which was then extended. This is a common occurrence where judgement as to how safe you are to practice in terms of fatigue becomes clouded by the commitment to the woman and the wish to continue to care for them as well as being coerced to continue to provide care.

In my opinion handover of care to secondary services should have occurred on admission after the obstetric consultation had taken place although this is apparently not supported by current hospital protocol. [RM B] documents that, by her understanding, she did hand over care at this juncture. In my opinion, under the circumstances of having provided prolonged care with an increasing need for vigilance of care, this would have been the optimal time for handover to have occurred.

17/09/18: *There has been no new information provided in relation to this question and my opinion therefore remains unchanged.* ***ADVICE UNCHANGED***

b. Adequacy of handover (if any). Please see alternative versions of events

Handover of care appears to have been poorly done.

There is confusion on [Mrs A's] part as to the role that [RM B] took after her admission to the hospital because of the ongoing involvement she had in her care.

The request for admission was received by the hospital at 1210. It is commented by [the DHB's CE] that hospital admission did not occur until 1230, so handover could not have occurred at 1220. The initial assessment is recorded by the obstetrician as having taken place at 1230 and the assumption is that [Mrs A] must have been settled in a labour room for the physical examination to have taken place. In prioritising care, it is possible that there was a paper lag in sending off the admission sheet and that the physical admission did occur at 1220. I also note that part of the handover policy for [the DHB] is that [a] sticker signifying that the handover of care has occurred is placed in the client's notes and this had not occurred. [RM D], who accompanied [Mr and Mrs A] and [RM B] in the admission process makes no comment on any formal handover of care.

[RM B] has documented her intention to hand over care and remain as a support person in response to [Mrs A's] request for her to do so. She discusses giving a verbal summary of events in a separate room in preparation to a handover to the on-call obstetrician prior to his initial assessment of [Mrs A]. She states that [Mr and Mrs A] knew that she had handed over care prior to the arrival of the anaesthetist and the siting of the epidural which is current hospital policy as a pre-requirement for LMC handover. She left the room where [Mrs A] was labouring to go to the office to update and print out her notes; she comments on a conversation she had in the office with the maternity manager, [RM H]. [RM H] asked her if she 'planned to handover care' to which [RM B] responded 'of course I am.' While [RM B] further comments in her response that in her view care had been already handed over and she had documented that as occurring at 1220, she did not formally advise [RM H] that she, in her view, had already handed over care at the time of their conversation.

There was no summary of the labour care provided prior to admission by [RM B] included in [Mrs A's] hospital notes on admission. [RM B] needed to print out and ? complete her documentation before it could be added into the clinical notes. While there had been a verbal summary of care privately given to the obstetrician, there was no verbal handover of care given to the staff midwife, [RM E]. This placed [RM E] in the situation of providing midwifery care for a woman in labour with no written or verbal information available of her labour thus far. [RM E's] understanding was that handover of care would occur as per protocol with the siting of the epidural. In a complex situation a thorough handover of care is an established part of safe practice and without this process a formal handover has not occurred. There is further lack of clarity in [RM B's] role with her continuing to provide advice to [Mr and Mrs A] and hands on care beyond the point at which she stated she regarded herself as having handed over care.

This creates a very confusing picture as to who is responsible for care and at what mutually understood point this occurred. It is a situation well recognised as being one in which errors happen, hence the development of clear protocols around handover processes.

The NZCOM Handbook for Practice/Standards of Midwifery Practice Standard Seven states that: the midwife is accountable to the woman, to herself, to the midwifery profession and to the wider community for her practice. The criteria for which includes:

- In situations where another dimension of care is needed, ensures negotiation takes place with other health practitioners to clarify roles and responsibilities.

In my opinion adequate handover did not occur and this is a moderate departure from acceptable midwifery care given the developing complexity of the labour.

17/09/18: *The additional information makes [the DHB's] expected handover process clearer. The transfer of clinical responsibility from primary to secondary care maternity services as stated in [the DHB's] protocol has two procedural options. Either it can*

occur once the transfer of care has been agreed to between the woman, LMC, obstetric services and midwifery shift leader, after which it is documented in the woman's notes and a handover sticker is completed and placed in the patient's health record. Alternatively, the transfer of clinical responsibility can occur as per the LMC's access agreement (LMC has declared they will not manage epidural). The handover process then occurs when the anaesthetist arrives to site the epidural, and it is again entered in the clinical notes as prescribed.

As per [RM D's] statement, [RM B's] access agreement of 2006 documents her election to not provide secondary care. It is not apparent if in her access agreement she has declined to manage epidural anaesthesia. [RM B] herself, however, has stated that it was her established practice to hand over care on admission when secondary care was involved of which the Maternity Manager of the day was aware. I have assumed that the title of Maternity Manager is interchangeable with that of midwifery shift leader. The protocol includes this as an option for handing over care regardless of the decision as to whether to manage epidural anaesthesia or not, so the point of handover rests with the LMC.

There is evidence of the call to both the on-call obstetrician and staff midwife at 1155 made by [RM B] advising of the intent to transfer in from home and consult with secondary services. She has documented in her notes that she stated that she anticipated that epidural anaesthesia would be required, and it was possible that a caesarean birth would be needed, all of which services are provided under secondary service care. The time line in the information originally supplied by the HDC Legal Investigator does not match the time of admission as it is stated in this that CTG monitoring was started and Entonox given at 1210 and these are facility-based care options. The consensus is that admission occurred at 1220 at which time [RM B] has stated she handed over care; her colleague [RM D] confirms this.

There is an entry in the notes held by [RM B] at 1220 that there was a handover of care to core midwives and O&G and that [Mrs A] understood that she was now under secondary care. The consultation with the on-call obstetrician did not occur until 1230. The Maternity Manager was not present. In the hospital clinical notes there are admitting details which suggest there was a discussion between [RM B] and the on-duty obstetrician as to [Mrs A's] labour thus far and the identified concerns. There is no documentation in the hospital notes of [RM B's] intent to hand over care. The required sticker indicating that handover had occurred was not placed in [Mrs A's] hospital notes, which omission [RM B] regards hospital staff be accountable for. As the notes held by [RM B] needed to be printed out before they could be added into the hospital documentation there was no immediate written record available to hospital staff that [RM B] had handed over care. The required agreement as per DHB protocol to do so between the woman, the LMC, obstetrician and midwifery shift leader had not occurred at this point as the midwifery shift leader had not been spoken to.

The midwifery shift leader, [RM H], does not recollect a conversation where she asked [RM B] if she planned to hand over care and [RM B] confirming that she did. [RM B]

states that this occurred. The incoming staff midwife [RM E] states that at no point in time did the obstetrician or [RM B] inform her that there had been a handover of care and she was not present at the 3-way discussion that occurred on admission, nor did she receive a verbal handover from [RM B]. As the handover protocol is set out in [the DHB] protocol a 3-way conversation is not required nor must the incoming staff midwife who will be assuming care be given a direct handover of care. A 3-way conversation between the woman, the LMC and the practitioner to whom clinical responsibility is to be transferred however is the expectation within the NZCOM Handbook for practice; this would include the handover to secondary services and to the midwife who would be assuming care.

I believe that [RM B] remaining as a support person but still taking on some midwifery responsibilities and offering midwifery advice to [Mrs A] further confused the issue as to when the handover of care occurred, although [RM B] disputes that there was any confusion over this. Similarly, the collegial support offered by [RM E] in assisting with cares also created confusion as to who was ultimately responsible for care. It would be regrettable if such support was withheld in the future as a result of the confusion in this clinical situation. Ultimately this must be considered against [Mrs A's] continued declining of a caesarean delivery in a deteriorating situation, and the conflicting versions of the advice that she was receiving that may have influenced her decision.

