Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Deputy Health and Disability Commissioner

(Case 20HDC00496)

Contents

Introduction

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

2. This report discusses the care provided to Ms A by Registered Midwife (RM) B, RM C and Nelson Marlborough District Health Board (NMDHB) (now Te Whatu Ora Nelson Marlborough).[1]

3. In 2019, Ms A gave birth to her daughter, Baby A, at Wairau Hospital. There were complications in the second stage of labour, and Baby A was born in poor condition and

[1] On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, which disestablished all district health boards. Their functions and liabilities were merged into Te Whatu Ora|Health New Zealand. All references in this report to NMDHB now refer to Te Whatu Ora Nelson Marlborough.

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required full resuscitation, therapeutic hypothermia[2] and transfer to tertiary-level care. Subsequently, Baby A was diagnosed with severe hypoxic ischaemic encephalopathy (HIE).[3]

4. In March 2020, HDC received a referral from Te Tatau o te Whare Kahu|Midwifery Council enclosing a 'harm report' from the Accident Compensation Corporation (ACC) about a treatment-related incident believed to present a risk of harm to the public. Ms A agreed to the Commissioner assessing the care she received.

5. The following issues were identified for investigation:

- *Whether RM B provided Ms A with an appropriate standard of care in 2019.*
- *Whether RM C provided Ms A with an appropriate standard of care in 2019.*
- *Whether Nelson Marlborough District Health Board provided Ms A with an appropriate standard of care in 2019.*

6. The parties directly involved in the investigation were:

Ms A	Consumer
RM B	Midwife
RM C	Midwife
Dr D	Obstetrician
RM F	Midwife

7. ACC midwifery advisor RM E is also mentioned in this report.

Summary of care

Background

8. In 2019, Ms A (then aged in her late teens) registered with RM B as her midwife and lead maternity carer (LMC).[4] Ms A was 33 weeks pregnant with her first pregnancy and had recently moved to the Nelson Marlborough region. Ms A had a complex mental health history including bipolar affective disorder[5] and anxiety. Prior to her relocation, she had been under the care of the mental health team, with care then transferred to the NMDHB mental health team.

9. A growth scan at 33 weeks and 3 days' (33+3) gestation showed that Ms A's baby was measuring large for gestational age.[6] Following consultation with an obstetrician, Dr D, at

[2] Also known as cooling, therapeutic hypothermia is an intervention to decrease adverse neuro-developmental outcomes following perinatal asphyxia (deficient supply of oxygen to the body during birth).
[3] HIE is brain injury caused by insufficient oxygen delivery to the brain. It is a serious birth complication that can cause severe developmental delay, lifelong disability and death.
[4] At the time of events, RM B was employed by Nelson Marlborough DHB as an LMC midwife.
[5] Any of several mood disorders characterised usually by alternating episodes of depression and mania.
[6] Estimated fetal weight 2746g (above 90th centile on customised GROW chart (the GROW chart (Gestation Related Optimal Weight) is customised for the characteristics of each pregnancy).

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35 weeks' gestation, Dr D recommended that Ms A's pregnancy not go beyond 41 weeks and that labour be induced if spontaneous labour had not eventuated by then.

10. At 40+1 weeks' gestation, Ms A underwent a membrane sweep[7] to stimulate labour. On examination, her cervix was favourable[8] for induction of labour (IOL). Her baby was in the cephalic[9] occiput posterior position,[10] with the head not yet fully descended into the pelvis, at fetal station -2cm.[11] Ms A had been noted to be feeling anxious about the birth and the size of the baby. She lived rurally and was also concerned about getting to the hospital if she were to go into labour spontaneously at home. An IOL was scheduled for 41 weeks' gestation. The IOL plan was for artificial rupture of membranes (ARM)[12] to be performed, followed by administration of Syntocinon[13] if contractions did not follow naturally.

Induction, labour and birth

11. At 40+3 weeks' gestation, Ms A met with RM B in the maternity unit at Wairau Hospital. Ms A asked for labour to be induced that day, rather than to wait until the following Monday. Following consultation with Dr D and senior midwifery staff it was agreed to proceed with an IOL that afternoon. Ms A's partner (the baby's father) and mother attended to support her during labour.

12. IOL commenced with an artificial rupture of membranes (ARM) at 1.42pm, followed by a Syntocinon infusion commencing at 5pm to encourage contractions. Continuous CTG[14] monitoring was in place and the first stage of labour proceeded uneventfully. At 9.20pm the tocograph[15] monitoring Ms A's contractions was removed at Ms A's request. Monitoring of the fetal heart rate (FHR) continued.

13. At 9.45pm Ms A was fully dilated and entered the second stage of labour. Shortly afterwards, at 10.05pm, she was noted to be 'tired, sore and frustrated'. By around 11pm the FHR pattern showed suspicious abnormalities indicating possible fetal distress, but this was not recognised. At 11.20pm a core midwife,[16] RM C, entered the room to provide additional

[7] A procedure to stimulate labour without administering medications. A digital examination of the cervix is performed, and the amniotic sac (membranes) are separated from the cervix in a sweeping motion.
[8] The clinical notes record that Ms A's cervix was anterior, 4cm dilated and 80% effaced (cervical effacement is when the cervix softens, thins and shortens in preparation for labour and delivery).
[9] Describing a fetal position in which the head is down for birth of the head through the birth canal first.
[10] A fetal position where the baby is head down with the back of the baby's skull facing the mother's spine (facing toward the mother's abdomen). An occiput posterior position increases the chances of slow progression of labour.
[11] The fetal station is a measurement of how far the baby's head has descended through the woman's pelvis, using the ischial spines as an anatomical mark. The station is measured in centimetres above (negative) or below (positive) the ischial spines. A station of 0 indicates that the baby's head is fully 'engaged' in the pelvis.
[12] Intentional rupture of the amniotic sac. Also known as 'breaking the waters'.
[13] Syntocinon is a synthetic oxytocin infusion administered intravenously to induce or enhance labour.
[14] Cardiotocography (CTG) is a technique for assessing fetal wellbeing in labour by monitoring the fetal heart rate and uterine contractions.
[15] The tocograph is one of two monitoring devices that form a cardiotocogaph. The tocograph monitors uterine contractions. The other part of the cardiotocogaph monitors the baby's heart rate via ultrasound.
[16] Core midwives are employed by Te Whatu Ora and are based in hospitals and maternity units. They are also known as 'hospital midwives'.

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support. By 11.45pm Ms A had been actively pushing for two hours with little progress. At around midnight, the FHR pattern became pathological, but this was not recognised until 12.30am.

14. The midwives called for obstetric support at 12.30am and for paediatric support at 12.35am. By this time the baby's head was crowning but had stopped advancing. An episiotomy[17] was performed and the baby's head was born at 12.40am. Shoulder dystocia[18] was identified, and RM B performed internal manoeuvres in attempts to release the baby's shoulder but was unsuccessful. At around 12.40am Dr D arrived and took over care, and Baby A was born at 12.41am in poor condition.

15. The emergency call bell was pushed, and full resuscitation was commenced immediately by Dr D and staff from the paediatric ward who responded to the emergency call bell.

16. At one minute after birth, Baby A had an Apgar score of one.[19] The on-call paediatrician arrived at approximately 12.50am and took over resuscitation efforts. Baby A took her first breath at 14 minutes of age. Subsequently, she was transferred to the neonatal intensive care unit at a main centre hospital and diagnosed with severe HIE.

Summary of concerns

17. Following Baby A's birth, NMDHB completed a Serious Adverse Event Review (SAER) of the care provided to Ms A and her baby. A copy of the SAER report was provided to HDC. The SAER identified a number of care and service delivery problems in the care provided to Ms A.

18. ACC received a treatment injury claim following Baby A's HIE diagnosis. To assess this claim, ACC obtained independent advice from a registered midwife, RM E. RM E also identified concerns in the care provided to Ms A.

19. Following review of the information gathered in the course of this investigation, and in recognition of the detailed review and assessment carried out by the SAER and ACC, I have focused my decision on particular concerns identified by the SAER and ACC. These concerns are summarised in the table below.

[17] A cut made in the perineum (the tissue between the vaginal opening and the anus) to widen the vaginal opening during childbirth.

[18] A condition where one or both of a baby's shoulders becomes stuck inside the pelvis after the birth of the head during vaginal delivery. Obstetric manoeuvres can be required to deliver the baby after gentle downward traction has failed.

[19] The Apgar score is a clinical indicator used to evaluate the condition of a newborn infant shortly after birth (usually at 1 minute and 5 minutes after birth). The score is based on a rating of 0, 1, or 2 for each of the five characteristics of colour, heart rate, response to stimulation of the sole of the foot, muscle tone, and respiration, with 10 being a perfect score. At one minute after birth, Baby A was pale (0), floppy (0), with a heart rate of 70bpm (1) and no respiratory effort (0) or reflex response (0).

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	Concern	Identified by
1	Decision to undertake IOL in high-risk woman with pre-existing co-morbidities and complex condition in the late afternoon going into after-hours when staffing resources reduced. Paediatric team and Duty Nurse Manager not told of high-risk induction at night.	SAER
2	Staffing/working environment — core midwife working an unexpected additional shift and LMC working >12 hours without a break.	SAER
3	Inadequate intrapartum monitoring of contractions — cardiotocograph (CTG) monitor time incorrect and speed of recording not accurate; tocograph removed during labour; and abdominal assessment of contractions not documented.	SAER and ACC
4	Delayed escalation of care/inadequate communication with obstetrician.	ACC
5	Delayed recognition of an abnormal CTG/fetal heart rate (FHR) trace requiring urgent specialist review.	SAER and ACC
6	Emergency call procedures not followed.	SAER
7	Inappropriate use of lignocaine (local anaesthetic) in emergency episiotomy.	SAER
8	Mismanagement of shoulder dystocia.	ACC
9	Incomplete/non-contemporaneous written clinical records	SAER

Responses to provisional opinion

Ms A

20. Ms A was given the opportunity to comment on the 'summary of care', 'summary of concerns' and 'opinion' sections of the provisional decision, excluding the 'my decision' sections. She expressed her gratitude to HDC for investigating the concerns about the care she received and said that it is important that women in these situations are heard and acknowledged, and that changes are made to ensure that similar events do not happen to others.

