Midwife, RM B

A Report by the
Deputy Health and Disability Commissioner

(Case 19HDC00333)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a woman by her midwife during the antenatal period of her pregnancy. The Deputy Commissioner highlights the importance of clear decision-making and open communication to ensure that a woman has the opportunity to make informed decisions about the plan to monitor the growth of her baby, and be a partner in her own care.

2. The woman had an ultrasound growth scan at 35 weeks' gestation. The scan report indicated that her baby was large for its gestational age with an abdominal circumference that was close to the 95th centile. The report recommended customised growth charts and serial growth scans to monitor the woman's baby, but the midwife took no further action in response to the recommendations in the report, and did not provide the woman with a copy of the report or discuss the recommendations with her.

Findings

3. The Deputy Commissioner found the midwife in breach of Right 4(1) of the Code. The Deputy Commissioner was critical that the midwife reviewed the scan report but took no further action; did not provide a copy of the scan report to the woman; and did not discuss the report, recommendations, and findings with the woman. In addition, the Deputy Commissioner was critical that there was no plan in place for monitoring the growth of the baby when specialist intervention was warranted, that the fundal height was not measured in centimetres, and that discussions about the growth chart and an obstetric review were not documented.

4. The Deputy Commissioner also found the midwife in breach of Right 6(1) of the Code for failing to provide the woman with information that she was entitled to receive, including the recommendations in the ultrasound scan report and in the *Referral Guidelines*.

Recommendations

5. The Deputy Commissioner recommended that the midwife confirm that she has undertaken training on informed consent and documentation and provide HDC with an audit of her documentation.

6. In accordance with the recommendation in the provisional opinion, the midwife provided an apology, and this has been forwarded to the woman.

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Complaint and investigation

7. The Health and Disability Commissioner (HDC) received a complaint about the care provided to Ms A by Registered Midwife (RM) B.[1] The following issue was identified for investigation:

- *Whether RM B provided Ms A with an appropriate standard of care in 2018.*

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

9. The parties directly involved in the investigation were:

Ms A	Consumer
RM B	Provider/self-employed registered midwife/ lead maternity carer (LMC)

10. Further information was received from:

Dr C	Obstetrician and gynaecologist
Dr D	Anaesthetist
District health board	
Accident Compensation Corporation (ACC)	

11. Also mentioned in this report:

Dr E	Obstetrician
RM F	ACC advisor — midwife
Dr G	ACC advisor — obstetrician and gynaecologist

12. Expert advice was obtained from RM Nicky Emerson (Appendix A) and from obstetrician and gynaecologist Dr Ian Page (Appendix B).[2]

Information gathered during investigation

Background

13. Ms A became pregnant in 2018; this was her first pregnancy. At the time of events, Ms A was in her twenties. Ms A booked RM B as her LMC.

14. This report concerns the care provided to Ms A by RM B during the antenatal period.

[1] The complaint about RM B was referred to the Commissioner by the Midwifery Council of New Zealand under section 64 of the Health Practitioners Competence Assurance Act 2003.
[2] Dr Page identified no departures in the care provided to Ms A by the DHB.

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Antenatal care

15. Ms A had her first booking appointment with RM B at approximately 7 weeks' gestation. At this visit, RM B recorded Ms A's weight as 85kg and height as 168cm, but did not record that her body mass index (BMI) was 30.[3]

16. During her antenatal period, Ms A was seen by RM B on 11 occasions. At each visit, RM B recorded the fetal heart rate (FHR)[4] and took Ms A's blood pressure (BP). At each consultation, RM B recorded that the fetal growth was assessed by palpating the uterus to identify the fundus,[5] and that she used anatomical landmarks to estimate the gestational size of the baby.[6] However, the fundal height[7] was not measured and recorded in centimetres, and no customised growth chart[8] was commenced during the antenatal period. Ms A's pregnancy proceeded normally during her first and second trimesters.[9]

17. RM B reviewed Ms A on 3 Month1,[10] in her third trimester (31 weeks' gestation). RM B recorded that Ms A was 31 weeks' gestation, but did not measure the fundal height in centimetres.

18. On 17 Month1 (33 weeks' gestation), RM B recorded that Ms A had "no headaches, no oedema[11]" and was sleeping well. RM B assessed that the fetal growth was 33 weeks' gestation.

Ultrasound scan 26 Month1

19. On 26 Month1, at 35 weeks' gestation, an ultrasound growth scan (USS)[12] was performed. RM B told HDC that growth scans are not offered routinely in New Zealand after 20 weeks' gestation, and that Ms A herself requested the USS to review the well-being of her baby.

20. The USS report findings indicated that the estimated weight of the baby was 3.33kg (+/–15%) and that no abnormalities were noted, and stated:

[3] Body mass index (BMI) is a useful tool to estimate whether a person is underweight, overweight, or at a healthy weight in relation to height. BMI is calculated by dividing weight, in kilograms, by height, in metres squared. A BMI between 18.5 and 24.9 is classified as normal. A BMI between 25 and 25.9 is classified as overweight, and a BMI above 30 is classified as obese.
[4] A normal fetal heart rate ranges from 120 to 160 beats per minute (bpm).
[5] The fundus is the top of the uterus.
[6] Gestation on palpation.
[7] The fundal height is the measurement from the top of the uterus to the pubic symphysis (pubic bone) and roughly corresponds to gestational age. The NZ College of Midwives' guidelines at the time recommended that from 24 weeks' gestation the fundal-symphysis height should be measured and recorded in centimetres at each antenatal appointment.
[8] GROW charts track the growth of a baby during pregnancy, based on the mother's individual characteristics, such as ethnicity, body mass index, etc.
[9] The first trimester refers to weeks 1–12 of a pregnancy. The second trimester refers to weeks 13–26 of a pregnancy.
[10] Relevant months are referred to as Months 1–5 to protect privacy.
[11] Swelling caused by excess fluid being trapped in the body's tissues.
[12] An ultrasound scan to assess the baby's size and amniotic fluid volume.

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> "This baby is large for gestational age with the AC [abdominal circumference] close to the 95th centile[13] on the ASUM [Australasian Society for Ultrasound in Medicine] chart. Correlation with maternal factors such as BMI and ethnicity required. Recommend serial growth study. (Customised growth chart software is available at www.gestation.net/charts.) [Ms A] has a copy of her growth charts with her."

21. Ms A provided HDC with a copy of her growth chart that was completed at the scan on 26 Month1. The growth chart records that the estimated fetal weight was 3.33kg, femur length was 7cm, abdominal circumference was 350mm, and the BPD[14] was 90mm.

22. A copy of the USS report was sent to RM B at the Antenatal Clinic where she worked. Ms A was not sent a copy of the scan report.

Antenatal visit 1 Month2

23. On 1 Month2, at 35 weeks' gestation, RM B reviewed Ms A at home and checked the FHR and took Ms A's blood pressure, which was noted to be normal. In the maternity record, RM B noted that the baby's presentation was head first (fetal cephalic presentation)[15] and that Ms A reported no headaches or oedema, and that her urine was clear.

24. There is no record that on 26 Month1 a discussion was had about the USS report and the recommendations to commence a growth chart and for further growth scans. RM B told HDC that at the time of this consultation (1 Month2), she had not yet received a copy of the USS report, as it took about a week to arrive in the post.

25. RM B stated:

> "… I visited [Ms A] at home on 1 [Month2], 5 days after the scan … [W]e discussed the growth chart at this visit, options for another scan and the recommendation for an obstetric consultation. I palpated [Ms A] and was confident that in no event was [her] baby over 5000 [grams] … I discussed with [Ms A] that the common practice in New Zealand is that there is no option of an induction[16] or elective caesarean section birth … [Ms A] declined an obstetric appointment and also my offer of a follow-up [USS] scan."

26. RM B stated that she told Ms A that in her experience an induction would not be offered, and that in New Zealand there is no option of an induction or elective Caesarean section birth for suspected macrosomia.[17] RM B said that she also discussed the risks of a vaginal

[13] Centiles (equal to 100) measure growth parameters against the average — for example, if the estimated fetal weight (EFW) is at the 75th centile at 34 weeks' gestation, then that weight is greater than 75% of other babies and smaller than 25% of other babies at 34 weeks' gestation; or if the EFW is at the 27th centile at 40 weeks' gestation, it means that 73% of babies weigh more, and 27% of babies weigh less.
[14] Biparietal diameter is a measurement of the diameter of a developing baby's skull, from one parietal bone to the other, and is used to estimate fetal weight and gestational age. The normal range is 88mm +/– 2.
[15] The baby's head is down near the birth canal.
[16] A labour started artificially.
[17] A baby born much larger than average for their gestational age.