Revisiting my advice on adequacy of the handover process, [the DHB's] protocols were observed in part. I have considered that [RM H] states that she does not recollect asking [RM B] if she was handing over care rather than refuting that any comment as to this had occurred. The documentation in [RM B's] own notes while not immediately available to staff state that handover had occurred at 1220; there was a verbal update of care to the on-call obstetrician by her in the presence of [Mrs A] and it is [RM B's] belief that the responsibility for placing a handover sticker in the clinical notes is a staff responsibility.

Against this that the lack of a formal verbal handover of care to the midwifery services must be considered. The comment [RM B] made to [RM H] that of course she was handing over care does not meet the expectations of a full handover.

The NZCOM Handbook for Practice/Standards of Midwifery Practice Standard Seven as cited in my previous advice requires negotiation to take place with other health practitioners to clarify roles and responsibilities. Standard Six requires that:

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

I regard prioritising printing off notes requiring an absence of thirty minutes over giving a full verbal handover to the incoming midwifery practitioner to be inappropriate. [RM H] includes in her statement making the offer to do this for [RM B], but it was not taken up. In the original statement by [RM B] she has said that her colleague [RM D] was in the room as a support person only, therefore [RM E] was presumed by [RM B] to be responsible for the midwifery care from 1220. Despite this

being her understanding, [RM B] did not give [RM E] a verbal handover while also knowing that she didn't have access to the records of the labour so far. In [RM B's] original statement she comments: 'I would like to make it clear that the transfer was for failure to progress and not for foetal distress' which assumes that the alarming degree of fetal distress developed after admission to the hospital facility. The confusion over handover and who carried ultimately responsibility for [Mrs A's] midwifery care therefore occurred at a critical point in time. It must be considered that had the handover process been clear and 1:1 midwifery care that assumed full responsibility and established a trusting midwifery partnership with [Mrs A] been put in place would this have led to different decision making by [Mrs A] or not?

My advice after carefully considering all the additional information remains that the inadequacy of handover represents a moderate departure from acceptable midwifery care. ***ADVICE UNCHANGED***

My recommendation for the future is that [the DHB's] protocol for handover should be strengthened by including a direct handover to the core midwife assuming clinical care. I feel the handover to the Midwifery Shift Manager is important in terms of running the unit but a first-hand handover process directly to the incoming midwifery practitioner assuming clinical care is essential. It appears it cannot be assumed that what seems a common-sense process will always take place. That if there are computer generated notes that need to be printed off and the LMC elects to do this personally, this should be done after a summary of events thus far are written in the admitting notes so that there is immediate core staff access to the current history, a full verbal handover of care has been given to the incoming midwife who will be assuming responsibility for clinical midwifery care and that this formal handover is documented as having occurred.

c. Adequacy of care if [RM B] was remaining as a 'support person'.

A support person has no defined role in the provision of maternity care. It is the role traditionally filled by the woman's whānau and friends. It is not expected that a support person would participate in the provision of clinical care but that they would be there in the capacity of providing emotional and physical support to the woman as appropriate and at her request. As support people, they are not open to professional critique of the nonprofessional care that they provide.

When the LMC takes on that role there is a blurring of boundaries. By taking on a support role only they are abdicating the professional midwifery responsibility, yet it is known that they have professional knowledge and an established relationship with the woman, therefore they continue to be looked to for professional advice. [RM B] stated that, by her understanding, she was present as a support person only from 1220pm and no longer acting in her professional capacity as the LMC midwife. Yet she continued to involve herself at a clinical level in terms of both physical care and advice further contributing to a lack of clarity as to whether handover had occurred. This was inappropriate and as she now recognises she should have removed herself from any involvement with clinical care.

To reiterate, the NZCOM Handbook for Practice/Standards of Midwifery Practice Standard Seven criteria includes:

- In situations where another dimension of care is needed, ensures negotiation takes place with other health practitioners to clarify roles and responsibilities

This process did not occur. In my opinion the ongoing involvement by [RM B] was detrimental to the clarity of the handover of her role as LMC and the assumption of the midwifery responsibility by the facility staff midwives.

As the question posed is phrased, the aspects of care that [RM B] chose to involve herself with were random, so it is not possible to evaluate [RM B's] care within the hospital setting in terms of overall adequacy and if she had assumed the role of a support person she was no longer responsible for clinical care.

As I have been asked to comment on the midwifery care provided by [RM E] and [RM F], staff midwives, I will comment as to the adequacy of midwifery care provided by them in my response to those questions when critiquing the midwifery care provided, if it is assumed that [RM B] was present in the role of a support person.

My opinion is that if [RM B] remained as a support person, she was not responsible for the provision of clinical care.

17/09/18: *[RM B] remaining on as a support person to [Mrs A] but still participating in some aspects of midwifery care created confusion for staff midwives as to when the handover of care to them occurred. But as a support person only [RM B] is not responsible for the provision of clinical care therefore her input cannot be appraised as such which negates the question asked.* ***ADVICE UNCHANGED***

My recommendation for the future is that midwives remaining with their client in a support role do not participate in the provision of care or the giving of professional advice.

d. Adequacy of care if [RM B] had not handed over to hospital staff.

In the absence of a formal handover by [RM B] of care, and in keeping with [the DHB's] protocol of handover of care not being able to be facilitated until the siting of an epidural, the assumption is that [RM B] was still acting as the LMC care provider. If this is upheld, then the care provided by [RM B] at this time was inadequate. She was focussed on reproducing her notes, presumably for inclusion in [Mrs A's] hospital clinical records and absented herself from the room where [Mrs A] was labouring to work in the office for a time she has estimated as around thirty minutes.

[RM D], from the account given by [RM E], was still present in the room with [Mrs A], but the role [RM D] was taking is defined as support person only. CTG monitoring had been commenced and after a long period of no progress and increasingly clear signs of an obstructed labour, reassurance as to fetal wellbeing by means of CTG monitoring and an immediate interpretation of the trace was of priority. In addition, there was a

need to obtain baseline maternal recordings, collect blood samples to obtain a full blood count as is standard practice before siting an epidural and the siting of an IV cannula which is a further pre-requisite for epidural anaesthesia. This was now a compromised labour where immediate caesarean delivery had been recommended by the consulting obstetrician and declined. The choice for the continuation of the labour called for on-going vigilant monitoring. There was now a high probability of the development of maternal and fetal distress requiring further urgent review of [Mrs A's] decision to continue with the labour.

The NZCOM Handbook for Practice/Standards of Midwifery Practice Standard Six states that: Midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk. The criteria include:

- Ensures assessment is on-going and modifies the midwifery plan accordingly
- Ensures potentially life-threatening situations take priority
- Identifies deviations from the normal, and after discussion with the woman, consults and refers as appropriate
- Has the responsibility to refer to the appropriate health professional when she has reached the limit of her expertise.

In my opinion if [RM B] was continuing to act in the capacity of [Mrs A's] LMC, her absence from the room for thirty minutes, therefore not being able to evaluate the CTG trace, and her failure to begin initiating processes to enable an epidural to be sited represents a mild departure from acceptable midwifery care. This opinion assumes that [RM B] was aware that there was a staff midwife present, [RM E], attending to [Mrs A] and prioritizing care; if there was not that awareness then my opinion is that this is a moderate departure from acceptable midwifery care.

15/09/18: *My advice after reviewing the new information remains unchanged that this is a mild departure from acceptable midwifery care if it is assumed that [RM B] knew that [RM E] was in attendance and prioritizing her care, without which knowledge this is a moderate departure from acceptable midwifery care. My recommendation for the future is as previously stated around effective handover processes and immediate availability of relevant details of care.*

e. Communications regarding the possible need for Caesarean section. Please see alternative versions of events.