RM B

21. RM B was given the opportunity to comment on relevant sections of the provisional decision. She accepted the decision and recommendations without further comment.

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RM C

22. RM C was given the opportunity to comment on relevant sections of the provisional decision. She advised that she fully accepted the decision and provided a written apology for forwarding to Ms A. RM C said that she has always been deeply invested in the care and welfare of mothers and babies, and she regrets the decisions she made that contributed to the harm to Baby A and the distress to Ms A and her family.

Te Whatu Ora

23. Te Whatu Ora was given the opportunity to comment on the provisional decision and it advised that it had no further comments or feedback.

Opinion: Introduction

24. I acknowledge the distress experienced by Ms A, her daughter and her whānau as a result of the events described in this complaint. At the time of events, Ms A was a young woman having her first baby, and she relied on her care team to monitor her baby's wellbeing adequately, to collaborate effectively, and to escalate care promptly when indicated. Unfortunately, it appears that this did not occur and, as a result, Ms A's baby suffered serious complications, which potentially will have a profound impact on her future wellbeing.

Opinion: RM B — breach

Introduction

25. RM B was Ms A's LMC and therefore had primary responsibility for her care during pregnancy, labour and birth. She was required to provide Ms A with services that complied with relevant standards, including:

- The New Zealand College of Midwives (NZCOM) Standards of Practice (NZCOM Standards);[20]
- The NZCOM consensus statement on the Roles and Responsibilities in the Hospital Setting;
- The Ministry of Health 'Guidelines for Consultation with Obstetric and Related Medical Services' (MoH Referral Guidelines);[21] and
- The NMDHB's internal policies/guidelines applicable at the time of events.

26. Following review of the information gathered, and with reference to the above standards, I am critical of RM B's failure to:

- Validate the time and date settings on the CTG machine prior to commencing CTG monitoring;

[20] The NZCOM Standards provide the framework for midwifery practice in New Zealand.
[21] The MoH Referral Guidelines provide the criteria and pathways for referring pregnant women for consultations with other clinicians.

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- Document the discussion with Ms A about the risks of removing the tocograph, her decision in this regard, and the plan to monitor contractions in the absence of a tocograph;
- Consult with Dr D when the tocograph was removed at 9.20pm;
- Document the frequency of contractions at appropriate intervals in the second stage of labour;
- Provide full and timely information to Dr D regarding the clinical picture as labour progressed;
- Consult with Dr D at 11.45pm when Ms A had been actively pushing for two hours with little progress;
- Recognise that by 11pm the CTG showed an FHR pattern that was potentially suspicious and that by 11.58pm the CTG showed a pathological FHR pattern that was an indication to discontinue Syntocinon immediately and seek urgent obstetric review;
- Promptly perform an episiotomy (after obtaining consent from Ms A) without waiting for preparation and administration of anaesthetic; and
- Document several aspects of Ms A's care adequately throughout her labour.

27. I will discuss each of these concerns in turn.

Induction of labour — artificial rupture of membranes and Syntocinon infusion

28. Following Ms A's request for an IOL RM B spoke with Dr D and senior midwifery staff, and they agreed for the IOL to go ahead. RM B documented in the clinical records:

> '[Ms A] has requested ARM in light of favourable [membrane sweep] [two] days ago. Discussed this with [Dr D] who [Ms A] met almost [four] weeks ago in clinic. Is happy for this to happen if [senior midwifery staff agree]. [Senior midwifery staff] agreed it [is] ok to go ahead with this.'

29. Dr D told HDC that he received a call from RM B in the afternoon to confirm the IOL plan. There is no documentation of this in the clinical records. Dr D told HDC:

> 'As [senior midwifery staff] approved the IOL, I would have agreed for the LMC midwife to do an [ARM] if the CTG was normal, the presentation cephalic, and the cervix favourable. I would have said that I will come to see [Ms A] before starting [a Syntocinon] infusion. I assumed the midwife would record our conversation in [Ms A's] notes. I would write my consultation in the notes later when I would see [Ms A].'

30. The Nelson Marlborough District's IOL guidelines require that prior to an ARM, the baby's presentation should be confirmed as cephalic[22] with the fetal head engaged.[23] The IOL guidelines require that artificial rupture of membranes be performed only if the baby's head

[22] The IOL guidelines state that IOL is not generally recommended for non-cephalic fetal presentations such as breech (buttocks down) or in a transverse lie (positioned horizontally across the uterus).
[23] Engagement is when the widest part of the baby's head has descended into the mother's pelvis (fetal station 0).

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is engaged. The FHR should be checked and documented, and a vaginal examination should be performed to assess the cervix.[24] The IOL guidelines also require documentation of the colour and volume of liquor obtained during the procedure, and that the FHR is checked and documented immediately after the procedure.

31. CTG monitoring was commenced at 12.45pm. NMDHB's SAER identified that the CTG monitor time was incorrect. NMDHB explained that the SAER identified inconsistencies between the CTG machine-generated time stamp on the recording tape and the progress times manually recorded by staff on the tape and in other documentation. NMDHB said that midwives are expected to routinely check the time setting on a CTG machine prior to the start of monitoring. This is also stated in the District's clinical guidelines for intrapartum fetal monitoring (fetal monitoring guidelines) relevant at the time of events.[25]

32. At 1.35pm it was documented that Ms A was experiencing irregular contractions and the FHR baseline was 135 beats per minute (bpm).[26] At 1.42pm RM B performed a vaginal examination and an ARM. Ms A's cervix was 4cm dilated and the baby was in the occiput posterior position with cephalic presentation. Following the ARM, RM B documented that there was clear liquor draining and the FHR was 142bpm.

33. At 4.30pm Dr D reviewed Ms A in the hospital. Dr D told HDC:

> 'I discussed the plan with [RM B] and [Ms A], which was to start an infusion of oxytocin to augment labour, to have continuous CTG and to perform regular vaginal examinations, usually 4 hourly (as per protocol). I checked that she had intravenous access [and blood tests]. I noted that she could have an epidural if the CTG was normal and stated that, as usual practice at Wairau Maternity, the midwives could call me anytime, as required.'

34. Dr D documented the plan in the clinical records (entry at 4.45pm):

> 'For IOL/augmentation after ARM …
>
> [B]ig boy [nil] diabetes.
>
> [Plan]
> - CTG as per protocol
> - Syntocinon augmentation as per protocol
> - [Intravenous access] + [blood tests] [confirmed]
> - If CTG [normal] can have an epidural
> - Call [obstetrician] as required.'

[24] The IOL guidelines require that artificial rupture of membranes be performed only if the cervix is at least 2cm dilated and effacing.
[25] The District's fetal monitoring guidelines state: 'Date and time settings on CTG machines should be validated whenever used.'
[26] Normal FHR findings in labour are considered to be when the FHR is between 110bpm and 160bpm, there is baseline variability of 6–25bpm, accelerations of 15bpm for 15 seconds and no decelerations from baseline (as per The RANZCOG Intrapartum Fetal Surveillance Clinical Guidelines 2014 (3rd edition)).

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35. The District's IOL guidelines require continuous CTG monitoring while an oxytocin infusion is in progress, and palpation of uterine contractions every 15–30 minutes. The RANZCOG Guideline also recommends CTG monitoring when labour is induced or augmented with oxytocin. The District's IOL guidelines outline a regimen for the rate of infusion, starting at 6ml per hour and doubling the rate every 30 minutes, aiming for a maximum of three to four moderate to strong contractions in 10 minutes.

36. At 5pm a Syntocinon infusion was started at 6ml per hour. The clinical records show that Ms A was having one to two contractions in ten minutes and the CTG trace was 'overall reassuring'.[27] At 5.30pm the rate of Syntocinon was increased to 12ml per hour. At 5.40pm it was documented that contractions were two to three in 10 minutes, and the CTG continued to be 'overall reassuring'.[28] At 5.55pm the rate of Syntocinon was increased to 24ml per hour. An entry in the clinical records at 7.20pm documents that Syntocinon continued at 24ml/hour, and contractions were three to four in 10 minutes. The Syntocinon infusion continued at 24ml/hour throughout Ms A's labour until birth.

37. RM B told HDC that the core midwife on shift came to review the CTG each time the Syntocinon infusion was increased. There is no documentation of this in the clinical records.

My decision

38. I am satisfied that RM B's administration of the Syntocinon infusion in the first stage of labour was in accordance with Dr D's instructions and the IOL guidelines. However, I am critical that RM B did not document her discussion with Dr D regarding the IOL plan, nor that the core midwife reviewed Ms A each time the infusion rate was increased. I am also critical that RM B did not validate the time settings on the CTG machine prior to commencing CTG monitoring, as required by the District's fetal monitoring guidelines.

Monitoring in first stage of labour

39. The District's fetal monitoring guidelines provide that where continuous FHR monitoring is required, the trace should be reviewed at least every 15–30 minutes and it should be recorded in the clinical record that the CTG has been reviewed, including the findings and actions taken (if any). The guidelines also recommend that midwives seek regular continuous monitoring reviews by their colleagues at least every hour to have a 'fresh pair of eyes' review the tracing and findings to enhance ongoing assessment.