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birth for a large baby. She stated that she continued to palpate Ms A's baby at every visit, and was confident that there was no reason for any further concerns.

27. RM B said that Ms A's decision to decline an obstetric appointment or follow-up scan was reasonable in the circumstances as she was monitoring the growth of the baby. RM B also stated that a customised growth chart would not have provided any further information to add to the clinical picture. She acknowledged that a customised growth chart may have indicated that a consultation was warranted, in accordance with *The Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines*[18]*)* (see Appendix E). However, she submitted that a consultation was offered.

28. The *Referral Guidelines* require that in certain situations the LMC recommend to the woman (or parent(s) in the case of the baby) that a consultation with a specialist is warranted given that her pregnancy, labour, birth, or puerperium (or the baby) is or may be affected by the condition.

29. RM B acknowledged that there is no record of the discussions about induction and consultation in the maternity notes, and accepts that this should have been recorded.

30. Ms A told HDC that she "100% would not refuse" to have a follow-up scan, and reiterated that she had made the request for the growth scan on 26 Month1. Ms A said that RM B told her that a referral to a specialist would be declined because she did not have diabetes. Ms A told HDC that she accepted RM B's advice and considered that a referral would not be fruitful.

Receipt of USS report of 26 Month1

31. RM B told HDC that approximately one week after the scan was performed on 26 Month1 (around 3 Month2), she received a copy of the USS report in the post and it was then filed in Ms A's notes. This was after the antenatal consultation on 1 Month2. A copy of the USS report was not shared with Ms A. RM B stated that it was not a deliberate omission not to provide a copy of the scan report to Ms A.

Further antenatal visits and labour

32. Between 15 Month2 and 5 Month3 Ms A was seen by RM B on four occasions, and RM B assessed the fetal growth by palpating the uterus to estimate the gestational size of the baby, but she did not measure the fundal height in centimetres. RM B did not discuss with Ms A the result of the USS report and the recommendations for a growth chart and further scans, at any of the antenatal visits. RM B told HDC:

> "I regret that I did not discuss the specific scan report recommendations with [Ms A]. My reasoning at the time which I now accept was not fully considered, was that there

[18] Ministry of Health, *Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines)*, Wellington: Ministry of Health, 2012. The guidelines previously appended to Section 88 of the Maternity Services Notice 2002 are to be used in conjunction with the Primary Maternity Services Notice 2007.

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was a 3 weeks wait for scans, and the local policy regarding induction for large babies in the absence of diabetes."

33. On 23 Month2, at 38 weeks' gestation, RM B documented that the baby was full term.[19]

34. RM B saw Ms A on 5 Month3, at 40 weeks' gestation. RM B recorded that she performed a vaginal examination (VE) stretch and sweep[20] with consent, and noted that the baby's position was head down in the uterus,[21] with the baby's head at station[22] –2 above the pelvis.[23] She recorded her plan as: "[T]o keep waiting, will consult with obstetrician regarding induction."

35. At 11.00pm on 6 Month3, at 41 weeks' gestation, RM B documented that Ms A had begun to experience strong contractions.

36. At 7.30am on 7 Month3, RM B visited Ms A at home and documented: "Visit with [Ms A]. Experiencing long strong contractions coming regularly. Baby has been active, [FHR] 140 bpm." RM B performed a VE with consent, and documented that the cervix was 5cm dilated,[24] the membranes were intact, the baby's head was down in the uterus, and the baby's head was at station –1. RM B recorded that the plan was to stay at home for longer and then transfer to the public hospital.

Delivery

37. At 9.40am on 7 Month3, Ms A was admitted to the maternity unit at the public hospital and reviewed by a hospital midwife, who recorded that Ms A's blood pressure, pulse, and temperature were normal. The FHR was also noted to be normal.[25] RM B arrived at the maternity unit at 10.25am.

38. RM B listened to the FHR at 11am and 11.30am, and this was normal. At 12pm, RM B recorded that the FHR was 138 bpm, Ms A's cervix was 7–8cm dilated, and the baby's head was at station –1 facing down in the uterus.[26] From 12pm to 4pm, RM B monitored the FHR by intermittent auscultation[27] approximately every 20–60 minutes.

[19] Between 39 weeks' gestation and 40+6 weeks' gestation.
[20] A procedure performed in an attempt to initiate labour.
[21] Cephalic presentation.
[22] "Station" is an assessment that determines the descent of the fetal head 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.
[23] The ischial spines are the narrowest part of the mother's pelvis.
[24] A woman is considered to be in the active stage of labour once the cervix dilates to around 5 to 6cm. The second stage of labour usually begins when a woman's cervix is fully dilated to 10cm.
[25] The FHR was 141bpm. A normal fetal heart rate is between 110–160bpm.
[26] Posterior position.
[27] Listening to internal sounds of the body using a stethoscope.

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39. At 4.00pm, RM B performed a VE with consent and documented that a lip of cervix was present,[28] the baby's head was at station 0 to –1, the membranes were intact, and the FHR was 136bpm.

40. At 5.15pm, Ms A was having strong contractions every three minutes. RM B documented that the FHR was taken approximately every 15 minutes.

41. At 7.00pm, RM B performed a further VE, and the cervix was 7–8cm dilated and unchanged since 4pm. The membranes were ruptured manually, releasing meconium- stained[29] liquor. RM B told HDC that because of these findings, she sought an obstetric review.

42. Ms A told HDC:

> "Throughout my labor [RM B] sat in the corner of the room at a desk doing I have no idea what, but wasn't very helpful. She did suggest I go for a walk to which I did, several times. [RM B] managed to at one point get me on all fours on the bed and attempt something with a sheet, I cannot recall why or what this was to help with."

43. RM B told HDC:

> "[Ms A] did labour somewhat longer than the *Referral Guidelines* however, this was not unexpected due to the posterior position of the baby and as [Ms A] was coping well and not seeking pain relief other than a shower; and was able to mobilise; I considered up until [7pm] that it [was] reasonable to await events."

Review by Dr C and obstetric care by DHB

44. At 7.15pm, the on-call obstetrician consultant, Dr C, reviewed Ms A and noted that there had been no progress with the labour since 4pm, and that contractions were irregular. Dr C noted the risk factors of high BMI, large baby, failure to progress, and the presence of meconium. She recorded her plan to commence Syntocinon,[30] commence cardiotography (CTG)[31] monitoring, consider an epidural,[32] and reassess in two hours' time.

45. CTG monitoring and Syntocinon were commenced as planned, and Ms A was given an epidural for pain relief. At 10.55pm, RM B performed a VE and noted that a thick anterior lip of cervix was present.

46. At 12am, Dr C examined Ms A again and discussed the management options with her. A decision was made to proceed with an emergency Caesarean section for failure to progress at 9cm dilation.

[28] As the cervix nears full dilation, one side of the cervix may be present (a cervical or anterior lip).
[29] Meconium is the earliest stool of an infant. The presence of meconium in the liquor may indicate that the fetus is in distress.
[30] A medication used to increase the speed of labour.
[31] Cardiotocography (CTG) monitoring is the combined monitoring of the baby's heartbeat in utero and the mother's uterine contractions. This allows for an interpretation of the fetal heart rate either alone or in relation to the contractions, and may be used to assist with the identification of fetal well-being and/or distress.
[32] Used to provide pain relief during labour.

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Emergency Caesarean section

47. The Caesarean section commenced at 12.20am. The baby was delivered at 12.22am in good condition and weighed 4,350 grams. The Apgar score[33] at the time of birth was assessed as 9. Dr C told HDC that Ms A's estimated blood loss of 300ml was within the normal range for a Caesarean delivery.

Post-partum haemorrhage

48. At 2am on 8 Month3, the recovery nurses noted that Ms A had post-partum bleeding and requested a consultant review. At 2.10am, Ms A was returned to theatre and an intrauterine device[34] was inserted to manage the bleeding. However, Ms A's bleeding continued, and a return to theatre was planned for further management. Dr C had a discussion with Ms A about a hysterectomy as a possible way to manage the bleeding. Multiple procedures and surgical attempts were made by the Obstetrics team to stop the bleeding, but it continued.