[RM B] version i:

As previously commented, [RM B] has stated that she advised [Mrs A] that the decision of whether to have a caesarean birth was one that [Mrs A] herself would make in consultation with an obstetrician and it was out of midwifery scope of practice prior to transferring to hospital from home.

The NZCOM Handbook for Practice/Standards of Midwifery Practice Standard Six states that: Midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk. The criteria include:

- Works collaboratively with other health professionals and community groups as necessary

Despite [RM B] having stated that this was outside the midwifery scope of practice, she did assert an ongoing influence over decision making by continuing to refer to the on-call obstetrician as 'Mr Slice and Dice'. To keep reinforcing [RM B's] opinion of her obstetric colleague to her client was to sabotage the possible outcomes of the now agreed to consultation. By demeaning the obstetric professional integrity of the consultant and their ability to make an unbiased conservative decision to support ongoing labour if it was a reasonable option for them to do so, the professional opinion is demeaned before it is even given. Yet it has already been stated by [RM B] that such a decision is outside the midwifery scope of practice hence the reason for transfer and seeking such an opinion. [RM B] admits to her poor judgement.

On transfer to hospital [RM B's] account of events details that caesarean delivery was only proposed to [Mrs A] by the obstetrician as an option and that 'he seemed happy for her to try an epidural first which is what she ([Mrs A]) had requested.' She also notes that there was no information given to [Mrs A] about possible outcomes of continuing labour in the presence of prolonged labour with no progress and strong indicators of obstruction by the obstetrician. [RM B] made no attempt to rectify this despite identifying the gap. She discusses quoting the obstetric opinion of there being only a 20% possibility of [Mrs A] being able to have a vaginal birth with both [Mr and Mrs A] present as a way of mentally preparing them for the strong possibility of a caesarean birth instead.

The NZCOM Handbook for Practice/Standards of Midwifery Practice Standard five states that: Midwifery care is planned with the woman. The criteria include:

- Facilitates and records outcomes of conversations related to the decision-making process

There is no record of the conversation between the on-call obstetrician and [RM B] or of her subsequent conversation with [Mr and Mrs A]; there is only a record of her advice in again reinforcing [Mrs A's] right to decline a caesarean birth.

[RM B] further states that she believed that the outcome would ultimately be a caesarean birth. This would therefore have been an appropriate time to help [Mrs A] shift her thinking to viewing caesarean birth as a lighthouse in the storm from that of an extreme of intervention and to revisit her requests as detailed on her care plan should a caesarean birth be necessary. To have done so would have further alerted both [Mr and Mrs A] as to the high possibility of the need for a caesarean birth and enabled discussion around this preventing further delay in making the decision when the need became inevitable. While the statistical estimate by the obstetrician around

the likelihood of a caesarean birth had been stated to [Mrs A] by [RM B], the reality is when dealing with exhausted people information must be given in ways that reinforce it. Further, as this obstetric opinion had been devalued, for [RM B] to have revisited the care plan around caesarean birth no matter how briefly would have demonstrated a shift in her support of this opinion. It would have also concurred with her stated belief that she also believed that a caesarean birth would be necessary.

The NZCOM Handbook for Practice/Standards of Midwifery Practice Standard Five criteria further includes:

- Considers the safety of the woman and baby in all planning and decision making

My opinion in response to Question 2, C version i, considers in part [RM B] referring to [Dr C] as 'Mr Slice and Dice' and concluded that care at that juncture was of an acceptable midwifery standard. My opinion in this question also takes this reference into account but concludes in this context it is in breach of acceptable midwifery care. I will clarify my reasons for this shift to pre-empt critique of this. In the first situation, the need for a caesarean birth and an obstetric opinion as to this from [Dr C] was not clinically clear. The reference to [Dr C], albeit disrespectful, was made in the context of providing an option for [Mrs A] to transfer immediately when a different obstetrician would be involved in her ongoing plan of care.

In this second situation continuing to emphasise the opinion that [Dr C] always advocated for an immediate caesarean without due justification to a woman with a strong preference to birthing her baby at home with minimal intervention reinforces distrust in his decision making. [Dr C] was now the on-call obstetrician responsible for making obstetrical decisions around the care of women in the hospital unit and he was directly involved in [Mrs A's] care. His opinion was therefore now going to be based on her labour history and his clinical findings, thus first-hand information. [RM B's] perception of [Dr C] was therefore no longer being promoted to [Mrs A] as an opinion of his philosophical leanings, but as a critique of his actual clinical skills at a time when the decision making guided by this was becoming critical.

My opinion of communication regarding the possible need for caesarean section version i is that this is a mild departure from acceptable midwifery standards.

17/09/18: *As instructed I have not been influenced by [Dr C's] new statement. There has been further explanation by [RM B] as to what discussion she had with [Mrs A] around the need for a caesarean birth stating that with the deteriorating situation she told [Mrs A] 'many times that the baby was showing signs of severe distress and that was the only option left.' Given that [RM B] had been supportive of [Mrs A's] wish for minimal intervention her clear advice to her that this was now the only option carries weight and that she is now supporting obstetric advice as to the need for caesarean delivery despite all prior conversation. My advice is therefore revised and that version i is acceptable midwifery care.* ***ADVICE CHANGED***

My recommendation is again that documentation reflects clearly what took place and accurately includes discussion and advice given when decision making points are reached.

Version ii (informed by documentation of events and core staff observations)

There was an ongoing reminder by [RM B] to [Mrs A] that she had the right to say no to a caesarean birth, which indeed she does. [RM B's] statement to [Mrs A] that 'the doctor on call wants to slice and dice you and get the baby out, you have the right to say no' was witnessed and commented on by a staff midwife.

This further reinforcement of [Mrs A's] right to decline caesarean was made after [RM B's] preliminary discussion with [Dr C] out of the labour room. After the discussing of [Mrs A's] labour progress thus far, he expressed his opinion that a caesarean birth was indicated, and this information was then relayed to [Mr and Mrs A] by [RM B] as stated above. There was no balancing of the right to decline treatment/interventions by discussion with [Mrs A] and her husband around the possible outcomes of declining a caesarean intervention for [Mrs A] and her baby. This is part of the informed consent process upheld in all New Zealand Health care (Ministry of Health Guidelines, 2012) and [Mrs A] states that she did not have a sense of how concerning her situation had become. This is further upheld by her husband leaving the hospital to return home, something that presumably would not have occurred had there been an awareness by [Mr and Mrs A] of the level of concern developing around the labour.

Again, the continued advocating by [RM B] for [Mrs A's] right to decline a caesarean delivery must be viewed in context with the broader picture that was now presenting. To recap, this was an IVF pregnancy with a known higher risk for IUGR; [RM B] had strongly recommended [Mrs A] to have a scan late pregnancy because of reduced fetal growth. It was a postdates pregnancy. There had now been a prolonged labour with a mal presentation and signs of obstruction. Prior to discussion with [Dr C] around [Mrs A's] progress at 1220 and returning to [Mrs A's] room, [RM B] does not dispute that she was in the role of LMC. Her comment about [Dr C] and the right to reject his advice occurred around that time influencing [Mrs A's] decision making as her LMC.

After [Mrs A] had been examined by [Dr C], [RM B] advocating for [Mrs A's] right to decline a caesarean birth was not revisited by her in the light of the clinical information available from that examination. Contractions were assessed as being sufficiently strong and frequent to counter commencing augmentation with syntocinon, therefore effective uterine contractions had not overcome the obstruction. The vaginal findings were that the baby was in deep transverse arrest, there was caput (swelling of the fetal scalp) and cervical oedema causing regression of dilatation also symptomatic of obstructed labour and there had been no progress over a prolonged period. While the decision to perform a caesarean birth is an obstetrician's one, the clinical findings had become clearer that a caesarean birth needed serious consideration. As the person who had continued to advocate for [Mrs A's] right to decline a caesarean birth, [RM B] had an obligation to re-discuss this in

the light of the clinical information now available. Even if she had now considered she had assumed the role of a support person, she had given her this advice in her role as her LMC.