40. Following the last increase of Syntocinon at 5.55pm, at 6.20pm RM B recorded Ms A's vital signs[29] and documented in the clinical notes:

[27] At 5pm the clinical notes record: baseline FHR of 135bpm, accelerations present and variability >7bpm, with nil decelerations.
[28] At 5.40pm the clinical notes record: baseline FHR of 135bpm, accelerations present and variability >7bpm, with nil decelerations.
[29] Blood pressure 140/80; pulse 104; respiratory rate 14; temperature 36.6°C.

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> 'CTG continues … super difficult to monitor FHR in this position. Tried to monitor it by hand. Consent given from [Ms A] to put [a fetal scalp electrode (FSE)][30] clip onto baby's head.'

41. RM B explained to HDC that as Ms A was moving around the room, the tocograph of the CTG kept moving around her abdomen, and this made it difficult to monitor the FHR.

42. At 6.30pm RM B performed a vaginal examination and attached the FSE to the fetal head. The baseline FHR was 152bpm and the fetal head remained at station -2. Ms A's cervix was 7cm dilated. Ms A was not tolerating the examination because of discomfort, and the fetal position was unable to be assessed.

43. Between 6.30pm and 9.10pm Ms A's labour progressed uneventfully. FHR recordings with normal features were documented approximately every 20–30 minutes.[31] CTG monitoring continued during this time and was noted to be 'reassuring'. The frequency of contractions was documented at 7.20pm, 8pm and 8.45pm, each time as three to four contractions in ten minutes. A vaginal examination performed at 7.30pm showed that the cervix was 7–8cm dilated and the baby remained in the occiput posterior position, with the fetal head at station -2. By 9pm the cervix was 9cm dilated with an anterior lip.[32]

44. At 9.20pm the tocograph monitoring Ms A's contractions was removed. RM B documented: 'Removed toco[graph]. Not picking up contractions very well [and] super annoying for [Ms A] … FHR 132[bpm].' RM B told HDC that Ms A had become frustrated with the tocograph and started to take it off. RM B said:

> 'I encouraged her to leave [the tocograph] on, explaining that it's important to monitor contractions so we are not over stimulating the uterus, but she refused, and responded that "it wasn't working anyway". The toco[graph] came off and she continued to mobilise around the room. The FSE stayed on.'

45. NMDHB's SAER identified the removal of the tocograph as a key concern in the care of Ms A: 'Syntocinon [IOL] without contin[u]ous contraction monitoring — toco[graph] not working well and abdominal assessment of contractions not documented.'

46. At 9.30pm RM B documented that Ms A was experiencing three to four contractions in ten minutes and the baseline FHR was 140bpm with normal variability and accelerations as well as variable decelerations to 110bpm.

47. NMDHB said: 'We are unaware of whether risks associated with removal of the tocograph were fully explained to [Ms A] at the time.'

[30] An electrode placed through the cervix onto the scalp of a fetus to monitor the fetus's heart rate.
[31] FHR recordings: 6.30pm: 152bpm; 7.20pm: 135/137bpm; 7.30pm: 132bpm; 8pm: 140bpm; 8.20pm: 135bpm; 8.45pm: 135bpm; 9.10pm: 137bpm.
[32] A cervical anterior lip occurs when the top of the cervix swells, but the rest of the cervix has dilated completely.

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My decision

48. I acknowledge that this was a challenging situation. The CTG appears to have been ineffective in monitoring the FHR and Ms A's contractions, and she was finding the tocograph very uncomfortable. RM B addressed the difficulties in monitoring the FHR by applying an FSE. She documented the FHR recordings every 15–30 minutes in line with the requirements set out in the District's fetal monitoring guidelines, with one exception of a 50-minute period between documented reviews at 6.30pm and 7.20pm. On the whole, I am not critical of RM B's care in the period between 6.20pm and 9.10pm.

49. However, while I acknowledge that the decision to remove the tocograph was Ms A's choice to make, I have several concerns about RM B's care at this point.

50. First, I am concerned that RM B may not have fully explained to Ms A the risks of removing the tocograph.

51. Standard two of the NZCOM Standards states: 'The midwife upholds each woman's right to free and informed choice and consent throughout the childbirth experience.' The criteria for this includes: 'The midwife shares relevant information, including birth options and is satisfied that the woman understands the implications her choices.' I acknowledge that RM B said she explained that the tocograph was important to ensure that the uterus was not being over-stimulated. However, there is no evidence that she explained the risk this could pose to fetal wellbeing. In my view, it cannot be assumed that a woman would understand the impact of uterine hyper-stimulation on fetal wellbeing. I consider that RM B should have explained this to Ms A clearly before deciding to remove the tocograph, and I would be critical if she did not.

52. Second, if RM B did explain to Ms A that the tocograph was important for measuring the frequency of uterine contractions to ensure that the uterus was not being overstimulated, I consider that this should have been documented. The criteria for standard two of the NZCOM Standards include: 'The midwife documents decisions and her midwifery actions.' While I acknowledge that RM B documented that the tocograph had been removed, I am critical that she did not document the details of the discussion, Ms A's decision to remove the tocograph, or a plan to monitor Ms A's contractions adequately.

53. Third, I consider that RM B should have consulted with Dr D and advised him that the tocograph had been removed.

54. The MoH Referral Guidelines provide a list of conditions that fall into the following four categories for referral: primary,[33] consultation,[34] transfer[35] and emergency.[36] 'Induction of

[33] Referral to a primary health provider is indicated (eg, to a general practitioner, physiotherapist, maternal mental health services).
[34] The LMC must recommend to the woman that a consultation with a specialist is warranted.
[35] The LMC must recommend to the woman that the responsibility for her care be transferred to a specialist.
[36] An emergency necessitates the immediate transfer of clinical responsibility to the most appropriate practitioner available.

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labour' is a condition in the 'consultation' referral category, meaning that this is a condition for which the LMC must recommend specialist consultation.

55. As outlined earlier in this report, I accept that RM B consulted appropriately with Dr D prior to commencing the IOL. However, Dr D's agreed plan for Ms A's IOL required continuous CTG monitoring. This was also a requirement in the IOL guidelines and was recommended in the RANZCOG Guideline. As noted by RM E in her advice to ACC, the tocograph is essential for correct reading of the CTG. At the point when the tocograph was removed, Ms A was not being monitored in line with the IOL guidelines, the RANZCOG Guideline, or Dr D's approved IOL plan. As an IOL requires specialist consultation (in accordance with the criteria set out in the MoH referral guidelines), I consider that any change to the agreed IOL plan should have prompted RM B to consult with Dr D again, and I am critical that she did not.

Monitoring of contractions in second stage of labour

56. At 9.45pm RM B performed a vaginal examination and documented that Ms A's cervix might be fully dilated[37] and that the baby might be in the occiput transverse[38] or occiput posterior position, although there was difficulty assessing the cervix and fetal position as Ms A was not tolerating the examination owing to discomfort. RM B documented that the fetal head remained at station -2. The documented FHR was 130bpm.

57. At 10.05pm it was documented that Ms A continued to experience three to four contractions in ten minutes. Following this, there are no documented recordings of the frequency of contractions. RM B told HDC that contractions were palpated abdominally, but there is no record of this in the clinical records.

58. RM B told HDC:

> 'As the labour advanced [Ms A] became more distressed. I did consider trying to replace the tocograph but at the time I did not want to agitate her any further as I knew her mental health was fragile and wanted to sustain her emotional wellbeing for the duration of labour and birth.'

My decision

59. RM B said that contractions were palpated abdominally in the second stage of labour. Unfortunately, due to the lack of documentation, I am unable to assess whether contractions were palpated at appropriate intervals following the removal of the tocograph.

60. Standard three of the NZCOM Standards states: 'The midwife collates and documents comprehensive assessments of the woman and/or baby's health and wellbeing.' A criterion for meeting this standard is that 'the midwife documents her assessments and uses them as the basis for on-going midwifery actions in consultation with the woman'.

[37] Full dilation of the cervix is when the cervix is dilated to 10cm. Full dilation of the cervix marks the beginning of the second stage of labour.
[38] A fetal position where the baby is head down with the back of the baby's skull facing the mother's left hip (left occiput transverse) or right hip (right occiput transverse).

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61. As discussed, the District's IOL guidelines recommend aiming for a maximum of three to four contractions in ten minutes when administering Syntocinon, and continuous CTG monitoring is required to ensure that the uterus is not being overstimulated and fetal wellbeing is not compromised. Despite this, RM B recorded the frequency of Ms A's contractions only twice after the tocograph was removed (at 9.30pm and 10.05pm). On this basis, it is clear that RM B did not document the frequency of Ms A's contractions adequately in the second stage of labour, and I am critical of her care in this regard. Further, I consider that RM B's failure to document the frequency of Ms A's contractions at appropriate intervals likely compromised her ability to identify a pattern of increasing fetal distress in the final hours of labour (as discussed in paragraphs 79–96).

Communication with obstetrician in second stage of labour

62. At 10.05pm, 45 minutes after removal of the tocograph, RM B documented that Dr D called for an update and she 'informed [him] of [Ms A's] fantastic progress'. Dr D told HDC that during this conversation RM B told him that '[Ms A] was fully dilated and that there were no concerns with the CTG'.

63. In the same entry at 10.05pm, RM B documented that Ms A had begun to push and was getting 'tired, sore and frustrated'. The FHR recordings were documented as being 'overall reassuring' with accelerations, variability of >5bpm and no decelerations, although the baseline FHR is not documented. Ms A was having three to four contractions in ten minutes.

64. At 10.45pm RM B performed a vaginal examination but again was unable to assess dilation of the cervix or the position of the baby, as Ms A was 'extremely uncomfortable' and not tolerating the examination. RM B documented: 'Head still high. Not much movement despite active pushing 45 min[utes].'