49. Dr C and a second consultant and obstetrician, Dr E, and an anaesthetist, collectively decided that a hysterectomy was required to stop the bleeding, and that this was a necessary lifesaving procedure. A hysterectomy was performed and Ms A was transferred to the Intensive Care Unit at 5.35am for recovery.

Subsequent events

50. Ms A told HDC that she was seen regularly by the Maternity Mental Health service, and that she is very grateful for the advice and help received from them.

51. On 12 Month3, Ms A received the USS report dated 26 Month1 from her hospital notes. This was the first time she had seen the USS report.

52. Ms A provided HDC with a copy of a text message she sent to RM B on 4 Month5. The text message shows that Ms A asked RM B why she had not received a copy of the USS report.

53. RM B told HDC that she was first made aware of her omission to provide Ms A with a copy of the USS report when Ms A advised her of this in Month5. RM B stated that initially she informed Ms A that she could not find the scan report in her records, but that later she found the report. RM B told HDC that a copy of the report was also in the hospital notes.

Further information

Ms A

54. Ms A told HDC that she has had to deal with the grief of not being able to extend her family without surrogacy while being first-time parents.

[33] The APGAR score is a test given to newborns soon after birth. The test checks a baby's Appearance (skin colour), Pulse (heart rate), Grimace response (reflexes), Activity (muscle tone), and Respiration (breathing rate and effort). A score of 8–10 is normal.

[34] A Bakri balloon intrauterine device used to reduce or control post-partum hemorrhage temporarily when conservative treatment is warranted.

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RM B

55. RM B told HDC:

> "I acknowledge and accept RM Emerson's point[35] that [Ms A] should have been informed of the scan report recommendations to enable her to make a fully informed choice and to reflect partnership between me and [Ms A] in decision making."

56. RM B also stated:

> "Had I had more discussion with [Ms A] regarding the recommendation for a consult; there may have been more opportunity for [Ms A] to receive information about induction and macrosomia. I apologise unconditionally to her for not ensuring that she had this opportunity under the pathways expected by [the *Referral Guidelines*]."

57. Regarding a referral for an induction or a Caesarean section, RM B stated:

> "The practice in New Zealand is not to offer secondary intervention for suspected macrosomia unless baby's estimated fetal weight (efw) is >4500g where mother has gestational diabetes; or in every case where efw is >5000g. In such cases, caesarean rather that induction is offered. I understand this to be the RANZCOG position." (See Appendix E.)

58. RM B told HDC that in Month3, eight babies under her care were due and born, and that usually she cares for one to three women monthly. She said that as a result, Ms A's notes were recorded retrospectively on 15 Month3, and that usually she is more up to date with her documentation.

Clinical advice for ACC

59. A claim was made to ACC by Ms A for a treatment injury regarding the haemorrhage following the Caesarean section, which led to a hysterectomy and caused grief and loss.

60. As part of its review of this claim, ACC asked RM F and Dr G, obstetrician and gynaecologist, to provide external advice on these events to determine whether injury occurred during the course of, or as a result of, being given treatment. A summary of RM F's report and Dr G's report are included as Appendix C and Appendix D respectively. In summary, RM F was critical of RM B's care following the clinical findings on 26 Month1 and during labour. Dr G was critical that Ms A's obstructed labour was neither recognised nor managed adequately by RM B. I note that HDC and ACC have differing roles and therefore the focus of their advice is not the same. This is explained further below in paragraph 94.

Responses to provisional opinion

61. Ms A and RM B were given the opportunity to respond to the relevant sections of the provisional opinion.

[35] Paragraph 70 of this report.

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62. Ms A told HDC that she accepts the "information gathered" section of the provisional report, and RM B told HDC that she accepts the provisional opinion and the recommendations.

Opinion: RM B — breach

Introduction

63. This case highlights the importance of clear decision-making and open communication to ensure that a woman has the opportunity to make informed decisions about the plan to monitor the growth of her baby, and be a partner in her own care. There were deficiencies in the care provided to Ms A following the identification of a large baby at 35 weeks' gestation. I acknowledge the tragic outcome for Ms A. As a young woman, she required the lifesaving procedure of a hysterectomy, and, as a result, the decision to conceive further children is no longer available to her.

64. My expert advisors, RM Emerson and Dr Page, consider that the management of Ms A's labour by RM B and the DHB was appropriate. With regard to the management of Ms A's Caesarean and hysterectomy, Dr Page and ACC advisor Dr G agree that the care provided by the DHB was appropriate. I accept this advice. Accordingly, this investigation has focussed on the care provided by RM B to Ms A antenatally, as set out below.

USS report

65. Ms A had a growth USS at 35 weeks' gestation. The scan report indicated that her baby was large for its gestational age with an abdominal circumference that was close to the 95th centile. The report recommended customised growth charts and serial growth scans to monitor the growth of Ms A's baby. RM B told HDC:

> "I regret that I did not discuss the specific scan report recommendations with [Ms A]. My reasoning at the time which I now accept was not fully considered, was that there was a 3 weeks wait for scans, and the local policy regarding induction for large babies in the absence of diabetes."

66. RM B did not discuss the USS report with Ms A, or provide her with a copy of the report, until after the birth, and Ms A was unaware of the recommendations made in the report.

67. Initially, RM B told Ms A that she could not find the USS report. However, RM B told HDC that she received a copy of the USS report about one week after the growth scan was performed, and it was filed in Ms A's notes. RM B stated that this was not a deliberate omission, and that she first became aware of her oversight when Ms A requested a copy of the USS report in Month5. RM B also said that the USS report is included in the hospital notes.

68. My expert advisor, RM Emerson, advised that the onus is on the midwife to follow up on all clinical investigations, in particular those that she has ordered. On the evidence available, I

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find it more likely than not that RM B reviewed the USS report when it was received and filed, but she did not taken any action in response to the information in the report.

69. RM B acknowledged that Ms A should have been informed of the scan report recommendations to enable her to make a fully informed decision and reflect partnership in decision-making.

70. RM Emerson advised that RM B should have discussed the USS report recommendations with Ms A to enable her to participate in the decision-making to monitor the growth of her baby, and should have documented that discussion. RM Emerson stated:

> "In my opinion the issue is not whether an earlier induction was warranted based on baby's size. In my opinion the issue is whether [Ms A] was informed of the scan recommendations (to customise the growth, arrange serial growth scans) and of the recommendation to consult under section 88 [of the *Referral Guidelines*]. In my opinion, the decision to ignore the scan recommendations and section 88 recommendations was a shared responsibility between [RM B] and [Ms A]. The partnership between the midwife and the woman in decision making underpins Midwifery care in NZ."

71. I accept RM Emerson's advice. I am critical that having reviewed the USS report, RM B failed to discuss the result of the report and its recommendations with Ms A — in particular that further growth scans and a customised growth chart were indicated. Ms A had a right to receive appropriate information about the recommendations in the USS report so that she could make an informed decision about her care. RM B should have discussed and shared the report recommendations with Ms A and given her the opportunity to be a partner in the decision-making about further actions to monitor the growth of her baby. I am critical that this did not occur.

Referral Guidelines and management of large baby

72. As noted above, the USS report records that Ms A's baby was large, with the abdominal circumference close to the 95th centile, and the USS report recommended customised growth charts and serial growth scans to monitor the growth of Ms A's baby. However, no action was taken by RM B in response to the specific recommendations in the USS report.

73. On 26 Month1, Ms A's growth chart was completed at the scan. The growth chart records that the estimated fetal weight was 3.33kg, femur length was 7cm, abdominal circumference was 350mm, and the BPD[36] was 90mm.

74. RM B said that she discussed Ms A's growth chart and offered a follow-up scan and an obstetric review, but Ms A declined. RM B submitted that there was a three-week wait for scans, and that in the absence of diabetes, Ms A would not have been offered an induction for a large baby. Ms A stated that RM B advised her that a referral to an obstetrician would be declined because she did not have diabetes. However, RM B told HDC that she recommended an obstetric review on more than one occasion, but this was declined by Ms

[36] Biparietal diameter is a measurement of the diameter of a developing baby's skull, from one parietal bone to the other, and is used to estimate fetal weight and gestational age. The normal range is 88mm +/– 2.