My opinion of communication regarding the possible need for caesarean section version ii is that this is a mild departure from acceptable midwifery standards.

17/09/18: *There continues to be conflicting statements as to what was said which makes offering advice complex. In the new information [RM B] refutes that she referred to [Dr C] as Mr Slice and Dice in the room in front of the staff midwife and states that she advocated strongly for [Mrs A] to accept the need for a caesarean delivery as the baby's condition deteriorated. Documentation and core staff observations suggest otherwise, however [RM B] is adamant that she advocated for [Mrs A] to accept the need for a caesarean delivery. The only other new information around this aspect of care is the comment by [RM H] that [RM B] upheld [Mrs A's] preference for a normal birth and did not appear concerned with her decision-making right up until the time that consent was given by [Mrs A] for a caesarean delivery. It must also be taken into account that while [RM B] continued to offer midwifery advice and participate in some care she regarded herself as being in the role of a support person from the point of admission. In the light of [RM B's] assertion of advocating strongly for the need for a caesarean delivery within the new information my advice is now that this meets acceptable midwifery standards.* ***ADVICE CHANGED***

Future recommendation is again that documentation needs to reflect clearly what took place including discussion. Informed consent requires the consumer having a full understanding of the situation and what the outcomes of declining recommended care could be. If a woman's decision could lead to severe compromise or death of her infant(s) or herself plain non-professional language needs to be used that clearly states the gravity of the situation. While this should not be a form of coercion there must be a transparency around the possible outcomes of her choices so there is no doubt as to the gravity of the decision making she is involved in.

f. Fetal assessments and monitoring, including but not limited to, CTG interpretation.

This must be evaluated in the context of the practice reality of admitting a very tired woman after a prolonged labour at home having frequent painful contractions which further impaired her ability to assimilate information. It is usual to refrain from continuing with clinical procedures during contractions to enable the woman to cope with their intensity, therefore the time frame of putting measures such as CTG monitoring in place is extended. This is a practice reality that is not always appreciated by non-midwifery care providers.

The midwife present when [Mrs A] was admitted into the unit, [RM E], was not given to understand that a handover of care was assumed to have occurred at that point as it was not in accordance with hospital protocol. The clinical notes by [RM E] are written retrospectively because of the acuity of the situation. She understood that per

the hospital protocol she had assumed midwifery responsibility for [Mrs A's] care from the siting of the epidural at 1405 hours and until that point [RM B] as the LMC carried the responsibility.

The CTG (continuous cardiotocography) monitoring commenced at approximately 1245. This allows a monitoring and paper recording of the baby's heart rate and the mother's contractions. It detects transient increases (accelerations) and transient decreases (decelerations). Shortly after commencing the CTG there was a period of loss of contact. It is usual to continue CTG monitoring for a minimum of twenty minutes in the absence of a clearly pathological trace before evaluating fetal wellbeing. This allows for the fetal normal circadian sleep/wake cycle (Sleepmedicine Reviews, 2003). During the sleep cycle, there is reduced fetal activity which is reflected in the CTG recording and can give the impression of reduced variability and absence of accelerations. By 1315 hours it was evident that there were decelerations occurring down to 100 beats per minute, but with a quick recovery to a baseline of approximately 150 — the baseline continued to show reduced variability and no accelerations. The normal range for the fetal heart rate is 110 to 160; while decelerations can occur with head compressions in late first stage or second labour as the fetal head passes through the narrowest diameter of the maternal pelvis this surmise was not applicable given the clinical findings on vaginal examination. At 1315 [RM B] documented that the 'CTG was really reassuring' with the implication that she advised [Mrs A] of this as part of the discussion she then had with her. My opinion of the CTG trace differs in that taken in conjunction with the clinical findings, it was non-reassuring and abnormal.

The CTG monitoring was followed by a further period of loss of contact during the siting of the epidural — monitoring is made difficult during siting an epidural because of the positioning of the woman for this procedure. As the CTG was abnormal and there was approximately 25 minutes where the CTG trace was unreliable because of siting the epidural, attaching a scalp clip would have been a good option to consider prior to the siting of the epidural if [Mrs A] had consented to this. Overall the outcomes for infants are improved by continual monitoring as opposed to intermittent monitoring (Cochrane Data base, 2013).

From 1400 hours, the CTG became increasingly concerning with prolonged decelerations to 60–80 bpm now lasting for a duration of 90 seconds; there were no accelerations present and reduced variability continued. A decision was therefore made to attach a fetal scalp clip to obtain a more reliable recording of the fetal heart rate at 1425. During the procedure and the insertion of an indwelling catheter it was noted that there was now copious meconium present; this is a further ominous sign as to a deterioration in fetal wellbeing. The initial scalp clip became detached which was not detected for seven minutes when CTG monitoring via abdominal external transducer was recommenced. While the use of a fetal scalp clip had been requested by the consultant obstetrician in the interests of obtaining an accurate assessment of the fetal heart rate, reviewing the CTG trace an accurate recording was obtained via

abdominal external transducer from this point onwards, negating the need to reattach a scalp clip.

[RM E] handed over care to the afternoon shift with midwife [RM F] then assuming midwifery responsibility for [Mrs A's] care. There is a conflict around what time this occurred with [RM E] stating the handover of care and request for an obstetric review occurred at 1445, while [RM F] states she entered [Mrs A's] room at 1455 and was immediately very concerned by the CTG trace and requested [Dr C] to attend to review it. This ten-minute difference may be explained if the handover occurred outside [Mrs A's] room.

The vaginal assessment as to progress with its implications for fetal wellbeing was performed appropriately. Care by [RM F] was also appropriate.

Both staff midwives include in their account their advice to [Mrs A] that in their opinions a caesarean birth was indicated as the baby was in distress and needed to be delivered.

In my opinion the fetal assessments, including CTG interpretation, was acceptable midwifery care.

[RM D]
Please comment on the adequacy of care provided, including:

1. ***Labour care at home.***
   a. ***Fetal and maternal assessments and monitoring.***
   b. ***Timeliness of transfer and [RM D's] responsibility in respect of this.***
2. ***Labour care at hospital***

1. Labour care at home a. Fetal and maternal assessments and monitoring

[RM D] attended [Mrs A's] labour in the capacity of second midwife for a home birth attendance. Her role carries the expectation that she will be present at the actual birth to allow for a second person being available in the event of any difficulties occurring that are more competently managed by two professional care givers. The point at which the second midwife is called is at the discretion of the LMC and occasionally they may be asked to be present earlier if support is needed.

[RM D] does not state her date of registration as a midwife, but working back through her employment history it appears that [RM B] qualified prior to [RM D]. In a critical situation, it is the professional presumption that the more senior and experienced practitioner will take over the leading role in the provision of clinical care, e.g. an undiagnosed breech birth. [RM B] however was the senior practitioner and regardless of this, the ultimate responsibility for care remains with the LMC in a primary care situation.

There is no indication as to which midwife provided which aspects of care in the home situation other than the vaginal examination performed by [RM D] as the notes

provided are computer generated not allowing for distinction of handwriting and personally signed entries. The vaginal examination performed by [RM D] was done appropriately. As previously commented there is no record of any maternal base recordings having been done, I believe this is an omission of care particularly as the labour declared itself to becoming more complex should [Mrs A] have been open to this, but this is not clear. Vaginal assessments were done at appropriate intervals reflecting the concern around slow progress as was fetal heart rate monitoring. Ultimately the responsibility for ensuring this occurred lies with the LMC midwife, not the second on call midwife.