65. At 11pm RM B documented that Ms A was 'feeling the urge overwhelmingly to push involuntarily' and the CTG trace was 'reassuring'. The FHR was recorded as 133bpm, dipping to 110bpm when Ms A was pushing and returning to baseline in between pushes.

66. In interpreting the CTG trace, RM E advised ACC:

> 'By [11pm] the CTG shows a suspicious trace with regular significant decelerations. The documentation states, 'good trace'. There is no indication that the syntocinon was reviewed or decreased to [reduce] the contractions.
>
> Neither [RM B] or [RM C] appear to have recognised the suspicious trace.'

67. ACC also received a statement from Dr D to aid in its assessment of Baby A's treatment injury claim. Dr D advised in this statement:

> 'Looking at the CTG, around [11pm], the decelerations appear more marked. It is difficult to interpret the severity of the decelerations in the absence of recording of the contractions.'

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68. An entry in the clinical notes, written in retrospect, documents that at 11pm RM B called Dr D 'to inform [him] of [Ms A's] progress'. The content of the discussion is not recorded in the clinical notes. RM B told HDC that during the telephone call she reviewed the clinical situation with Dr D. RM B outlined this as including:

- The syntocinon infusion remained at 24mls/hr;
- Ms A had started pushing and was extremely uncomfortable and increasingly tired and frustrated;
- Contractions were palpated abdominally and Ms A was being encouraged to push, but was finding it difficult to push with each contraction as she was tired; and
- Early FHR decelerations[39] were present when pushing that returned to baseline between contractions.

69. Dr D told HDC that he cannot recall the details of this discussion, but he understood that Ms A had not made very much progress and birth was not imminent. He said that as Ms A 'had pushed for an hour only', he felt that she should try longer in the absence of any concerns with the CTG, and that this would increase her chances of achieving a vaginal delivery or an easier instrumental delivery.[40] Dr D told HDC that he did not understand from this conversation that RM B was asking him to come to the hospital. He said that if he had been told that Ms A was exhausted and struggling to push effectively, or that the CTG was abnormal, he would have come to the hospital.

70. RM B told HDC that Dr D was reassuring and encouraged her to encourage Ms A to push with every contraction and to change into a more upright position to aid the descent of the baby. RM B said that following her conversation with Dr D at 11pm, she recognised that she needed additional assistance. She said that rather than calling Dr D again, she requested continuous assistance from the core midwives. RM B told HDC:

> 'After this conversation [with Dr D] I became more assertive and directive however [Ms A] was overwhelmed, and I was now beginning to struggle offering support for her mental wellbeing, along with the clinical aspects of her care which needed just as much attention. To help with this I asked for assistance from the senior core Midwives …'

71. RM B told HDC:

> 'In retrospect … I should have asked the Obstetrician to come in to clinically assess [Ms A] when I called him at [11pm].'

[39] Deceleration of the FHR at the start of a contraction. The District's fetal monitoring guidelines outline that early decelerations occurring in the presence of an otherwise normal CTG trace (normal baseline FHR, variability and accelerations) are unlikely to be associated with fetal compromise.
[40] A birth where instruments such as forceps or a ventouse suction cup are used to help deliver the baby.

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72. In her advice to ACC, RM E said:

> 'The second stage of labour is usually completed within 3 hours in a first labour, in this case [Ms A] was fully dilated at [9.45pm]. An hour later, at [10.45pm] there had been little progress, despite contractions being recorded as 3–4 in 10 minutes. After 2 hours of good pushing with little progress [ie, by 11.45pm] there was an indication for increased surveillance and a referral for review by the obstetrician.'

My decision

73. The referral guidelines state that consultation can be in the form of a discussion between the LMC and the specialist on the telephone, and it is emphasised that 'full and timely communication between practitioners is important'.

74. I consider that RM B did not communicate full and timely information to Dr D during the second stage of Ms A's labour.

75. By 10.05pm the tocograph had been removed and RM B documented that Ms A was 'tired, sore and frustrated'. Twenty minutes earlier, at 9.45pm, a vaginal examination had shown that the fetal head remained at station -2, and the fetal position was unable to be confirmed. However, I am concerned that RM B failed to provide any of this information to Dr D in her conversation with him at 10.05pm, instead advising that Ms A was making 'fantastic progress' and, as recalled by Dr D, that there were no concerns with the CTG. This is clearly an incorrect representation of the situation at this time.

76. As the content of the 11pm discussion between RM B and Dr D is not documented, it is difficult to assess the adequacy of the information RM B provided to Dr D during this call. RM B said that she discussed the clinical picture with Dr D, including that contractions were being palpated abdominally and Ms A was increasingly tired and having difficulties pushing. On the other hand, Dr D said that if he had been told that Ms A was exhausted and struggling to push effectively or that the CTG was abnormal, he would have attended the hospital. Due to the conflicting accounts and the absence of documentation, I am unable to make a finding about the precise content of the discussion at 11pm.

77. I also note RM E's advice to ACC that there was indication for a referral for review by an obstetrician at around 11.45pm, following two hours of active pushing with little progress. This advice aligns with the MoH referral guidelines, which provide that where a woman birthing her first baby has been actively pushing in the second stage of labour for more than two hours with no progress, specialist consultation is indicated.

78. I agree that once Ms A had been actively pushing for two hours with little progress, RM B should have sought obstetric consultation as indicated in the MOH referral guidelines, and I am critical that this did not occur.

Delayed recognition of abnormal CTG

79. Both ACC's external midwifery advisor, RM E, and the District's SAER report identified that there was a delay in recognition of an abnormal CTG during Ms A's labour.

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80. RM E advised:

> 'The fetus began showing early signs of distress from [9pm]. Around this time, the tocograph, which is essential to correctly read the CTG, was removed. Although the CTG is difficult to interpret due to the lack of the tocograph, the fetal heart recording shows increasing indications of fetal distress from [10pm] … By [11pm] the CTG shows a suspicious trace with regular significant decelerations … From [11.58pm], the CTG is clearly pathological with repetitive decelerations.'

81. RM E also advised:

> '[T]here were regular decelerations present soon after [10pm]. This should have prompted the midwives to increase surveillance of fetal wellbeing, reduce the syntocinon infusion, and replace the tocograph to clearly review the timing of the fetal decelerations in relation to the contractions.'

82. Dr D said in his statement to ACC that on review of the CTG trace there were FHR decelerations that appeared 'more marked' at around 11pm and 'prolonged' at 11.20pm, although Dr D noted that it is difficult to interpret the severity of the decelerations in the absence of recording of the contractions. Nevertheless, Dr D said that even without the recording of contractions, by around 11.55pm the CTG FHR trace was pathological with complicated variable decelerations. He considers that he should have been informed of the pathological nature of the CTG recording by midnight at the latest,[41] and the oxytocin infusion should have been stopped immediately.

83. The District's fetal monitoring guidelines, which reflect the RANZCOG Guideline, set out that complicated variable decelerations with reduced or absent baseline variability is likely to be associated with significant fetal compromise requiring immediate management, which may include urgent delivery.

84. NMDHB told HDC:

> '[F]rom [11.08pm] [FHR] decelerations were seen which were likely to be associated with fetal compromise requiring action. From [11.55pm] the CGT tracing identified features likely to be associated with significant fetal compromise requiring immediate action.'

85. NMDHB's SAER outlined a chronology of events and commented that at 11.58pm there was a '30 min[ute] [d]elay in recognising and acting on abnormal CTG — [FHR] pattern'. The SAER also noted: 'Uterine contractile hyper stimulation for a period of approximately 30 minutes prior to birth.'

[41] Based on the time recorded on the CTG.

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86. The District's IOL guidelines state:

> 'In the event of a suspicious CTG lower the oxytocin infusion rate to allow the fetus to recover. If the CTG becomes pathological the oxytocin infusion should be discontinued immediately and Obstetric advice sought urgently.'

87. Between 11.20pm and 11.54pm RM B documented FHR recordings within normal limits.[42] At 11.58pm, RM B documented: 'FHR 142bpm. Good variability [and] accelerations. Reactive [CTG] trace.'

88. RM B told HDC:

> 'In hindsight, I accept that at [11.58pm] the trace, in fact had shown increased variability with no accelerations, typically the result of hypoxia[43] due to hyperstimulation.[44] Management in this case would be to cease [Syntocinon], notify senior staff and remain with the woman.'

89. The abnormal CTG was recognised at 12.30am and obstetric assistance was requested.

My decision

90. There is some discrepancy in opinion as to exactly when the FHR pattern was indicating fetal distress requiring further action by RM B (including increasing monitoring, reducing or discontinuing Syntocinon and/or seeking obstetric advice). RM E advised ACC that the FHR pattern showed early signs of distress from 9pm, with increasing signs of distress from 10pm. On the other hand, Dr D did not note any concerns about the 9pm trace and said that while there were some decelerations around 10pm, he considered that these appear to be benign. Given the difficulty in interpreting the CTG without the recording of contractions, I consider that further investigation is unlikely to resolve this discrepancy in opinion.

91. However, it appears that by 11pm the CTG trace showed FHR decelerations that were possible signs of fetal distress.

92. The facts of case 16HDC00977 also involved a situation in which a midwife had noted what she considered to be early FHR decelerations and slow progress of labour. In that case, the independent midwifery advisor advised HDC:

> 'Decelerations of the fetal heart are not uncommon in the second stage of labour but alongside slow progress would be viewed as abnormal. This would usually be sufficient information to elicit attendance by obstetric staff.'