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A. Ms A told HDC that she declined a referral on the basis of RM B's advice that a referral would not be accepted because she did not have diabetes.

75. In any event, RM B acknowledged that her discussion with Ms A, including that a specialist consultation was recommended (as per the *Referral Guidelines)*, was inadequate, and RM B apologised that Ms A was not offered an opportunity for an obstetric review in accordance with the *Referral Guidelines*.

76. The Ministry of Health 2012 *Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines)* that applied at the time defined "infant large for its gestational age" as an estimated fetal weight (EFW) over the 90th percentile on a customised growth chart. The *Referral Guidelines* state that in this situation, "[t]he LMC must recommend to the woman that a consultation with a specialist is warranted".

77. RM Emerson advised that the USS report of 35 weeks' gestation indicated that Ms A's baby was on the 95th centile, and this met the criteria for an obstetric consultation under the *Referral Guidelines.* RM Emerson said that antenatal referral was warranted, and that an obstetric review may have investigated the reasons why Ms A's baby was large, and may not have been limited to a discussion about induction. RM Emerson also opined that "there appeared to be no plan for monitoring the growth".

78. RM Emerson said that RM B was not required to generate a customised growth chart as recommended in the USS report. However, RM Emerson also advised:

> "I am critical of the choice to not follow the scan recommendations of serial growth study. My opinion remains that there was a moderate departure from accepted midwifery practice in not following [the] recommendations …"

79. I accept RM Emerson's advice. I acknowledge that RM B discussed with Ms A a referral to an obstetrician, but I am concerned that this discussion was not sufficiently clear and balanced as to the reasons why an obstetric review was warranted. As such, I find that RM B did not convey to Ms A adequately that in accordance with the *Referral Guidelines*, an obstetric review was indicated.

80. In my view, Ms A had the right to receive appropriate information about the recommendations in the *Referral Guidelines* in order for her to weigh up her options and make an informed decision about having an obstetric review. I am also concerned that in the absence of further scans, a customised growth chart, and importantly specialist input, there appears to have been no further plan for monitoring the growth of Ms A's baby in the event that further intervention including induction was warranted.

Documentation

Fundal height measurements

81. The New Zealand College of Midwives (NZCOM) consensus statement (22 February 2012), "Assessment of fetal wellbeing during pregnancy", states:

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> "From 24 weeks gestation it is recommended that the fundal-symphysis height should be measured and recorded in centimetres at each antenatal appointment, preferably by the same person."

82. RM B recorded the gestation on palpation at the antenatal visits, and measured the fundal height with her hands. The measurements are not recorded in centimetres.

83. RM Emerson is critical that RM B measured the fundal height using her hands, and did not measure the fundal height in centimetres from 24 weeks' gestation, as recommended by NZCOM.

84. I accept RM Emerson's advice. I acknowledge that during the antenatal period RM B assessed the fetal growth by using landmarks to ascertain the gestation of Ms A's baby. However, in the context a large baby, I am critical that RM B failed to measure Ms A's fundal height in centimetres from 24 weeks' gestation. I note that RM B now measures and records the fundal height in centimetres at each visit from 24 weeks' gestation. I consider this appropriate.

Record-keeping

85. Standard four of the NZCOM standards of practice provides that a "midwife maintains purposeful, on-going, updated records and makes them available to the woman".

86. RM B acknowledged that there is no record of the discussions about induction and consultation in the maternity notes, and accepted that this should have been recorded. She submitted that her documentation of Ms A's care was affected by a high workload. As a result, she recorded Ms A's notes postnatally on 15 Month3.

87. The importance of record-keeping cannot be overstated. I note that RM B documented the care after the events, and I am critical of the standard of her contemporaneous documentation. I note that RM B has attended further training on documentation, and I consider this to be appropriate.

Conclusion

88. By failing to discuss the recommendations in the USS report for further scans and to commence a growth chart, and by failing to recommend a referral to an obstetrician, opportunities were missed for further interventions and specialist advice to monitor the growth of Ms A's baby. In my view, RM B failed to provide services to Ms A with reasonable care and skill in the following respects:

a) After she reviewed the USS scan report, it was filed away and no further action was taken in response to the information in the report;

b) A copy of the USS scan report was not provided to Ms A. The USS report recommendations and findings were also not discussed with Ms A;

c) There appears to have been no plan for monitoring the growth of Ms A's baby when specialist intervention was warranted, as per the recommendation in the *Referral*

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Guidelines. Ms A was also not informed fully about the reasons an obstetric review was warranted;

d) The fundal height was measured using landmarks, and this was not consistent with current midwifery practice to measure the fundal height in centimetres; and

e) Discussions about the growth chart and an obstetric review were not recorded in the maternity notes.

89. Accordingly, I find that RM B failed to provide Ms A with an appropriate standard of care, and, as such, breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[37] RM B failed to advise Ms A of the recommendations in the USS scan report and in the *Referral Guidelines*. This was information that a reasonable consumer in Ms A's circumstances would expect to receive. Accordingly, I find that RM B breached Right 6(1) of the Code.[38]

Midwifery care provided at hospital — no breach

90. Ms A was admitted to hospital at 9.40am on 7 Month3, and RM B continued to provide care to her. At 7pm, RM B performed a vaginal examination and noted that the cervix had not changed since 4pm, and meconium was present in the liquor and, as a result, she sought an obstetric review. The ACC midwifery expert, RM F, advised that the care provided by RM B during labour was not appropriate.

91. However, RM Emerson reviewed RM F's advice and stated:

> "In my opinion, appropriate referral was made when there has been no cervical change from 4pm till 7pm and meconium was present in the liquor … My opinion remains that earlier intrapartum referral may have been prudent but in not doing so there is no departure from accepted midwifery practice …"

92. Dr G in his report to ACC noted that Ms A was 7cm dilated for 12 hours and considers that she had an obstructed labour that was neither recognised nor managed adequately. Dr G considers that Syntocinon was indicated at 2.00pm, five hours earlier than was administered, and that had this occurred, an emergency Caesarean would have been performed at 4.00–5.00pm (seven hours earlier) and a peri-partum hysterectomy may have been avoided.

93. However, my expert advisor, Dr Page, reviewed Dr G's advice and stated:

> "Our point of difference is the management of labour by the LMC. I have followed the national maternity referral guidelines with regard to progress (as assessed by cervical dilatation), and they are in line with the NICE guidelines on the matter. They state that progress can be considered to be normal if the rate is at least 2cm in 4 hours. [Dr G] also

[37] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."
[38] Right 6(1) states: "Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive …"

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refers to the referral guidelines on p 4 of his report, but then refers to a different standard of 1cm/hour on p5 but does not provide a reference to support it.

Going by what the LMC found on examination there was no need for earlier referral or intervention. I do not think we can assume that the LMC's assessments of progress were incorrect, although that is always a possibility — particularly when looked at with hindsight …"

94. I have considered both the ACC's advice and RM Emerson's and Dr Page's advice. I note that ACC's advice considered the link between the care provided to Ms A, and the outcome, as the role of ACC is to determine whether injury occurred during the course of, or as a result of, being given treatment. ACC seeks to identify retrospectively whether a treatment injury occurred. This is not a criticism of the ACC process, but it is necessary to highlight the purpose and limitations of the ACC report when it is referred to in this Office's opinion. HDC's independent advisors are asked to focus on the accepted standard of care, not the outcome, and they have the benefit of reviewing information obtained over the course of the investigation, which includes statements from the clinicians involved.

95. Accordingly, I accept RM Emerson's and Dr Page's advice and consider that the birthing care provided by RM B was appropriate.

Changes to practice

96. RM B told HDC that she has made the following changes to her practice:

a) She engages with a midwife mentor through NZCOM for continued support and guidance.

b) She applies Part 5 of the *Referral Guidelines* when a women declines a referral or consultation, and has developed a self-audit tool kit for these situations to apply for three months.

c) She ensures that documentation reflects the discussions with a woman at each antenatal visit.

d) She follows up scans referred with a full discussion with the woman and any follow-up carried out.

e) She uses a measuring tape to measure the fundal height at each antenatal visit after 24 weeks' gestation, and records this in the woman's notes.

f) She uses customised growth charts to assess fetal growth/well-being further.

g) She has enrolled in a documentation workshop run by NZCOM.

h) She has enrolled in the NZCOM online "Informed Consent" course.