In my opinion [RM D's] involvement with fetal and maternal assessments and monitoring was acceptable midwifery care.

b. Timeliness of transfer and [RM D's] responsibility in this.

[RM D], as stated above, was present in the capacity of the second on call midwife. While there is an expectation that she would offer collegial advice and support, she ultimately does not carry the final responsibility for decision making. If the second midwife overrode the authority of the LMC care provider and imposed a different decision on the situation, then there would be the expectation that she would be responsible for that decision and its implications and/or consequences. This did not occur. The first discussion of transfer occurred prior to [RM D's] involvement in care and was declined by [Mrs A]. From vaginal assessments that were conducted after [RM D] was present it was reasonable to assume, in the light of the prior rejection of a plan for transfer by [Mrs A] and her clearly stated preference in her care plan not to have time lines imposed on her labour, that progress was being made. In the presence of clear amniotic fluid, a reassuring fetal heart rate with a client expressing wishes to remain at home and previously declining of transfer, in the midwifery version of events, continuing to support her at home was reasonable. At the point when labour obstruction became more evident through vaginal examination transfer occurred.

In my opinion the timeliness of transfer under these circumstances is acceptable midwifery care. In her capacity, as second midwife, [RM D] ultimately does not carry a responsibility for this.

2. Labour care at hospital.

[RM D] had no defined role in care that took place in the hospital as an off-duty core midwife. She did not have a well-established relationship with [Mrs A] as the non LMC midwife having only met [Mrs A] once in her pregnancy prior to going to her home in established labour. I view her presence at the hospital as being in a supportive role to [RM B] as a colleague rather than as a midwifery care provider for [Mrs A]. Further, [RM D] had no legal responsibility to provide care and to all intents and purposes she played a very minimal role in care after [Mrs A] was admitted to hospital. In my opinion there is therefore no question to answer.

[RM E]
Please comment on the adequacy of care provided, including:

1. ***Labour care:***
   a. ***If care had been transferred and***
   b. ***If care had not been transferred***
2. ***[RM E's] responsibility in relation to arranging transfer of care***

1. Labour care: a. if care had been transferred:

In forming this opinion, I would like to revisit what has been previously stated by me in Question 3.f: This must be evaluated in the context of the practice reality of admitting a very tired, heavily pregnant woman coping with frequent painful contractions. In addition, she was accompanied by four other people and working space within birthing rooms can be limited. It is usual to refrain from continuing with clinical procedures during contractions to enable the woman to cope with their intensity, therefore the time frames around the provision of care is inevitably effected by this.

The NZCOM Handbook for Practice/Standards of Midwifery Standard Six states that Midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk. [RM E] prioritised her care.

CTG monitoring was commenced at 1245 after the consultation with [Dr C] had taken place. After asking [RM B] whether she would site the luer and being advised she was unable to, [RM E] returned to [Mrs A's] room to do this. This was a second priority to enable bloods to be collected for haematology evaluation and cross matching in case of caesarean delivery as well as creating intravenous access in preparation for epidural anaesthesia. By this time the CTG had been in place for 15 minutes and the trace was evaluated by [RM E]. As previously stated the CTG is evaluated at 20 minutes, unless clearly pathological from the onset, to allow for the fetal sleep cycle. She regarded it as being non-reassuring despite the opinions of [RM B] and [RM D] to the contrary. [RM E] then stated her concerns around the CTG trace to [RM H] in her capacity of CMM thereby taking responsibility for her own interpretation of the CTG trace despite having been reassured to the contrary by more senior midwives.

When [RM B] returned to the room shortly after [RM E] had entered it again and now offered to site the luer, [RM E], in the absence of any handover and enactment of the protocols around this, assumed that [Mrs A] was still under primary care and it was appropriate for [RM B] to do this. However, even if care had been transferred, inserting an IV luer is not a regular event in the provision of midwifery care so individual skills around this fluctuate. When a senior midwife who is the woman's LMC states she has an expertise with this and offers to site it, it is usual to accept such an offer in the spirit of collegial support and expediency of care.

[RM E] commenced maternal recordings at 1400 hours and a blood pressure is entered on the observation chart, the CTG having the ability to record maternal pulse. A maternal temperature wasn't taken until 1535 hours when it was first recorded by [RM F] per documentation. As her temperature was within normal range [Mrs A]

would have been asymptomatic of any indications of pyrexia and I accept that in the process of prioritising care maternal temperature may have been overlooked. [RM E] then assisted the anaesthetist in siting the epidural; when [Mrs A] was comfortable [RM E] then followed a process of informed consent to advise [Mrs A] that she would now be providing care. Accordingly, she obtained consent to perform a vaginal examination, insert an indwelling catheter and attach a fetal scalp clip. She noted the presence of meconium liquor and advised [Mrs A] of this and in response to [Mrs A's] request for her opinion as to what she thought about her situation [RM E] offered her professional opinion that she felt [Mrs A] needed a caesarean delivery. When the fetal scalp clip detached, [RM E] recommenced fetal monitoring with abdominal transducer obtaining an accurate recording which did not necessitate reattachment of the scalp clip. The trace remained non-reassuring in [RM E's] opinion and at this time she handed over care to [RM F] understanding that [Dr C] was to be re-contacted regarding the CTG trace for a further consultation.

In my opinion, the adequacy of care provided, including labour care if care had been transferred is that this was acceptable midwifery care.

Labour care, 1 b. if care had not been transferred.

For reasons stated above, in my opinion the adequacy of care provided, including labour care if care had not been transferred, is that this was acceptable midwifery care.

Labour care, 2. [RM E's] responsibility in relation to arranging transfer of care:

[RM E] acted per [the DHB's] protocol for handover of care to a staff midwife by an LMC midwife. [The] (CEO) states that 'support and care is provided by the core midwifery staff to the woman under the direction and leadership of the LMC.' In the absence of a formal handover [RM E's] understanding was that she would assume responsibility for care when the anaesthetist arrived to site the epidural and prior to that she was acting in a supportive capacity to [RM B]. She was unaware that [RM B] believed she had handed over care as there was no formal documentation of this or formal handover of care. The absence of [a] sticker being placed in [Mrs A's] notes at the time of siting the epidural is an omission that created further lack of clarity over who was responsible for care at what time. I assume that this is a joint responsibility of the LMC handing over care and the core midwife taking over care to place this sticker in the woman's notes.

While this omission signifying handover care is in breach of [the DHB's] protocol, I do not regard that the presence of the sticker would have had any bearing on the care that was given prior to this. [RM E] had assumed the greater role in the provision of care and the midwifery care provided was appropriate. The sticker, however, would have identified for [RM B] that handover as per protocol had not occurred at the time she believed it had.

In my opinion the omission of placing the transfer of care sticker in [Mrs A's] notes is acceptable given the intensity of the circumstances. [RM E] was obliged to write her notes in retrospect because of the need to prioritise midwifery care and I feel this has contributed to omitting to include the transfer of care sticker that would most likely have been remembered had [RM E] been able to document ongoing clinical notes concurrent with the provision of care.

Therefore my opinion is that [RM E's] responsibility in arranging transfer of care was met and was acceptable midwifery care.

[RM F]
Please comment on the adequacy of care provided, including:

1. ***Labour care:***
   a. ***Fetal monitoring***
   b. ***The responsibility of [RM F] regarding the timeliness of Caesarean section and in communication of fetal wellbeing to [Mrs A].***
   c. ***Documentation***
2. ***Postoperative care.***

1.a Labour care: Fetal monitoring.