[42] The clinical records document: 11.20pm: 129bpm; 11.30pm: 110bpm; 11.35pm: 115bpm with accelerations, 'good variability' and no decelerations; 11.45pm: 145bpm; 11.54pm: 124bpm 'when pushing'.
[43] Low levels of oxygen in the body tissues.
[44] Uterine hyperstimulation is a serious complication commonly associated with IOL. It is defined as excessive uterine activity (more than five contractions in ten minutes or contractions lasting longer than two minutes or less than 60 seconds apart) with fetal heart rate changes (RANZCOG intrapartum fetal surveillance guideline 3rd edition 2014).

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93. Taking this advice into account, I consider that in this case RM B should have recognised that by 11pm the clinical picture was abnormal and there was indication for requesting obstetric attendance. A Syntocinon infusion was in place without continuous CTG monitoring; Ms A was making slow progress, was not pushing effectively and was becoming increasingly frustrated and tired; and there was the presence of early FHR decelerations which, in RM E's opinion, were 'regular significant decelerations', and, in Dr D's opinion, had become 'more marked'. While I acknowledge that RM B sought additional assistance from the core midwives at this point, I do not consider this to be an adequate substitute for obstetric review in these circumstances.

94. Further, there is consensus in the advice from RM E, the responses from Dr D and RM B, and the findings of NMDHB's SAER that by 11.58pm the CTG trace showed a pathological FHR pattern. As per the District's IOL guidelines, if this had been recognised, this should have prompted RM B to discontinue Syntocinon immediately and seek urgent obstetric advice. RM B acknowledged that appropriate management at this point would have been to cease Syntocinon and notify senior staff. As discussed in paragraphs 120–125, at this point RM B stopped monitoring the CTG trace and asked RM C to continue monitoring while RM B moved to a position on the floor underneath Ms A to assess the progress of labour.

95. Standard six of the NZCOM Standards states: 'Midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk.' A criterion for meeting this standard is that the midwife 'identifies deviations from normal, and after discussion with the woman, consults and refers as appropriate'.

96. I consider that in failing to recognise that by 11pm the clinical picture was abnormal, and that by 11.58pm the CTG trace showed a pathological FHR pattern, RM B failed to comply with standard six of the NZCOM Standards, and I am critical of her care in this regard.

Emergency episiotomy

97. At 12.30am the midwives identified a pattern of FHR decelerations and tachycardia. RM C left the room to call Dr D. At 12.35am, there was a prolonged deceleration in the FHR and RM B pressed the call bell for assistance. RM C re-entered the room and RM B asked her to call the paediatrician.

98. A second core midwife, RM F,[45] was on shift that evening. RM F was working on the postnatal ward but was available for support if requested in an emergency.

99. At approximately 12.35am, in response to RM B pushing the call bell, RM F entered the room while RM C called the paediatrician. RM F told HDC that on entering the room she could hear a low FHR tone and the baby's head was crowning. Ms A was getting onto the bed and RM F assisted her into the McRoberts position.[46] RM F said that she encouraged Ms A to

[45] RM F was employed by Te Whatu Ora Nelson Marlborough at the time of events.

[46] A position used during birth in which the thighs are flexed tightly toward the abdomen while simultaneously shifting the hips away from the body. This position is used to facilitate delivery of the baby by widening the pelvic diameters.

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push with the next contraction to deliver the baby's head, which had been born to the forehead. An entry in the clinical notes, written by RM F in retrospect at 3.30am, documents:

> 'Contraction occurred and [Ms A] encouraged to push … no advancement of fetal head. Estimate time now [12.37am] or [12.38am].'

100. RM F told HDC:

> 'In most situations the head could have been born with that contraction … in accordance with the low FHR and seeing the head did not advance I advised RM B to perform an episiotomy to deliver the head. I opened the scissors for her in anticipation of this happening immediately.'

101. RM C returned to the room and RM B asked her to prepare a local anaesthetic. The clinical notes document that at 12.40am the anaesthetic was administered, RM B performed an episiotomy, and the baby's head was born.

102. The District's SAER identified that an anaesthetic is not required or effective prior to performing an episiotomy in an emergency situation (due to the time required for the anaesthetic to take effect).

103. RM B told HDC:

> '[Ms A] was in complete distress … At that point in my career, I had never given [anyone] an episiotomy without any form of pain relief before. I did strongly consider doing the episiotomy without an anaesthetic however I was afraid of how [Ms A] may immediately respond and did not want to cause further aggression or distress to her.
>
> In hindsight I acknowledge that in an emergency where episiotomy is clinically indicated that doing so with [anaesthetic] is contraindicated. In the future, if the birth needs to be expedited due to [fetal] distress it is recommended to do an episiotomy without it.'

My decision

104. A criterion for meeting standard six of the NZCOM Standards is that the midwife 'demonstrates competency to act effectively in any maternity emergency situation'.

105. Based on the findings of the SAER and RM B's acknowledgment above, it is clear that, due to the emergency that was unfolding, RM B should have performed the episiotomy without waiting for an anaesthetic to be prepared and administered. I consider that in not doing so, RM B did not act effectively in an emergency situation and, therefore, failed to comply with standard six of the NZCOM Standards. I acknowledge that RM B has reflected and taken appropriate learnings from these events.

Conclusion

106. Right 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code) states: 'Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.'

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107. RM B was Ms A's LMC and responsible for her care until Dr D arrived at 12.40am to deliver Baby A. I am critical of RM B's failure to:

- Validate the time and date settings on the CTG machine prior to commencing CTG monitoring, as was required by the District's fetal monitoring guidelines;
- Document the discussion with Ms A about the risks of removing the tocograph, her decision in this regard, and the plan to monitor contractions in the absence of a tocograph, as required by standard two of the NZCOM Standards;
- Consult with Dr D when the tocograph was removed at 9.20pm, as this was a deviation from the agreed IOL plan, which required specialist consultation as per the MoH referral guidelines;
- Document the frequency of contractions at appropriate intervals in the second stage of labour, thereby failing to meet standard three of the NZCOM Standards;
- Provide full and timely information to Dr D regarding the clinical picture as labour progressed, as required in the MoH referral guidelines, including that by the time of RM B's conversation with Dr D at 10.05pm Ms A was becoming 'tired, sore and frustrated', and that at the last vaginal examination (at 9.45pm) the fetal head remained high and the fetal position had not been able to be confirmed;
- Consult with Dr D at 11.45pm when Ms A had been actively pushing for two hours with little progress, as indicated in the MoH referral guidelines;
- Recognise, as required in standard six of the NZCOM Standards, that by 11pm the CTG showed an FHR pattern that was potentially suspicious, and that by 11.58pm the CTG showed a pathological FHR pattern that was an indication to discontinue Syntocinon immediately and seek urgent obstetric review; and
- Promptly perform an episiotomy (after obtaining consent from Ms A) without waiting for preparation and administration of anaesthetic. I consider that in failing to do so, RM B failed to provide services that complied with standard six of the NCZOM standards.

108. In addition, I am concerned that on a number of occasions RM B did not document aspects of Ms A's care adequately. Standard four of the NZCOM Standards states: 'The midwife maintains purposeful, on-going, updated records and makes them available to the woman and other relevant persons.'

109. I am critical that RM B did not document the following adequately:

- The details of her discussion with Dr D in which the IOL plan was confirmed;
- That the core midwife reviewed Ms A each time the Syntocinon infusion rate was increased; and
- The content of the discussions with Dr D at 11pm.

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110. On review of the deficiencies outlined above, I find that RM B failed to provide Ms A with services that complied with professional and other relevant standards, and, accordingly, breached Right 4(2) of the Code.

Decision to commence induction of labour — other comment

111. NMDHB's SAER identified the timing of Ms A's IOL as a contributing factor to the complications that occurred in Ms A's care. The SAER noted that the decision was made to undertake an IOL in a high-risk woman with pre-existing co-morbidities and a complex condition in the late afternoon going into after-hours, when staffing resources were reduced.

112. NMDHB provided HDC with a copy of the Nelson Marlborough District's clinical guidelines for induction of labour (IOL guidelines) current at the time of events. The IOL guidelines provide that women with uncomplicated pregnancies should be offered an IOL between 41+0 and 42+0 weeks' gestation to avoid the risks of prolonged pregnancies. The guidelines also list a range of circumstances in which earlier IOL, between 40–41 weeks' gestation, should be considered, including 'any concern regarding maternal or foetal wellbeing'.[47] A large for gestational age fetus is not a clinical indication for an earlier IOL. The IOL guidelines also state: 'Induction of labour should not routinely be offered on maternal request alone.'

113. RM B told HDC that initially she was hesitant to agree to Ms A's request for an earlier induction. However, she had been told that only one staff member was rostered on for the following Monday on which the induction was scheduled. RM B also said that while short staffing was an issue at Wairau Hospital, on that day 'it was quiet'. Therefore, with staffing in mind, RM B discussed Ms A's request with her colleagues. Ms A's vital signs had been recorded[48] and she had reported good fetal movements.

114. RM B called Dr D to discuss Ms A's request. Dr D told HDC:

> '[RM B] stated that [Ms A] was very uncomfortable, not coping well and strongly requested an IOL. She also informed me that [Ms A] had a very favourable cervix. I understood that the situation was not easy and agreed that an IOL was appropriate … provided there were no staffing issues. I agreed to proceed with an [IOL] with ARM +/- oxytocin only provided the [senior midwifery staff] agreed.'

115. RM B spoke to the senior midwifery staff, and they agreed for the IOL to go ahead. RM B discussed with Ms A that IOL increased the risk of further interventions during labour and birth.[49] Ms A was eager to proceed.

[47] Other circumstances listed are: maternal hypertensive disease; assisted reproductive technology utilised for conception; maternal age >40 years; maternal diabetes; small-for-gestational-age fetus; reduced movements/ reduced liquor volumes.
[48] Blood pressure 142/89mmHg; pulse 110bpm; respiratory rate 14 breaths per minute; temperature 36.6°C.
[49] The risks documented were: epidural, forceps, ventouse (vacuum cup) delivery, Caesarean section.