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Recommendations

97. I recommend that RM B:

a) Provide evidence to HDC within three months of the date of this report, confirming her attendance at the NZCOM courses on informed consent and documentation.

b) Undertake an audit of her standards of clinical documentation using the approved "Midwifery Documentation and Record Keeping Audit Tool" (available from www.midwiferycouncilhealth.nz) and report back to HDC on the results of the audit within three months of the date of this report.

98. In accordance with the recommendation in the provisional opinion, RM B provided an apology, and this has been forwarded to Ms A.

Follow-up actions

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

100. A copy of this report with details identifying the parties removed, except the experts who advised on this case, will be sent to the Ministry of Health, the New Zealand College of Midwives, and the district health board, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: In-house clinical advice to the Commissioner

The following expert advice was obtained from RM Nicky Emerson on 15 October 2019:

> "Thank you for the request that I provide clinical advice in relation to the complaint from [Ms A] about her care provided by LMC Midwife [RM B]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors. I have been asked to review the documentation on file: Complaint from [the] (Barrister acting for [Ms A]) 12 February 2019, Complaint response from [RM B] 27 June 2019, Midwifery notes including text record, MMPO notes [from booking to 19 Month4] including scan reports.
>
> **Background:**
>
> [Ms A], a young woman in her first pregnancy had been well throughout. No obstetric or medical history of note. Allergy to wasp stings is documented. [Ms A's] BMI was raised at 30. [Ms A's] pregnancy was under the care of LMC [RM B]. At 35 weeks gestation [Ms A] requested an ultrasound scan. The scan reported a large baby and suggested serial growth scans and a customised growth chart. Referral for an obstetric opinion under section 88 was warranted. This did not occur. Spontaneous labour occurred at 41 weeks gestation. The labour slowed and the decision was made to go to theatre for a caesarean section. Following the operation, despite employing all available measures, [Ms A's] blood loss necessitated a life saving subtotal hysterectomy.
>
> **Advice request:**
>
> I have been asked to advise whether the standard of care provided to [Ms A] was appropriate in the circumstances and why? In particular: Whether the midwife adequately monitored [Ms A] during the antenatal period; Whether the midwife should have sought obstetric advice regarding whether an elective caesarean section was indicated due to baby's size; Any other comments regarding [Ms A's] labour and management of the post partum haemorrhage; Comments regarding the appropriateness of the midwife's reflection and changes to practice.
>
> **Whether the midwife adequately monitored [Ms A] during the antenatal period?**
>
> [Ms A] booked with [RM B] [at 7 weeks' gestation]. [Ms A] was seen 11 times in her pregnancy. Antenatal care, in my opinion was in keeping with accepted routine Midwifery practice for a healthy woman. Growth of fundal height however is not measured in centimetres from 24 weeks as recommended by NZCOM; however gestation on palpation is recorded. *(NZCOM Consensus statement — Assessment of fetal well being during pregnancy Feb 2012) From 24 weeks it is recommended that the fundal-symphysis height should be measured and recorded in centimetres at each antenatal appointment, preferably by the same person.* At [Ms A's] request, [RM B] sent her for a growth scan on 26 [Month1] at 35 weeks gestation. The scan reported the following: *This baby is large for gestational age with the AC* (abdominal circumference) *close to the 95th centile on the ASUM chart* (Australasian Society for Ultrasound in

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Medicine). *Correlation with Maternal factors such as BMI and ethnicity required. Recommended serial growth study. (Customised growth chart software is available at www.gestation.net/charts) [Ms A] has a copy of her growth charts with her.* At the next routine antenatal appointment [RM B] states '*After the scan we discussed the results at a routine ante-natal visit — [Ms A] had a copy of her growth charts that showed estimated weight and measurements.'* [RM B] goes on to say that she had a discussion with [Ms A] stating that the recommendation is for consultation with an Obstetrician, though in her experience, unless there is antenatal diabetes, the woman is turned down for induction. [RM B's] complaint response 27 June 2019 quotes consensus guidelines from Auckland, Hutt Maternity and Canterbury discussing the risk/benefit for Induction of labour versus expectant management for large babies. In forming an opinion, I have considered the following: The scan report was generated at 35 weeks gestation, the recommendation was to customise the growth and arrange serial growth scans on the basis of a large baby; *Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines)* — Section 88 states (page 25, line 4013) Infant large for gestational age — EFW (Estimated fetal weight) on a customised growth chart >90th percentile — consultation.

The pregnancy continued for 6 weeks without any further scans or consultation regarding the baby's size. I have considered and agree with [RM B] regarding the debate of risk/benefit of induction of labour for large babies in the absence of diabetes. I do however note that a referral to an Obstetrician may have resulted in further consideration/investigation of why [Ms A's] baby was big. The referral may not have been confined to a discussion regarding whether/when to induce labour. In my opinion the issue is not whether an earlier induction was warranted based on baby's size. In my opinion the issue is whether [Ms A] was informed of the scan recommendations (to customise the growth, arrange serial growth scans) and of the recommendation to consult under section 88. In my opinion, the decision to ignore the scan recommendations and section 88 recommendations was a shared responsibility between [RM B] and [Ms A]. The partnership between the midwife and the woman in decision making underpins Midwifery care in NZ. The shared decision making is not reflected in midwifery documentation that I have reviewed; therefore [Ms A] is unlikely, in my opinion, to have made a fully informed choice regarding the care plan of her large baby. The above has been acknowledged by [RM B] in her complaint response and discussed further on in this report.

Whether the midwife should have sought obstetric advice regarding whether an elective caesarean section was indicated due to baby's size

As outlined above, under s88 the recommendation for obstetric advice was evident following the 35 week ultrasound scan. In addition a customised growth chart and serial growth scans were recommended. In my opinion, whether elective caesarean was indicated cannot be determined retrospectively as the opportunity to seek an obstetric opinion and to monitor growth by scan did not occur.

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Any other comments regarding [Ms A's] labour and management of the post partum haemorrhage

Labour

I have reviewed the labour care provided by [RM B] and in my opinion it is in keeping with accepted midwifery practice for the following reasons. The baby was in a posterior position during labour and this is associated with longer labour, progress had been slow. Obstetric consultation took place following a routine assessment when no further progress had occurred at 7.15pm. The risks of increased BMI, large baby, failure to progress and meconium stained liquor are documented by the obstetric team at the 7.15pm assessment. Following assessment, the obstetric team elected to augment [Ms A's] labour for a further 5 hours. The decision making was led by the obstetric team from the 7.15pm assessment and for the remainder of the labour.

Post Partum Haemorrhage

I have no comment regarding the post partum haemorrhage as this obstetric emergency was managed by the Obstetricians; however, it appears from the clinical notes that every possible action was taken in an effort to preserve [Ms A's] uterus prior to her life saving subtotal hysterectomy.

Comments regarding the appropriateness of the midwife's reflection and changes to practice.

[RM B] has noted that the baby was bigger than average but not too big to be born vaginally. She states that '*I do not believe that my failure to recommend more than once that [Ms A] have an antenatal consultation for suspected macrosomia can be said to have made a difference to the outcome. However, having said that, I have reflected on [Ms A's] complaint and appreciate that had I had more discussion with her regarding the recommendation for a consult; there may have been more opportunity for [Ms A] to have a conversation and receive information about induction for macrosomia. I apologise unconditionally to her for not ensuring she had this opportunity under the pathway expected by s88.'* As a result of the complaint [RM B] is enrolling in the following courses: Enrolling in Dotting the I's and Crossing the T's workshop; Enrolling in the NZCOM online 'Informed Consent' course. In my opinion [RM B's] acknowledgement of her omission to consult under s88 and the omission to discuss in depth and document the discussion is appropriate. The proposed documentation workshop and informed consent workshop will be beneficial to her practice. I remain concerned that the scan report recommendations are not addressed by [RM B] in her complaint response. She has addressed that the s88 recommendations were not followed but has not addressed the scan recommendations. I appreciate the debate regarding the role of customised growth charts in the context of a large baby however as I have questioned above, there appeared to be no plan for monitoring the growth. Fundal height was measured in landmarks alone and not in centimetres as recommended by NZCOM. No follow up scan/scans were arranged to monitor growth. [RM B's] comments regarding the baby's size and ability to be born vaginally are retrospective. If midwifery skills were to inform further monitoring of growth, disregarding scan and S88 recommendations then in my opinion [Ms A] would fairly

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expect to take part in that conversation. In my opinion Midwifery in New Zealand is based on a partnership with the woman and informed consent underpins this partnership. The decision not to refer or to scan further in my opinion is a shared decision.