[RM F] assumed responsibility for care for [Mrs A] at 1455. She immediately checked the CTG after introducing herself to [Mrs A] and informing her that she would now be providing her midwifery care. On assessing the CTG trace as being very concerning she indicated this to [Mrs A] and immediately called [Dr C] to attend. She removed the recorded trace from the CTG machine and showed this to [RM H] in her capacity of CMM and this was signed by [RM H] signifying she had seen it. [RM F] then continued to provide midwifery care including fetal monitoring. The CTG accompanied [Mrs A] to caesarean theatre and ongoing monitoring of the fetal heart by abdominal transducer was continued within the limitations of being able to achieve this while [Mrs A] was being prepped for surgery. As the decision to have a caesarean section had now been agreed to by [Mrs A], with a pathological CTG trace speed was of the utmost importance. To have temporarily attached a fetal scalp clip would have created further delay and would not have changed the outcome as the caesarean process was already underway.

My opinion is that the labour care provided by [RM F] in terms of fetal monitoring was acceptable midwifery care.

1.b. The responsibility of [RM F] regarding the timeliness of caesarean section and in communication of fetal wellbeing to [Mrs A].

The NZCOM Handbook for Practice/Standards of Midwifery Practice Standard Six states that: Midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk. The criteria include:

- Demonstrates competency to act effectively in any maternity emergency situation

- Identifies deviations from the normal, and after discussion with the woman, consults and refers as appropriate

[RM F] states offering immediate and very clear information to [Mrs A] as to her interpretation of the CTG monitoring and of her concerns for [Mrs A's] baby. She asked [Mrs A] if she would consent to an immediate emergency caesarean. When this was again declined and declined for a third time when [Dr C] attended 5 minutes later because [Mr A] was absent from the hospital and could not participate in the decision, [RM F] suggested that [Mrs A's] husband be called immediately. Upon [Mr A's] return, [RM F] immediately asked [Dr C] to come back into the room and restate why an emergency caesarean was imperative whereupon consent for this was now obtained.

In my opinion [RM F] met her responsibilities around the timeliness of caesarean section and of communicating concerns regarding fetal wellbeing to [Mrs A] in keeping with acceptable midwifery care.

1.c, Labour care: documentation.

The NZCOM Handbook for Practice/Standards of Midwifery Practice Standard Seven states that: The midwife is accountable to the midwifery profession and the wider community for her practice. The criteria include:

- Clearly documents her decisions and professional actions

[RM F] meets these criteria. She has communicated clearly in her documentation her assessments, her communications around them to [Mrs A], the actions she has taken in response to these and the outcomes of the consultations she has initiated. She has continued to document care given, fetal heart rate recordings and the reasons for any disruptions of continuous fetal heart rate monitoring. This has all been achieved in the context of an intense emergency.

In my opinion [RM F's] labour care documentation is of an acceptable midwifery standard.

2. Postoperative care.

[RM F] has provided good post-operative care with appropriate ongoing monitoring of [Mrs A's] wellbeing and post-operative recovery. She has facilitated [Mrs A] visiting [Baby A] in SCBU and being able to have a conversation with [Baby A's] paediatrician later in the evening as to [Baby A's] condition.

In my opinion [RM F's] postoperative care is of an acceptable midwifery standard.

Other

1. ***Any comments about midwives [RM J] or [RM K].***

[RM J] acted in good faith when informally visiting [Mrs A] when she was in labour after admission to hospital. It is only speculation as to whether any of her comments around achieving a vaginal birth had any influence on [Mrs A's] decision making. From

[RM J's] account, it was only after she had visited with [Mrs A] that she was given to understand that [Mrs A] was having a difficult labour and declining the recommendation of a caesarean delivery at that point in time. However, this incident serves as a firm reminder that all midwives need to be mindful of the implications of any comments that they make to women in a professional setting.

[RM K's] comments arising from her antenatal visit supports that [Mrs A] was well informed and had read extensively about care options and choices.

2. Adequacy of policies and procedures at [the DHB].

The handover policy of [the DHB] is the policy that has been most debated, therefore this is the policy I will focus on. There is comment by [the] (CEO) that as per [the DHB's] Maternity Protocol that transfer of clinical responsibility, from primary to secondary care, occurs at the time that the Anaesthetist arrives to site the epidural. This was not sited until 14.05, 1 hour 45 minutes after the initial involvement of secondary services for consultation and a plan of care was subsequently made. While midwives develop some ability to work efficiently despite sleep deprivation, the reality is that cognitive function inevitably becomes impaired after a prolonged period without sleep. [Mrs A's] labour had now become abnormal requiring increased vigilance. I feel after the provision of prolonged labour care in an abnormal labour that there should be an ability for the LMC to handover care from admission onwards at the discretion of the LMC midwife for safety reasons; tired people make mistakes.

The NZCOM Handbook for Practice/Standards of Midwifery Practice Standard Six states that: Midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk, the criteria for which include 'demonstrates awareness of her own health status and seeks support to ensure optimum care for the woman is maintained.' I am of the opinion that 'health status' should recognise the impairment of a midwife by fatigue after prolonged overnight labour attendance. There should be an ability to handover care at whatever point the midwife feels she is unable to offer care of an appropriate standard. This should be free of coercion to continue to provide care because of protocols or hospital staffing ratios. The possibility of the midwife not self-recognising that she has reached this point because her cognitive ability is being impacted on by fatigue in combination with her ethical desire to see the labour through to achieve continuity of care must also be considered by those who are working alongside her.

3. Any other matters in this case that you consider warrant comment.

Midwifery partnership needs to be well understood by the women involved in the midwifery model of care. Partnership underpins all midwifery practice and the recognition of the individual and shared responsibilities needs to be understood by both parties. [Mrs A] comments 'that the midwife is there to do what is best for the baby and me, not to do what I wanted!' Partnership supports the woman to be autonomous in her decision making by offering her information and guidance. Informed consent is now enshrined in all New Zealand health care giving people the

right to both decline treatment and to have formally consented to all care that is provided unless they are clinically unable to participate in the decision making through cognitive impairment. Health professionals are obligated to work co-operatively with the recipients of their care to do what the consumer wants. Caesarean delivery was advocated for by the consultant obstetrician on two occasions and by the two core midwives involved in [Mrs A's] care; this must be consented to by the consumer.

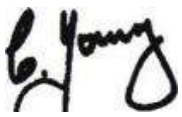
The use of a computer for recording client's clinical notes has been seen in this instance to create difficulties. The lack of availability of written records of antenatal visits as they occurred has led to speculation as to whether these represent an accurate account of events — this has been disputed by [RM B] who has now rectified this in her own ongoing practice. Without an available record of each visit the woman is reliant on her memory as to findings and advice. There was a further difficulty in that the labour record was also computerised. This meant that there was a delay in its availability to core staff and secondary services when hospital admission took place. [RM B] required approximately half an hour to complete this record and make it available which removed her from her client's care to do so.

It is also not possible to identify from the computer-generated notes which midwife undertook what aspects of care unless they are named as having provided the care, whereas handwriting is identifiable and the midwife is responsible for signing each entry she makes in her own right.

In hand written notes entries that only partially fill a line are expected to have a line added in to designate that the entry is complete. This means that additional notes cannot be added in retrospectively ensuring that this is an accurate account of what occurred at that time. This safe guard is again absent in computer generated notes. These aspects may need further consideration where computerised records are used. The importance of documentation is very much in evidence in this situation where there is conflict over what occurred and what is documented as having occurred. I note that [RM B] has attended a workshop on documentation and changed the way she now does antenatal visits to enable women to hold their accumulative records; these are positive changes that she has undertaken voluntarily.