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116. As outlined previously, Dr D told HDC that he received a call from RM B in the afternoon to confirm the IOL plan.

My decision

117. I am mindful that ultimately the decision to proceed with induction was an obstetric one, conditional upon the agreement of senior midwifery staff. Nevertheless, RM B clearly played a role in the decision-making, and therefore I have considered her actions in this regard.

118. It is apparent that at 40+3 weeks' gestation Ms A was very uncomfortable, increasingly anxious about the birth of her baby, and strongly requesting an IOL that day. I acknowledge that the District's IOL guidelines state that an IOL should not be offered routinely before 41 weeks' gestation on maternal request alone. However, the IOL guidelines include 'any concern for fetal or maternal wellbeing' as a consideration for IOL prior to 41 weeks' gestation. In my view, there was reasonable concern for Ms A's mental wellbeing to consider an earlier IOL, taking into account Ms A's mental health history, her increasing anxiety about the size of her baby, her concerns about getting to the hospital from her rural home, and the possibility that the planned IOL could be postponed because of insufficient staffing and the impact this would have had on Ms A's mental state.

119. RM B was required to seek obstetric consultation to outline Ms A's circumstances and request for an IOL that day. I consider that she consulted with Dr D appropriately, and, at his request, sought appropriate approval from senior midwifery staff before proceeding with the IOL plan. I am not critical of her care in this regard.

Communication between LMC and core midwife — other comment

120. At 11.20pm core midwife RM C[50] entered the room at RM B's request to support RM B and Ms A. RM C had not been rostered on that evening and was doing an unexpected night shift to cover staff illness.

121. RM B told HDC that at approximately 11.58pm she asked RM C to continue documenting and monitoring the CTG as she moved to a position on the floor to observe Ms A's perineum and assess progress. RM B said that from this position she was unable to view the CTG machine but was confident that RM C was monitoring this and assumed she would alert RM B to any concerns. RM B also said:

> 'When I asked [RM C] to clinically continue observing the CTG I should have continued to check in with her and continued to monitor the CTG myself rather than assume she would alert me if she had concerns.'

122. RM C told HDC that she could see the CTG reading but had no way to assess the progress of the baby's descent.

123. Between 12.05am and 12.25am there is no documentation of the FHR or CTG trace findings in the clinical records. However, RM C recalled that at 12.05am she observed 'brief [FHR]

[50] RM C was employed by Te Whatu Ora Nelson Marlborough at the time of events.

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decel[erations] with a quick return to baseline' with each contraction. She said that she told RM B this and RM B responded that she could hear this.

124. RM B said that at 12.30am she 'popped [her] head up' to check the CTG and saw a pattern of decelerations and tachycardia.[51] RM B said she asked RM C to call the obstetrician immediately.

125. On the other hand, RM C recalled that at 12.30am she told RM B that there was now a pattern of decelerations and tachycardia on the CTG and she left the room to call the obstetrician.

My decision

126. The New Zealand College of Midwives consensus statement states:

> 'All midwives, whether employed or self employed, have a responsibility to communicate and decide their respective roles and responsibilities in relation to each woman's care while in the hospital setting.'[52]

127. RM B was Ms A's LMC and remained responsible for her care when RM C entered the room to assist. In my view, RM B quite reasonably asked RM C to monitor the CTG and document care while she moved into a position to observe the progress of the baby's descent. There is no evidence that this request was not communicated to RM C adequately. I note that RM B has said that in hindsight she should have continued to 'check in' with RM C and monitor the CTG herself. While I agree that it would have been prudent for RM B to request updates about the CTG from RM C, especially as apparently she could hear the pattern of FHR decelerations, I consider that it was not unreasonable for RM B to assume that RM C would alert her to any concerns with the CTG, or take action herself, given that RM B had specifically asked RM C to monitor the CTG.

Request for obstetric and paediatric attendance — other comment

128. The District's SAER identified that the hospital's emergency call system 8888 was not used to request urgent specialist attendance. The emergency call system is a central telephone operations line to be used to request urgent assistance from emergency teams, including from on-call staff.

129. At 12.30am the midwives identified a pattern of FHR decelerations and tachycardia. RM C left the room and called Dr D at 12.32am. RM C called Dr D on his cell phone rather than the 8888 emergency call system. Dr D was nearby and agreed to attend immediately (he arrived within about eight minutes).

[51] An abnormally fast heart rate. An FHR consistently over 160bpm is considered tachycardic (as per the New Zealand College of Midwives practice guidance document 'Intermittent auscultation for the assessment of intrapartum wellbeing' July 2020).
[52] NZCOM 2001 Consensus Statement — Roles and Responsibilities in a Hospital setting.

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130. RM B told HDC that at 12.35am, there was a prolonged deceleration in the FHR and she pressed the call bell for assistance. RM F entered the delivery room and applied oxygen to Ms A. RM C re-entered the room and RM B asked her to call the paediatrician.

131. RM C documented in her reflections:

> 'At [12.35am] there was a prolonged decel[eration] and I left the room to call the paediatrician. There was at least a three to five minute delay in his arrival as the listed on call paediatrician told me he had "traded with [the locum[53] paediatrician]", but the message had clearly not been delivered to maternity and it took time to get off the phone with him and connect with [the locum paediatrician].'

132. In the meantime, at 12.35am RM B assisted Ms A to move onto the bed in anticipation of delivery of the baby.

My decision

133. Although recognition of the abnormal CTG was delayed, once this was identified at 12.30am RM B appropriately ensured that obstetric and paediatric attendance was requested. I consider that it was reasonable for RM B to assume that RM C would request this assistance using the hospital's emergency call system, and I do not hold her responsible for the delays caused in calling the on-call paediatrician directly.

Consent to episiotomy — other comment

134. Ms A told HDC that she did not feel that she was given time to consent to the episiotomy, as RM B performed the incision with only 'a second's notice'. There is no documentation in the clinical records of a discussion with Ms A about the need for an episiotomy or whether she consented to it.

My decision

135. Given the passage of time and the lack of documentation of a consent discussion for the episiotomy, I am unable to determine with certainty what information was provided at the time. While I would be critical if RM B did not advise Ms A of the reasons for recommending an episiotomy, to enable her to make an informed decision, I accept that it was an obstetric emergency where the imminent wellbeing of Ms A's unborn baby was the immediate priority. As such I acknowledge the urgent situation in this case and the challenge this presented in terms of a detailed discussion of the benefits, risks and options.

Management of shoulder dystocia — other comment

136. RM E advised ACC:

> 'The attending midwives ([RM B, RM C and RM F]) encouraged [Ms A] to push despite the shoulder remaining impacted on the symphysis pubis.

[53] A doctor who temporarily fills a position at a hospital or practice.

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> Mismanagement of the shoulder dystocia may have contributed to the delay in birth and the poor condition of the baby at birth.'

137. RM B told HDC that shoulder dystocia was evident and communicated. RM F said that she had encouraged Ms A to push when she first entered the room (as noted in paragraph 99) but did not encourage Ms A to push again after this.

138. After the episiotomy and birth of the baby's head, RM F immediately applied suprapubic pressure[54] in an attempt to release the baby's shoulder, but this was unsuccessful. RM B outlined further attempts she made to release the shoulder:

> 'I tried internal manoeuvres — sliding my fingers along the length of baby's back toward the anterior shoulder, applying pressure to try and push the shoulders towards baby's chest. This was unsuccessful. I then tried to deliver the posterior arm, this had worked before, but in this instance, it was too tight.'

139. At approximately 12.40am Dr D arrived and applied increased suprapubic pressure and downward traction[55] to the fetal head. At 12.41am Baby A was born in poor condition.

My decision

140. In case 16HDC00977 a shoulder dystocia was also present. In that case, HDC received advice from an independent obstetrician, who advised:

> 'Technically speaking, a shoulder dystocia cannot occur until such time as the head is delivered when, for the first time, the anterior fetal shoulder may fail to fit under the pelvic brim anteriorly at the symphysis … A shoulder dystocia is not predictable and 50% of all shoulder dystocias occur in the absence of any associated risk factors, such as macrosomia.'[56]

141. In this case, I accept that the midwives appropriately recognised the shoulder dystocia following the birth of the baby's head, did not encourage Ms A to push, and performed various manoeuvres in attempts to release the impacted shoulder. On review of the clinical records, it appears that these manoeuvres were made for less than a minute, as it is documented that the baby's head was born at 12.40am and Dr D arrived to take over care at 12.40am, with Baby A born at 12.41am. On this basis, I consider that there was no mismanagement of the shoulder dystocia.

[54] Pressure applied with a palm or fist to the abdomen just above the pubic bone. In the McRoberts manoeuvre, pressure is applied downward to assist dislodgment of a baby's shoulder.
[55] Gentle downward traction is a technique used in combination with the McRoberts manoeuvre to release the baby's impacted shoulder when shoulder dystocia is occurring during labour.
[56] Fetal growth beyond a certain weight, usually 4000g or 4500g, regardless of gestational age: RANZCOG Clinical guidance statement on diagnosis and management of suspected fetal macrosomia, November 2021.

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Opinion: RM C — breach

Introduction

142. It is usual practice in a maternity unit for an LMC midwife to ask core midwives for assistance. When this occurs, the core midwives are responsible for the care they provide, even if overall responsibility for the care is not handed over to the core midwives.

143. I acknowledge that RM B held ultimate responsibility for Ms A's care. However, RM C had a responsibility under Right 4(2) of the Code, as a midwife in the room providing midwifery care to Ms A, to provide services that complied with legal, professional, ethical, and other relevant standards.