Summary

In summary I have been asked to comment on the Midwifery care provided by [RM B] to [Ms A] during her pregnancy and labour. In my opinion the care meets accepted Midwifery standards with the exception of monitoring of a large baby. In my opinion it cannot be known retrospectively whether the outcome would have been different for [Ms A] however she does not appear to have been given the opportunity to make an informed decision regarding referral and follow up scans. In my opinion this represents a moderate departure from accepted Midwifery practice. The issue of informed consent has been acknowledged in [RM B's] complaint response and she has taken steps to address this through appropriate Midwifery education. I hope my report has addressed any remaining questions. I extend my heartfelt condolences to [Ms A] and [her partner] and wish them the best in the ongoing care of their precious [baby].

Nicky Emerson BHSc-Midwifery
Midwifery Advisor
Health and Disability Commissioner"

The following further expert advice was obtained from RM Emerson on 17 December 2019:

"I have reviewed the documentation from [RM B] in response to your additional questions and I have reviewed my advice, the clinical notes and [RM B's] original complaint response.

- I accept that [RM B] was not required to generate a customised chart despite the scan recommendation.
- [RM B] states in the response 10 December 2019 that on 1 [Month2] she visited [Ms A] at home and states *As previously advised, we discussed the growth chart at this visit, options for another scan and the recommendation for an obstetric consultation. I palpated [Ms A] and was confident that in no event was the baby over 5000gms. In the actual event the baby was 4350gms. I discussed with [Ms A] that the common practice in New Zealand is that there is no option of an induction or elective Caesarean section birth — see my response dated 27 June 2019 referring to various DHB policies. [Ms A] declined an obstetric appointment and also my offer of a follow up scan. Living remote rural and taking into account the $30.00 surcharge for the scan, may have had some influence on her decision. In terms of management of growth, I continued to palpate baby at every visit and was confident that there was no reason for further concerns.*
- *As well as the discussion about growth, at this meeting we discussed the risks of large baby being born vaginally, being shoulder dystocia, PPH, perineal tears and caesarean section births. I have experienced many larger babies at delivery and am*

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fully aware of the risks entailed and ensure that women are always provided with this information where there is a suspected large baby.

- In her original complaint response 27 June, [RM B] states *I do not believe that my failure to recommend more than once that [Ms A] have an antenatal consultation for Macrosomia can not be said to have an influence on the outcome. However, having said that, I have reflected on [Ms A's] complaint and appreciate that had there been more discussion with her regarding the recommendation for a consult; there may have been more opportunity for [Ms A] to have a conversation and receive information about induction and macrosomia. I apologise unconditionally to her for not ensuring she had this opportunity under the pathways expected by s88.*

I have considered the above and I have considered the clinical documentation provided by [Ms A] (which is in keeping with [RM B's] clinical documentation). In my opinion [RM B] has elected to rely on her clinical skills to assess the size of [Ms A's] baby and elected that there was no gain in further scanning or customising growth (customising — I accept has limited value in the context of a large baby). There is no documentation supplied by either [Ms A] or [RM B] to evidence a discussion regarding the size of [Ms A's] baby. The lack of documentation is discussed in [RM B's] complaint response 29 June stating that the documentation was written retrospectively as she had a very busy month. She has enrolled in the NZCOM documentation workshop since.

[Ms A's] complaint states that she feels that she should have been referred to an obstetrician and she should not have been allowed to go to 41 weeks due to the size of her baby.

I am critical of the choice to not follow the scan recommendations of serial growth study. My opinion remains that there was a moderate departure from accepted midwifery practice in not following *S88 recommendations (page 25, line 4013, Infant large for gestational age — EFW (estimated fetal weight) on a customised chart >90th percentile — consultation)*. Whether this has impacted on the outcome, in my opinion, cannot be determined retrospectively.

I hope this has helped with any remaining questions raised.

Regards
Nicky."

The following further expert advice was obtained from RM Emerson on 16 November 2020:

"**1.** Thank you for the request that I review my clinical advice and the additional documentation in relation to the complaint from [Ms A] about the care provided by LMC [RM B]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

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2. **I have reviewed the additional documentation on file:** Complaint from [Ms A] and [her partner] (no date) plus appendices (A,A2,B1,B2,C; Copy of blood results for [Ms A], Text records from [Ms A] 14 & 15 [Month3] and 4 [Month5], Population growth centiles for baby (graphs) 26 [Month1], Blank antenatal summary); Complaint response from [RM B] 27 June 2019, Response to my initial advice from [RM B] 14 August 2020, [DHB] Complaint response (internal review) 20 August 2020, [DHB] review of Midwifery care 6 August 2020, Request to review advice from HDC 3 November 2020, Treatment injury advice from ACC ([RM F]) 13 April 2020.

3. **Background:** [Ms A], a young woman in her first pregnancy had been well throughout. No obstetric or medical history of note. Allergy to wasp stings is documented. [Ms A's] BMI was raised at 30. [Ms A's] pregnancy was under the care of LMC [RM B]. At 35 weeks gestation [Ms A] requested an ultrasound scan. The scan reported a large baby and suggested serial growth scans and a customised growth chart. Referral for an obstetric opinion under section 88 was warranted. This did not occur. Spontaneous labour commenced at 41 weeks gestation. The labour slowed and the decision was made to go to the theatre for a caesarean section. Following the operation, despite employing all available measures, [Ms A's] blood loss necessitated a life saving subtotal hysterectomy.

4. **Advice Request:** I provided advice 15 October 2019 and have been asked to review further documentation as listed above, and amend my original advice if necessary.

As requested I have reviewed the additional documentation supplied by the HDC. Some minor differences are noted with my original opinion 15 October 2019, the ACC view of labour care and [the DHB] interpretation of the labour CTG. In my opinion these differences do not impact my opinion 15 October 2019.

The text records supplied from [Ms A] do warrant comment however.

1. I note that [Ms A] has supplied a text record from [RM B] 4 Month5. [Ms A's] baby was born on 8 [Month3].

'*Hello [RM B]. Hey I was just going over my notes and everything inside it, i noticed … the scan guy on the last scan we had on the 26th [Month1] had stated that pretty much we should have been monitoring baby because he was so big..Now i never got these results from you and i wouldnt have known about it if i didnt get notes from the hospital.. Why didnt i get this scan result off you, when i did every other one?*'

2. In her complaint response page 5, 27 June 2019; referring to receipt of the 35 week scan report [RM B] states:

The report takes about a week to get to me in the post. When I received it, it was filed in her notes and not passed onto [Ms A]. This was not deliberate and only realised that [Ms A] did not have a copy when she texted me in early [Month5]. I did find the copy on a second look in the file after initially telling her I couldn't find it — I didn't tell her I hadn't seen it. There was a copy in the hospital notes.

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3. In response to my initial advice from [RM B] 14 August 2020 states *I regret that I did not discuss the specific scan report recommendations with [Ms A]. My reasoning at the time which I now accept was not fully considered, was that there was a 3 weeks wait for scans, and the local policy regarding induction for larger babies in the absence of diabetes.*

I am unable to resolve the above discrepancies regarding when the scan report was seen by [RM B], however [RM B's] text to [Ms A] on 4 [Month5] questions [Ms A]. [RM B] is asking why the scan report was not given to her by [Ms A]. In my opinion the onus is on the midwife to follow up on all clinical investigations, in particular those that she has ordered. It is not the woman's responsibility to supply results to the midwife.

NZ Midwifery Competencies for midwifery state the following

2.2 confirms pregnancy if necessary, orders and interprets relevant investigative and diagnostic tests, carries out necessary screening procedures, and systematically collects comprehensive information concerning the woman's/wāhine health and well-being.

NZ College of Midwives Standards of Practice

Standard Four: The midwife maintains purposeful, on-going, updated records and makes them available to the woman.