The lack of ability to resource scans in local communities, particularly around public holidays, is an ongoing problem leading to inappropriate delays in accessing appointments. I believe this is a nationwide problem that impacts on care.

In conclusion, I would like to offer [Mr and Mrs A] and their [child] [Baby A] my sincere empathy.



Dr Carolyn Young (RM. RN, PhD)
Expert Advisor"

Appendix B: Independent obstetric advice to the Commissioner

The following expert advice was obtained from Dr Ian Page:

"Thank you for your letter of 13 June and the enclosed documents, requesting expert advice to the Commissioner on the care provided by [Dr C] to [Mrs A] and [Baby A] on 6 [Month3]. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

I am a practising Obstetrician & Gynaecologist and have been a consultant for 28 years. I obtained my MRCOG in 1985, my FRCOG in 1998 and my FRANZCOG in 2002. I have been employed for the past 17 years by Northland DHB. I have been a member of the RANZCOG Expert Witness register since 2012.

Summary of the Case

The following is an abbreviated version of the timeline of care provided by yourself (Appendix A), observing the agreed and factual points.

[Mrs A] became pregnant with the assistance of in-vitro fertilisation (IVF). At about 30 weeks' gestation [Mrs A] moved to [another region], where she registered with midwife [RM B] as her LMC in [Month1]. At 41+2 weeks' gestation (on 5 [Month3]) [Mrs A] went into labour. Her midwife ([RM B]) met her at home at 9.10pm, and assessed her progress in labour at 12.30am on 6 [Month3]. At that point [Mrs A's] cervix was 6cm dilated, and the membranes were not felt. At 3.15am [RM B] recorded spontaneous rupture of membranes (SROM) with clear liquor. At 5.56am a further vaginal examination was performed showing the cervix to be 7cm dilated. At 7.46am [RM D] had arrived and performed another vaginal examination, when the cervix was reported as being 8–9cm dilated. At 9.43am, following homeopathic treatments by [RM D], a further cervical examination showed there was an anterior rim of cervix left. At 11.55am another vaginal examination was performed, at which the cervix was found to be 7cm dilated.

[Mrs A] was then transferred to the hospital. At about 12.20pm she was reviewed by [Dr C], who noted the history of a long labour, and after examining her diagnosed cephalopelvic disproportion (CPD) due to occipito-posterior position, and recommended delivery by caesarean section. [Mrs A] declined this, requesting an epidural in the hope that her baby might still turn to occipito-anterior and allow labour to progress normally.

The CTG was commenced at about 1pm, and was non-reassuring. Epidural anaesthesia was instituted at about 2pm. At about 3pm [Dr C] was asked to review the CTG. He noted it showed prolonged deep decelerations, and that there was old meconium in the liquor. He again advised delivery by caesarean section. At 3.15pm the CTG was determined to be pathological and he repeated his advice about caesarean section. Written consent was obtained at about 3.45pm. At 4.28pm the operation began, and

a small baby ([Baby A], 2.45kg) was delivered in poor condition at 4.30pm. The operation was completed at 5.12pm.

Advice Requested

You asked me to review the documents and advise whether the care provided to [Mrs A] and [Baby A] by [Dr C] at [the DHB] was reasonable in the circumstances and why. You also asked me to comment specifically on:

1. Communication with midwives, particularly [RM B].
2. Communication with [Mrs A] during labour, and in particular regarding the need for Caesarean section. You also asked me to comment on the alternative fact scenarios:
    a. If, as [Mrs A] describes, [Dr C] addressed the whole room but did not discuss directly with her, prior to surgery, the risks and benefits of a Caesarean, and did not explain the gravity of the situation — [Mrs A] said that she did not know what distressed meant.
    b. If [Dr C] described the information recorded in his clinical records.
3. Timeliness of Caesarean section following 3.45pm (the time recorded that [Mrs A] agreed to the operation). The operation commenced at 4.28pm.
4. Adequacy of postoperative care, and post-operative communication with [Mrs A]. [Mrs A] said that after the surgery, [Dr C] did not explain in detail the nature of a tear in her uterus.
5. Any other matters in this case that I consider warrant comment.

Sources of Information

In assessing this case I have read:

- Letter of complaint from [Mr A] dated 17 [Month5] including statements from [Mrs A] and doula [Ms G].
- [RM B's] responses … including enclosures.
- [RM D's] response dated 9 [Month7] including enclosures.
- [The DHB's] response dated 17 [Month6] including [Dr C's] letters of 3 [Month4] and 12 [Month5].
- [The DHB's] response … including statements from midwives and relevant policies and protocols.
- [The DHB's] response … and attachments (including additional attachment provided …).
- Additional information from [Mrs A] …
- Statements from [RM J] … and [RM K] …
- Clinical records from [RM B].
- Clinical records from [the DHB].

I have also read the draft timeline of care you provided, which outlines the different versions of events provided to you.

My Assessment

You asked me to review the documents and advise whether the care provided to [Mrs A] and [Baby A] by [Dr C] at [the DHB] was reasonable in the circumstances and why. You also asked me to comment specifically on:

1. *Communication with midwives, particularly [RM B].*

Communication is a two-way process, and the description of its success will vary between participants. Other observers will also draw varying conclusions.

[Mr A] described what he viewed as 'instant disdain' between [Dr C] and [RM B], and felt that [Dr C] had let his potential past experiences get in the way.

In her letter of 9 [Month7], [RM D] wrote that she had been present in the staff office previously when [Dr C] had discussed which LMC midwives he found most challenging to work with, including [RM B] in the list.

[RM E's] statement … suggests that [RM H] thought [RM B] had not fully informed [Dr C] of the circumstances under which she was bringing [Mrs A] into hospital. [RM E] then noted what she described as [RM B's] unprofessional comment to [Mrs A] regarding [Dr C], and that she believed it undermined any involvement or opinion that he would offer.

[Ms G] wrote that 'it became obvious to her that there were existing issues at play between [RM B] and the OB ([Dr C]) as the mood and conversation between them was tense and at times undermining from both sides.'

[Mrs A's] notes … record that [RM B] didn't seem to have a very high regard for obstetricians, and that [RM B] referring to the obstetrician as 'Mr Slice and Dice' frightened her.

[Dr C] told his CEO ([the DHB] letter 17 [Month6] refers) that his decision making was based on his clinical assessment, and not his relationship with [RM B] as believed by [Mr A].

2. *Communication with [Mrs A] during labour, and in particular regarding the need for Caesarean section. You also asked me to comment on the alternative fact scenarios:*
    a. *If, as [Mrs A] describes, [Dr C] addressed the whole room but did not discuss directly with her, prior to surgery, the risks and benefits of a Caesarean, and did not explain the gravity of the situation — [Mrs A] said that she did not know what distressed meant.*
    b. *If [Dr C] described the information recorded in his clinical records.*

[Mr and Mrs A's] letter of 15 [Month4] states quite clearly that [Dr C] told them very directly that [Mrs A] required a caesarean section when he had first examined her. [Mrs A] declined that advice, apparently influenced by the alternative advice from [RM B] that it was OK to wait as long as the baby was OK. [Mrs A's] perspective states that [Dr C] didn't speak directly with her at any time before the surgery, but that he appeared to address the entire room.

Doula [Ms G's] notes record that at 12.20pm [Dr C] strongly recommends a caesarean section, but that [Mrs A] declined his advice and she was reassured by [RM B] that going for an epidural wouldn't get in the way of a subsequent caesarean section if it was necessary.

[RM E], in her statement …, records that she told [Mrs A] that (due to the meconium, the obvious fetal distress displayed on the CTG and that she had not progressed since midnight) she needed a caesarean section.