144. Following review of the information gathered, I am critical of RM C's failure to:

- Advocate for appropriate monitoring of contractions upon her entry to the delivery room;
- Reassure herself of fetal wellbeing or adequately respond to the signs of fetal distress between 12am and 12.30am; and
- Appropriately use the emergency call system when it was recognised that urgent obstetric and paediatric assistance was required.

145. I will discuss each of these issues in turn.

Delayed recognition of abnormal CTG

146. At 11.20pm RM C entered the delivery room at RM B's request to support RM B and encourage Ms A. RM C documented her reflections of events shortly afterwards, and a copy of this was provided to HDC. In her reflections, RM C recalled that on entering the delivery room she noticed that the tocograph was not in place and she mentioned this to RM B, who responded that she was aware. She recalled that an FSE was in place and Ms A did not appear to be pushing effectively, although there was some improvement with verbal encouragement. She noted that the CTG had been reassuring and continued to be so.

147. As outlined in paragraph 121, around midnight RM B gave the clinical notes to RM C and asked her to continue documenting and monitoring the CTG as she took a position on the floor underneath Ms A to observe her perineum. RM C documented the events from 12.05am until 12.40am as follows:

> '[12.05am]: Peep of head seen when pushing.
>
> [12.10am]: Vertex advancing with each push.
>
> [12.25am]: Head no longer retracting between contractions.
>
> [12.30am]: Pattern of decel[erations]/tachy[cardia] noted. Obstetrician rung.
>
> [12.35am]: [Ms A] into lithotomy [position]. Head [half] out (to the ears).
>
> [12.40am]: [Local anaesthetic] in. Episiotomy cut by LMC.'

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148. RM C recalled in her reflection on the events:

> '[RM B] reported at [12.05am] that she could see a peep of head at the height of contractions. I observed that brief decel[erations] with a quick return to baseline were occu[r]ring with each contraction. I told [RM B] about this and she told me she could hear this happening (in her position she could not automatically see the CTG).
>
> At 12.10am [RM B] stated that the vertex[57] was advancing with each push and at [12.25am] [RM B] stated the head was no longer retracting between contractions.
>
> At [12.30am] I told [RM B] that there was now a pattern of decel[erations] and tachycardia established on the CTG and I left the room to ring the obstetrician.'

149. RM F told HDC that 'shortly before' RM C called the obstetrician at 12.30am, RM C gave RM F an update that the baby's head was visible and that the CTG was 'a bit up and down, but she thought the baby would be born soon'.

150. RM C told HDC:

> 'I have reflected on this very sad case. With the benefit of hindsight, I wish I had been more forceful and opinionated regarding the LMC's decision-making and insisted that the obstetrician be there at least 20–30 minutes earlier. However, at the time, I respected the LMC's position as the lead clinical caregiver.'

My decision

151. The New Zealand College of Midwives (NZCOM) consensus statement states:

> 'All midwives, whether employed or self employed, have a responsibility to communicate and decide their respective roles and responsibilities in relation to each woman's care while in the hospital setting.'[58]

152. Further, the NZCOM Standards of Practice (NZCOM Standards) set out that '[i]n all settings, the midwife remains responsible and accountable for her practice'.

153. On entering the room, RM C noted that the tocograph was not in place. While she mentioned this to RM B, it does not appear that she suggested at any point that the tocograph be replaced. Standard six of the NZCOM Standards states: 'Midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk.' A criterion for meeting this standard is that the midwife 'ensures assessment is on-going and modifies the midwifery plan accordingly'. I consider that RM C had a responsibility as a midwife in the room to advocate for adequate monitoring, including either replacement of the tocograph or, if Ms A refused this, regular palpation and documentation of contractions. I am critical that RM C did not do so.

[57] The top of the head.
[58] NZCOM 2001 Consensus Statement — Roles and Responsibilities in a Hospital setting.

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154. As discussed in paragraphs 79–89, there is consensus that by around midnight the CTG trace showed a pathological FHR pattern that was evident even without the recording of contractions to interpret this. At this point, RM B asked RM C to monitor the CTG trace. RM C acknowledged that she could see the CTG reading, but the pathological FHR pattern was not recognised for about 30 minutes, until 12.30am.

155. In case 16HDC00977, the facts also involved delayed recognition of an abnormal FHR pattern on a CTG trace as neither the LMC nor the core midwives were monitoring the trace. In that case, the independent midwifery advisor said:

> 'Staff midwives, who often are very experienced practitioners, provide advice and support to LMCs without assuming overall responsibility for care, however they are still responsible for the care they provide and in this situation should have been able to reassure themselves of fetal wellbeing as part of the assistance they were providing.'

156. I consider that this advice also applied in this case, and I am critical that RM C did not reassure herself of fetal wellbeing before 12.30am.

157. RM C reflected that she regrets not being more 'forceful and opinionated' and insisting that the obstetrician be called, and explained that at the time, she respected RM B's position as the lead clinical caregiver. This comment suggests that RM C recognised the concerning FHR pattern and the need for obstetric referral, but failed to act on her concerns as she considered that this was RM B's responsibility. This demonstrates a concerning lack of accountability. I accept that at around 12.05am RM C told RM B that the CTG showed brief decelerations returning to baseline with each contraction. However, there is no evidence that RM C communicated to RM B concerns about the pathological nature of the FHR trace or suggested at any time before 12.30am that the obstetrician be called.

158. In case 16HDC00977, the midwifery advisor also commented on a lack of adequate communication between the LMC and core midwives:

> 'The blurring of responsibility for care often leads to care deficiencies as it is easy to make the false assumption that someone else is taking responsibility.'

159. The criteria of standard six of the NZCOM Standards include that the midwife 'identifies deviations from the normal, and after discussion with the woman, consults and refers as appropriate'. On review of the information available, I am unable to determine whether RM C failed to recognise the pathological CTG trace or whether she did recognise this and failed to communicate her concerns to RM B adequately. In any case, I consider that in either scenario RM C failed to respond to the signs of fetal distress appropriately, and, in doing so, failed to comply with standard six of the NZCOM Standards. I am highly critical of her care in this regard.

Request for obstetric and paediatric attendance

160. As noted in paragraphs 128–132, the District's SAER identified that the hospital's emergency call system 8888 was not used to request urgent specialist attendance.

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161. RM C called Dr D at 12.32am and called the paediatrician at 12.35am. In both cases, RM C called the specialists on their cell phones rather than using the hospital's 8888 emergency calling system. Due to a change in the on-call paediatrician, this resulted in a delay in attendance by the on-call paediatrician.

My decision

162. The facts of case 16HDC00977 also involved delayed arrival of the paediatric team because the incorrect emergency call number had been used. In that case, this was in part due to a recent change in the emergency call numbers. The independent midwifery advisor said:

> 'When [the baby] was born the wrong code call further delayed the arrival of the paediatric team, this error was due to a recent change in emergency call numbers and therefore would be viewed with mild disapproval.'

163. In this case, there is no such mitigating factor. The criteria for standard six of the NZCOM Standards include that the midwife 'demonstrates competency to act effectively in any maternity emergency situation'. It is clear that by 12.30am emergency assistance was required. Effective action in this case would have been to use the hospital's emergency call system. I am critical that RM C failed to do so, thereby delaying emergency specialist attendance.

Conclusion

164. I consider that RM C failed to provide Ms A with services that complied with professional standards by failing to:

- Advocate for appropriate monitoring of contractions upon her entry to the delivery room;
- Appropriately respond to the signs of fetal distress between 12am and 12.30am; and
- Appropriately use the emergency call system when it was recognised that urgent obstetric and paediatric assistance was required.

165. Accordingly, I find that RM C breached Right 4(2) of the Code.

Te Whatu Ora Nelson Marlborough — breach

166. NMDHB was responsible for the operation of clinical services at Wairau Hospital, and Te Whatu Ora now carries responsibility for NMDHB's service failures.

167. Under Right 4(2) of the Code, NMDHB had a duty to ensure that the services Ms A received at Wairau Hospital complied with legal, professional, ethical and other relevant standards, and for ensuring that its staff were similarly compliant. In this particular situation, this included the care provided by core midwives RM C and RM F, as well as the care provided by RM B, as employees of NMDHB at the time of events.

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168. NMDHB was required to comply with the Health and Disability Services Standards 2008 (HDS Standards).[59] The HDS Standards are designed to establish safe and reasonable levels of services for consumers, and to reduce the risk to consumers from those services. This necessitated recognised/approved guidelines to be in place, with accepted codes of practice consistently followed by NMDHB staff.

169. As outlined in paragraph 19, the District's SAER identified a number of factors that contributed to the care and service delivery problems in the care provided to Ms A. I will now discuss the issues I consider were attributable to NMDHB at an organisational level.

Decision to proceed with IOL

170. NMDHB's SAER noted that Ms A's IOL was approved to commence in the late afternoon going into after-hours when staffing resources were reduced. Ms A's membranes were artificially ruptured at 1.42pm at 40+3 weeks' gestation, followed by commencement of a Syntocinon infusion at 5pm that evening.

171. As noted, there were concerns about Ms A's mental wellbeing if she had to wait for an IOL until the following Monday (41 weeks' gestation). RM B also said that she had been told that there was only one staff member rostered on for the following Monday on which induction was scheduled, and that while short-staffing was an issue at Wairau Hospital, on the earlier date 'it was quiet'.

172. Prior to commencing the IOL, Dr D asked RM B to confirm with senior midwifery staff that there would be adequate staffing levels to manage Ms A's labour and birth safely. Senior midwifery staff were apparently comfortable with this, as RM B obtained Dr D's approval before proceeding with the IOL plan.