Summary

In summary, following review of additional information my advice is unchanged from 15 October 2019.

In review of the additional information supplied regarding text records, discrepancy arises in relation to previous responses regarding when scan information was seen by [RM B].

Regardless of which version is accepted regarding the scan, in my opinion and in alignment with Midwifery Council competency 2.2 it is the midwife's responsibility to review and retain any investigations ordered.

If it is accepted that the scan was ordered, information was reviewed and not related to [Ms A] then my advice 15 October 2019 remains the same regarding the issue of the non informed participation in decision making — moderate departure from accepted Midwifery practice.

If it is accepted that the scan was not seen by [RM B] until after the birth, then in my opinion there is a moderate departure from accepted midwifery practice in not following up on an ordered investigation.

Nicky Emerson BHSc-Midwifery"

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The following further expert advice was obtained from RM Emerson on 10 December 2020:

"Thank you for the request that I review my clinical advice in relation to the ACC advice regarding the complaint from [Ms A] about the care provided by LMC [RM B]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

1. **I have reviewed the additional documentation on file:** Treatment injury advice from ACC ([RM F]) 13 April 2020.

2. **Background:** [Ms A], a young woman in her first pregnancy had been well throughout. No obstetric or medical history of note. Allergy to wasp stings is documented. [Ms A's] BMI was raised at 30. [Ms A's] pregnancy was under the care of LMC [RM B]. At 35 weeks gestation [Ms A] requested an ultrasound scan. The scan reported a large baby and suggested serial growth scans and a customised growth chart. Referral for an obstetric opinion under section 88 was warranted. This did not occur. Spontaneous labour commenced at 41 weeks gestation. The labour slowed and the decision was made to go to the theatre for a caesarean section. Following the operation, despite employing all available measures, [Ms A's] blood loss necessitated a lifesaving subtotal hysterectomy.

3. **Advice Request:** I provided advice 15 October 2019 and 16 November 2020 and have been asked to review again further documentation as listed above and amend my original advice if necessary.

I have reviewed the ACC Treatment Injury advice from [RM F] 13 April 2020. [RM F] states that '*the findings of a macrosomic fetus should have alerted [RM B] to the increased likelihood of an obstructed labour. This should have informed discussions, decisions and care provision during both the antenatal and intrapartum periods, including an earlier referral to seek obstetric advice'*. [RM F] states that *'there is no documentation to show palpation of the fetus, review of fetal weight, position or descent during antenatal care or on admission in labour or at any time during labour. There is no acknowledgement in the intrapartum documentation of the lack of fetal descent during labour.*' [RM F] concludes that the midwifery care during labour was neither reasonable nor appropriate.

In reviewing the ACC advice, I have considered the following.

- I agree advice and discussion culminating in antenatal referral for an Obstetric opinion was warranted. This is discussed in my opinion 15 October 2019.

1. I agree the findings of a macrosomic fetus should have alerted [RM B] to the possibility of an obstructed labour however the consideration of a ? posterior position documented at 12pm, is also associated with prolonged labour.

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2. Documentation of fetal weight review and lie is not recorded however fetal descent is documented at 12pm at –1, 4pm at 0 to –1 and as unchanged at 7pm when referral was made.

3. Following referral at 7pm, the Obstetrician has documented '*Reviewed primip spontaneous labour. No progress since 1600 (4pm). Risk factors of ↑ BMI, large baby, failure to progress (FTP), meconium present in the liquor (mec).*' The obstetric plan to site an epidural and to augment the labour with syntocinon is then documented.

In considering the above, my opinion remains; antenatal referral was warranted, earlier referral in labour may have been best practice however the possibility of a posterior lie was considered as a reason for slow progress and cervical dilation albeit slow, was documented until 7pm. In my opinion, appropriate referral was made when there had been no cervical change from 4pm till 7pm and meconium was present in the liquor. Obstetric documentation records failure to progress, large baby and meconium and the obstetric plan was to augment labour for a further five hours before an emergency caesarean. I consider, following anonymised discussion, that some of my colleagues would have considered the slow progress acceptable (whilst not ideal) in the context of a posterior lie. My opinion remains that earlier intrapartum referral may have been prudent but in not doing so there is no departure from accepted midwifery practice in referring for obstetric input at 7pm when progress was no longer evident, and meconium was present in the liquor.

Nicky Emerson BHSc-Midwifery."

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Appendix B: Independent advice to the Commissioner

The following expert advice was obtained from an obstetrician and gynaecologist, Dr Ian Page:

> "Thank you for your letter of 19 October 2020 and the enclosed documents, requesting expert advice to the Commissioner on the care provided by [the DHB] to [Ms A] in [Month3]. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.
>
> I am a practising Obstetrician & Gynaecologist and have been a consultant for over 30 years. I obtained my MRCOG in 1985, my FRCOG in 1998 and my FRANZCOG in 2002. I have been employed for the past 20 years by Northland DHB. I have been a member of the RANZCOG Expert Witness register since 2012.
>
> *Background*
>
> [Ms A] was well throughout her first pregnancy. Her BMI was 30, and she was under the care of LMC [RM B]. At 35 weeks' gestation [Ms A] requested an ultrasound scan. The scan reported a large baby and suggested serial growth scans and a customised growth chart. On 27 [Month3] spontaneous labour occurred at 41 weeks' gestation and [Ms A] was admitted to [the public hospital]. The labour slowed and the decision was made to go to theatre to perform an emergency caesarean section due to failure to progress in labour. Following the operation, despite employing all available measures, [Ms A's] blood loss necessitated a life-saving subtotal hysterectomy.
>
> *Advice Requested*
>
> You asked me to review the documents and advise whether the care provided to [Ms A] by [the DHB] was reasonable in the circumstances and why. You also asked me to comment specifically on:
>
> 1. Whether the care provided to [Ms A] during labour and delivery was appropriate.
>
> 2. Whether the care provided to [Ms A] post-operatively including the identification, management and treatment of her post-partum haemorrhage was appropriate.
>
> *Sources of Information*
>
> In assessing this case I have read:
>
> - Letter of complaint dated 12 February 2019
> - Midwifery records from LMC [RM B]
> - [The DHB's] response dated 20 August 2020
> - Statement from [anaesthetist]
> - Statement from obstetrician, Dr C, dated 24 July 2020
> - [The DHB's] internal review of midwifery care
> - Clinical records from [the DHB] covering the period of [Month3]

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Summary of the Case

[Ms A], aged [in her twenties], had an uneventful first pregnancy in 2018. Her LMC's notes record [Ms A's] height and weight, but do not record her BMI, and that the baby's growth was consistent with her dates throughout the pregnancy. Despite this at 35 weeks' gestation her LMC ordered an ultrasound scan to check the baby's growth and this was performed on 26 [Month1]. There is no mention of the scan being ordered in the notes. The report stated that the baby was large for gestational age, with the AC close to the 95%ile on the ASUM chart. The liquor volume was normal. The estimated fetal weight (EFW) was 3.33kg, which the sonographer recommended be plotted on a customised growth chart, and that serial growth scans be performed. There is no mention of the result being seen in the LMC's notes. There is no record of any testing for glucose intolerance, and no customised growth chart.

[Ms A] was admitted to [the public hospital] in spontaneous labour at 41 weeks' gestation at 9.40am on 7 [Month3]. She had been examined vaginally at home by her LMC at 7.30am and her cervix was said to have been 5cm dilated. Her LMC provided care during the day. At noon her cervix was found to be 7–8cms dilated, and at 4pm it was thought that there was only an anterior lip present. The baby's head was thought to be above the ischial spines, and possibly in an occipito-posterior position. At 7pm a further vaginal examination showed the cervix was only 7–8cm dilated, and the membranes were ruptured releasing meconium-stained liquor.

The duty obstetrician, [Dr C], was asked to review her and did so at 7.15pm. She noted there had been no progress since 4pm, and that the contractions were irregular. [Dr C] recommended that labour be augmented with Syntocinon and that progress should be reassessed after two hours. She also noted the baby was large.