[RM D], in her letter of 9 [Month7] to the Midwifery Council, states she was horrified that [Dr C] had not used the terms 'deep transverse arrest' and 'obstructed labour' in the labour room. She thinks that if these terms, rather than 'failure to progress' had been used, then consent for caesarean section would have been obtained more readily and promptly.

[Dr C], in his letter of 3 [Month4] which is confirmed by the clinical records, noted that both [Mrs A] and [RM B] decided to ignore his initial advice about undergoing caesarean section for delay in labour at about 12.30pm. When he was asked to review [Mrs A's] CTG at 3.05pm, he stated that the CTG had been abnormal since 1.30pm and he discussed this with the patient and [RM B], and offered caesarean section again. He subsequently stated that he warned [Mrs A] and [RM B] of the risk to the baby by delaying the decision making, but was told by [RM B] that [Mrs A] and her husband wanted to take their own time to make the decision. [Dr C] then examined [Mrs A], and says he again advised her and [RM B] to consider caesarean section without further delay and warned about fetal compromise (again confirmed by the clinical records). Her husband arrived at 3.45pm and agreed to the caesarean section. He and [Mrs A] were warned of the potential complications of the operation, due to the prolonged labour, and these were noted on the consent form. The baby was born at 4.30pm.

[RM F's] statement … records that at about 2pm she had told [Mrs A] of her concerns for the health of the baby, that the baby was in distress and would [Mrs A] consent to an emergency caesarean section. [Mrs A] declined, preferring to wait for her husband to return. [RM F] told [Mrs A] she [would be] asking [Dr C] to come *immediately* to review the CTG. At 3.15pm she noted the CTG trace was worsening, and explained again to [Mrs A] that her baby was in distress and needed to be delivered.

The statement from [Dr I] records her memories of the case, albeit from some time afterwards. She recalls that both [Dr C] and the hospital midwife had stressed the

urgency of the situation to [Mrs A], but that she refused to give consent until her husband returned.

3. *Timeliness of Caesarean section following 3.45pm (the time recorded that [Mrs A] agreed to the operation). The operation commenced at 4.28 pm.*

The case notes state that preparation for emergency LSCS commenced at 3.45pm, for which [Mrs A] was given sodium citrate (which would have had to be brought from the drugs cupboard), IV fluids continued and her catheter was draining concentrated urine, TEDS stockings *in situ*, ready for theatre and [a doctor] on ward giving epidural top-up. [Mrs A] was then transferred to the theatre, arriving at 4.03pm. The CTG was recommenced at 4.19pm, showing a baseline heart rate of 47bpm, and this was discontinued as [Mrs A's] abdomen was prepped for surgery.

The CTG timings suggest the decision for caesarean section was made just before 3.50pm, and the epidural top-up was given at 3.55pm. It records being in the theatre at 4.03pm, and then again at 4.19pm with no recording in between.

The letter from [the DHB] dated 17 [Month1] explains the apparent contradictions around the times. It notes that according to the Theatre Case Details the anaesthetist arrived at 4.00pm, the time of 4.03pm on the CTG may have been that prior to [Mrs A's] departure from the maternity unit, that theatre called for [Mrs A] at 4.05pm and she arrived at 4.12pm and transferred onto the operating table, the CTG at 4.19pm was that when [Mrs A] was on the operating table prior to surgery commencing at 4.26pm. This timeline would make sense, allowing for the time taken to ensure adequate anaesthesia has been established, the nurses have all the equipment ready and in place and that time out has been performed. This last is an essential safety process which is meant to occur before all operations.

[Dr I's] statement records that once consent had been given there was, from her perspective, no delay or interruptions before going to the operating theatre. She did not recall any delay due to the epidural anaesthesia.

The peri-operative check was signed by [a midwife] at 4pm.

The anaesthetic record has some readings from 3.55pm, and the SpO2 from 4.20pm.

The intra-operative record states the anaesthetic start time was 4.12pm, with the procedure starting at 4.28pm and finishing at 5.12pm.

4. Adequacy of postoperative care, and post-operative communication with [Mrs A]. [Mrs A] said that after the surgery, [Dr C] did not explain in detail the nature of a tear in her uterus.

The operation note details a tear at the left end of the uterine incision, extending down to the left fornix, which was sutured in layers with vicryl. The operation note concluded by saying no follow-up had been arranged.

The notes record that [Dr C] saw [Mrs A] at 7.35am on 7 [Month3]. The notes are appropriate with regard to her medical condition, but do not reflect any conversation or information exchange. However the note at 8am from [RM D] records that [Mrs A] had been seen by [Dr C], and was happy with the explanations given (although they were not detailed).

[Mrs A's] complaint says that [Dr C] did inform her about the uterine tear, but she had no idea what he was talking about immediately after the operation. She says when he saw her the next day he explained the uterus had a tear, but she doesn't know anything else about it. There are no notes in the clinical record about that conversation, and [Dr C] does not refer to it in his responses. [Mrs A] was then transferred to [Hospital 2], so there were no further opportunities for her to seek clarification of what the tear meant.

5. Any other matters in this case that I consider warrant comment.

Written consent *per se* is not necessary. It is simply a piece of paper recording part of the whole consent process, and if verbal consent has been given that is actually sufficient. However where there has been some difficulty in obtaining consent (as happened here) it is wise to ensure there is a written record.

The difficulties that can arise in the maternity system when different carers give different advice to a woman and her family are well known. Had [RM B] supported the advice given by [Dr C] the outcome for [Baby A] would probably have been very different.

Conclusion

Overall I believe the care provided to [Mrs A] and [Baby A] by [Dr C] at [the DHB] was reasonable in the circumstances. [Dr C] has stated his decision making was based on his clinical assessment, rather than any interactions between himself and [RM B], and the records support this. He was, however, placed in a very difficult situation by the lack of support for his advice by [RM B]. This may explain the perceptions about his communications with [RM B].

[Mrs A] was appropriately advised to undergo caesarean section when she was first seen.

Although the alternative of epidural anaesthesia and labour could have been considered as an alternative, the advice was reasonable given the clinical findings at the time. I do not agree with [RM D's] comment that had [Dr C] used the terms 'deep transverse arrest' and 'obstructed labour' to [Mrs A] that she would have agreed to caesarean section at that time, as they would mean very little to most women.

[Mrs A] was again advised to undergo the operation when both MWs [RM F] and [RM E], and then [Dr C], had concerns about [Baby A's] well-being. I think most obstetricians would not have offered but would have advised the operation when first made aware of the CTG and meconium, but that advice was subsequently given along

with the potential consequences of further delay. I cannot determine why [Mrs A] did not appear to understand the urgency/gravity of the situation when it had been stated to her by two midwives and [Dr C].

It is not clear whether or not [Dr C] directly addressed [Mrs A], as he has not commented on this. It is, however, necessary as part of the three-way communication between the woman, obstetrician and LMC for all to be included. That may be why [Mrs A] feels he addressed the room rather than herself.

Allowing for the difficulty in reconciling the different times recorded on different documents I believe the operation was performed in a timely manner once consent had been given. The only area where I think time might have been saved is between the giving of consent and then theatre calling for [Mrs A] (20 minutes, assuming both times given are correct). How much difference this would have made to [Baby A's] condition cannot be determined.

As [Dr C] has not specifically addressed the issue of post-operative communication with [Mrs A] I cannot comment further, beyond noting that as [RM D] recorded [Mrs A] was happy with the explanations it would have been reasonable for him to have drawn the same conclusion. It would appear that he felt the tear did not warrant any further action or explanation, as otherwise I would expect him to have arranged a follow-up appointment for [Mrs A].

I do not have any personal or professional conflict of interest to declare with regard to this case. If you require any further comment or clarification please let me know.

Yours sincerely,

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