173. Dr D told HDC:

> 'In my experience, with a favourable cervix (4cm dilated with bulging membranes on [40+1 weeks' gestation]) and some uterine activity, IOL with [ARM] and oxytocin would most likely result in a birth before midnight … I thought an IOL with ARM and oxytocin on [40+1 weeks' gestation] was reasonable and safe, provided there were no staffing issues. Provided the IOL could start soon, I thought it was a better option for [Ms A] rather than waiting for spontaneous labour or IOL on [41 weeks' gestation].'

174. NMDHB's SAER identified that on the evening of Ms A's labour RM C was working an additional night shift. It is unclear whether this was planned or known at the time Ms A's IOL was approved to commence (RM C's shift that evening started at 11pm).

175. NMDHB's SAER identified that the paediatrics team and Duty Nurse Manager were not told that an IOL was to commence that afternoon, going into after-hours.

[59] NZS 8134.0:2008 and NZS 8134.1:2008.

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My decision

176. I consider that Ms A's mental wellbeing was a valid factor to take into account in deciding whether to proceed with an earlier IOL. I also acknowledge the resourcing challenges faced by small rural hospitals such as Wairau Hospital. However, it appears that staffing levels were considered appropriately before the IOL was approved.

177. On balance, while I acknowledge that it was not ideal timing, I consider that it was not unreasonable to commence an IOL at 40+3 weeks' gestation. However, I am critical that this was not communicated to the paediatrics team or Duty Nurse Manager.

Staff concerns/working environment

178. NMDHB's SAER identified that RM B worked for over 12 hours without a break.

179. In reflecting on the events, RM B told HDC:

> 'In retrospect, I should have called for help sooner. I was struggling to care for [Ms A's] distressed response in labour. At the time, I was aware many staff members were coming to work burnt out and it felt like they were trying to get through their own issues. At the time, my LMC partner was having time off. With staffing shortages, there was a feeling of added stress amongst those on the ward. There were also previous times where I had asked for help with emotional support and staff would respond with some hostility, like helping was a burden amongst the other jobs they already had to attend to.'

My decision

180. I find RM B's description of the working environment at Wairau Hospital very concerning. There is an overall impression of an environment in which staff members felt stressed and unsupported, and, as a result, unable to work together effectively.

181. A healthy working environment in which staff members are supported adequately to take breaks, support each other, and ask for help when needed is critical to providing appropriate care to consumers. NMDHB was responsible at a service level to ensure that its staff members were working in an environment that did not pose a risk to the consumers using its services. I am concerned that NMDHB failed to foster a healthy working environment at Wairau Hospital.

Conclusion

182. As outlined in this report, there were a series of concerning features in how Ms A was cared for by multiple staff at Wairau Hospital, including:

- The paediatrics team and Duty Nurse Manager were not told of the commencement of an IOL in the afternoon going into after-hours;
- Both the LMC and core midwife failed to ensure adequate documentation of contractions during labour;

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- Neither the LMC nor the core midwife recognised and acted on the abnormal FHR pattern promptly when it became apparent;
- There was a blurring of responsibilities between the LMC and core midwife;
- A change in the on-call paediatrician was not communicated to the maternity unit, which, in combination with the core midwife's failure to use the emergency call system, resulted in delayed paediatric attendance;
- The LMC (employed by NMDHB) was working excessive hours without breaks;
- The LMC felt that she was working in an environment where asking for support from colleagues was 'a burden'.

183. Standard 2.2 of the HDS Standards requires:

> 'The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate and safe services to consumers.'

184. While I consider it appropriate to hold the individual midwives responsible for some of these issues, as I explain in paragraph 168, I also hold NMDHB accountable for achieving quality outcomes and for minimising risk. In my view, the above deficiencies demonstrate a concerning pattern of poor care for which ultimately Te Whatu Ora is responsible at a service level. I am also concerned that the failures identified are likely symptoms of an unhealthy working culture in which staff members felt hesitant to ask for support to the point that this had an adverse impact on patient care.

185. On this basis, I consider that NMDHB failed to ensure that the service provided to Ms A was managed in an efficient and effective manner that ensured the provision of timely, appropriate and safe services to Ms A and her baby. Accordingly, I find Te Whatu Ora in breach of Right 4(2) of the Code.

Changes made since events

RM B

186. RM B outlined several changes she has made since the events, including:

- Extensive reflection and de-briefing to evaluate and improve her practice, including through counselling, obtaining support from a midwifery mentor, and attending regular 'check-ins' with Wairau Hospital's Midwife Manager and the District's Associate Director of Midwifery.
- Undergoing fortnightly competence investigation and review by the New Zealand Midwifery Council.
- Participating in a Midwifery Standards review with the New Zealand College of Midwives that focused largely on this case.

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187. RM B advised that after these events she completed the following ongoing education workshops:

- The Fetal Surveillance Education Program (OFSEP) (November 2019)
- Healthy conversations skills training (MOH) (April 2020)
- Recognising compassion fatigue and building resilience workshop with MHERC (May 2020)
- Newborn Life Support resuscitation and emergency care workshop with the New Zealand Resuscitation Council (November 2020)
- Spinning babies workshop (December 2020)
- GROW workshop

188. RM B also advised that in 2021 she ceased practising as a midwife.

RM C

189. RM C told HDC that since these events she has retired from midwifery practice for personal reasons and will not be returning to practice.

Te Whatu Ora

190. Te Whatu Ora advised that several changes were made following the events, including:

- A Maternal Mental Health Referral Pathway document was produced through the Ministry of Health's Maternity Quality and Safety Programme and is in circulation to all clinicians involved in Maternity care.
- Staff vacancies were recruited.
- Roster auditing was completed and reported through to a roster meeting.
- EAP support was offered to staff experiencing personal stress.
- The District's fetal monitoring guidelines were updated to include guidance in the event a woman declines CTG monitoring. The fetal monitoring guidelines now state:

> 'If a woman declines monitoring — or a component of monitoring such as the toco[graph] — and she is requiring induction, augmentation or epidural, then the Obstetrician on call must be informed. These procedures may not be able to safely proceed without full monitoring and therefore a discussion with the woman about the implications is essential and a safe plan agreed and documented.'

- The District's fetal monitoring guidelines were updated to include scenarios and guidance for when to seek a 'fresh eyes' review of the CTG trace from colleagues, including in clinical situations where the FHR is considered abnormal.
- A new CTG sticker was developed and implemented to aid with interpretation of the CTG trace. The sticker includes a contractions assessment. From March 2021, monthly audits of the use of the stickers were carried out, with ongoing audit planned.

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- Non-urgent and planned inductions now commence only in the morning on Monday to Friday when suitable staffing resource and support is available.
- Staff are provided with ongoing education on adequate documentation.
- Audits of the use of the 8888 emergency call system for urgent consultations and emergencies are ongoing.
- A process was developed for keeping the paediatric team and after-hours Duty Nurse Manager updated on impending births and risk factors at a daily bed management meeting and an afternoon update meeting.
- It was acknowledged that LMC midwives are part of a team and require breaks and support as necessary to ensure safe, quality care.
- PROMPT[60] and Newborn Life Support study days are now undertaken as mandatory staff education.
- The emergency episiotomy process is included in PROMPT.
- A Neonatal Encephalopathy (NE) project was developed with the aim to reduce the risk of harm occurring to babies during birth. An initial audit of NE events identified 21 recommendations around opportunities to strengthen clinical skills, provide staff education, and improve resources and documentation. As at March 2021, 16 of these recommendations had been implemented.
- A 'Maternity Early Warning Score' was developed to assist in identifying acute deterioration in women admitted to hospital during pregnancy.

191. Te Whatu Ora told HDC that in addition, FTE calculations at Wairau Hospital were to be completed in early 2022 to analyse staffing requirements.

192. Te Whatu Ora also told HDC:

> '[Te Whatu Ora Nelson Marlborough] very sincerely apologises to [Ms A] and her whānau for the distress caused by the circumstances of [Baby A's] birth. [Ms A] trusted us with the safe delivery of her baby. The care we provided to [Ms A] and [Baby A] did not meet the standard of care, which we deeply regret. While we cannot undo the hurt caused, we have taken action which, we believe, will minimise the risk for other wahine and their pepi in future.'

Recommendations

193. Taking into account the changes made since the events, I recommend that RM B provide a written apology to Ms A for the failings in care identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Ms A.

[60] Practical Obstetric Multi-Professional Training is a multi-professional training package for obstetric emergencies.

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194. In response to the recommendation in the provisional opinion, RM C provided a written apology to Ms A for the failings in care identified in the report. Accordingly, this recommendation has been satisfied and nothing further is required from RM C.

195. Taking into account the changes made since the events, I recommend that Te Whatu Ora:

a) Provide a written apology to Ms A. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Ms A.

b) Conduct a review of the effectiveness of the changes outlined in paragraph 190 and report back to HDC.

c) Update HDC regarding the FTE analysis at Wairau Hospital (outlined in paragraph 191) and whether currently this is being met.

d) Provide HDC with copies of the last six months of audits of the use of the 8888 emergency call system for urgent consultations and emergencies.

e) Provide HDC with copies of the last six months of audits of the use of the CTG stickers.

Recommendations (b) to (e) above are to be provided to HDC within six months of the date of this report.

Follow-up actions

196. A copy of this report with details identifying the parties removed, except NMDHB/Te Whatu Ora and Wairau Hospital, will be sent to the Midwifery Council of New Zealand and the New Zealand College of Midwives, and they will be advised of RM B's and RM C's names.

197. A copy of this report with details identifying the parties removed, except NMDHB/Te Whatu Ora and Wairau Hospital, will be sent to the National Maternity Monitoring Group and the Neonatal Encephalopathy Working Group of the Perinatal and Maternal Mortality Review Committee at the Te Tāhū Hauora Health Quality & Safety Commission, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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