The Syntocinon was commenced at 8pm. At 10pm the duty anaesthetist arrived to insert epidural analgesia, and so the Syntocinon was discontinued until about 10.30pm when it was restarted. At 10.55pm vaginal examination by the LMC showed there was still a lip of cervix persisting. At midnight [Dr C's] notes record the cervix was 7cm dilated with the anterior lip persisting. The management options were discussed with [Ms A] and caesarean section decided upon. The caesarean section was commenced at 0020hrs on 8 [Month3], with the delivery of a healthy boy weighing 4350g at 0022hrs. The baby's head was difficult to extract from the maternal pelvis, requiring pressure from below and 2 puffs of GTN. The operation was completed in the usual manner with no other problems being noted. A further dose of Syntometrine was given to achieve good uterine tone. The procedure was completed at 0049hrs, and [Ms A] left the operating theatre at 0054hrs.

The SHO's notes at 2am on 8 [Month3] record that the recovery nurses were concerned about [Ms A's] vaginal bleeding (PPH). A Syntocinon infusion was running, and two boluses of Syntometrine were given at 1.45am and 2.10am. Bimanual uterine compression was performed, fluid resuscitation commenced and the duty consultant ([Dr C]) summoned. Tranexamic acid was given, and a decision made to insert a Bakri balloon. Blood loss at this point was estimated as being 1.5–2 litres.

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[Ms A's] epidural was still working effectively. At 2.28am the uterine cavity was checked by [Dr C] and found to be intact with no placental tissue within it. A Bakri balloon was inserted and inflated. A Syntocinon infusion was continued, and vaginal packs inserted. Blood loss at this point was estimated to be 2–2.5 litres.

Despite the balloon, bleeding continued and at 3.15pm [Dr C] decided that she should take [Ms A] back to the operating theatre. The possibility of performing a hysterectomy to stop the bleeding was discussed with [Ms A]. Under general anaesthesia in the theatre [Ms A's] abdomen was re-opened. The uterus was atonic. The caesarean section incision in the uterus was re-opened, and large blood vessels in the placental bed were noted to be bleeding. These were oversewn with figure-of-eight sutures. The uterine wall was closed, and a Balogun-Lynch suture placed. Despite this [Ms A] continued to bleed heavily and so a Bakri balloon was placed to try to tamponade the uterine cavity and stop the bleeding.

Unfortunately this was not successful. [Dr E], another consultant obstetrician, was asked to attend and did so at 5.20am. Ligation of the uterine arteries was performed but the bleeding continued. [Dr C] and [Dr E] and [the anaesthetist] concluded that a hysterectomy was necessary to stop the bleeding. This was performed, and [Ms A] subsequently transferred to ICU at 5.35am. During her time in theatre [Ms A] had received 4 litres of blood, 6 doses of Syntometrine, two infusions of Syntocinon, three doses of Carboprost and 1mg of Misoprostol.

[Ms A] was reviewed at 9.20am on 8 [Month3] by the duty consultant obstetrician. The operation was explained to [Ms A], including the rationale for the hysterectomy. The notes record that [Ms A] was upset by the information but understood that the procedure was necessary to save her life.

After an uneventful day in ICU [Ms A] was transferred to the maternity ward at 7.30pm. When reviewed the next morning at 10am the notes record she didn't need any further re-cap, as she was still trying to get her head around the events. She felt tired and light-headed. Her haemoglobin was 62, so she was transfused two units of blood. She was reviewed by the duty consultant obstetrician, who recorded that [Ms A] seemed a bit down and noted a referral to the maternal mental health (MMH) services was required. On 10 [Month3] review by the duty consultant again noted that a MMH referral was required. At that time [Ms A] was not yet ready to discuss the events leading to her hysterectomy. The next day the duty consultant recorded a long discussion about the surgery was held with [Ms A]. [Ms A] asked if knowing about the size of her baby earlier, or augmenting labour earlier, would have changed the outcome. The consultant noted the baby weighed 4.9kg (in fact it was 4.35kg) and that the labour lasted about 22 hours, and that it was very difficult to say if anything would have altered the outcome. An appointment with the MMH team was arranged for the next day.

On 12 [Month3] [Ms A] was reviewed by [Dr E] and was recorded as having no further questions at that stage. She was keen to go home that day and was discharged with a

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plan for a review meeting in about 6 weeks. The MMH team were contacted to see if they could visit before she was discharged, but this does not appear to have happened.

My Assessment

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

1. Whether the care provided to [Ms A] during labour and delivery was appropriate. I think the care provided during labour and delivery to [Ms A] by her LMC and [the DHB] staff was appropriate. Assessment of fetal well-being was carried out, as were observations of [Ms A's] well-being and progress in labour. Her progress, as assessed by cervical dilatation, was within the normal range for a primigravida. When this changed (at 7pm) amniotomy was performed and consultation with the obstetric team undertaken.

[Dr C] was aware that [Ms A] had a large baby when she reviewed her. It was quite appropriate for labour to be augmented with Syntocinon at that point with a clear plan for timely review of progress. The slight delay between the 2 hours originally stipulated, and the assessment occurring after 3 hours would be quite acceptable and would not have altered the outcome. There is no good evidence to suggest that a policy of caesarean section, rather than augmentation, would have led to a better outcome for [Ms A].

2. Whether the care provided to [Ms A] post-operatively including the identification, management and treatment of her post-partum haemorrhage was appropriate.

I think the management of [Ms A] after her caesarean section was also appropriate. Once it was recognised that she was having a PPH help was sought, resuscitation commenced and the usual pharmacological agents employed to try to stop it. Additionally Tranexamic Acid was used, along with mechanical compression of the uterus. The use of a Bakri balloon is well established for the management of atonic PPH, and this was also adopted quite rapidly.

When it became apparent that the situation was not under control further consultant assistance was summoned. The only other surgical option before hysterectomy is undertaken (in this situation) is ligation of the internal iliac arteries. Although described in many textbooks I have never performed it, nor do I know any consultant obstetricians who have. The difficult decision to proceed to hysterectomy was reached by two obstetric consultants together, with support from their anaesthetic colleague. This was good practice.

Arrangements were made for [Ms A] to be seen by the MMH team (although I cannot tell if the review occurred) and also to be seen some weeks later to go through events and have her questions answered. This is standard practice and is to be commended.

…

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

Yours sincerely,

Dr Ian Page MB BS, FRCOG, FRANZCOG
Consultant Obstetrician & Gynaecologist
Whangarei Hospital

References

1. Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines), Ministry of Health, 2012"

The following further advice was received from Dr Page on 22 February 2021:

"Thank you for sending [Dr G's] report for ACC for consideration. He and I are agreed that the care provided by [DHB] staff was appropriate. Our point of difference is the management of labour by the LMC. I have followed the national maternity referral guidelines with regard to progress (as assessed by cervical dilatation), and they are in line with the NICE guidelines on the matter. They state that progress can be considered to be normal if the rate is at least 2cm in 4 hours. [Dr G] also refers to the referral guidelines on p4 of his report, but then refers to a different standard of 1cm/hour on p5 but does not provide a reference to support it.

Going by what the LMC found on examination there was no need for earlier referral or intervention. I do not think we can assume that the LMC's assessments of progress were incorrect, although that is always a possibility — particularly when looked at with hindsight.

I hope these comments are of use.

Best wishes

Ian Page."

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Appendix C: Summary of RM F's advice to ACC

In summary, RM F advised:

a) Despite the recommendation in the scan report on 26 Month1 to commence a growth chart, RM B did not plot the fetal growth following this scan. A customised growth chart would have informed both RM B and Ms A of the significance of the size of the fetus in relation to Ms A's maternal factors (ethnicity, height, and weight) and as this was not completed, they were both making uninformed decisions.

b) There is no contemporaneous documentation on the discussion of the findings in the scan report on 26 Month1, or the agreed next steps or any acknowledgment of a macrosomic fetus and the implications for intrapartum care and outcomes.

c) "The findings of a macrosomic fetus should have alerted [RM B] to the increased likelihood of an obstructed labour. This should have informed discussions, decisions and care provision during both the antenatal and intrapartum periods, including an earlier referral to seek obstetric advice."

d) There is a lack of contemporaneous documentation during labour in relation to palpation of the fetus, review of fetal weight, position or descent (antenatally and during labour), and the lack of fetal descent during labour.

e) Overall RM B's antenatal care following the clinical findings on 26 Month1 and during labour was not reasonable or appropriate.

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Appendix D: Summary of Dr G's advice to ACC

In summary, Dr G, obstetrician and gynaecologist, advised:

a) Ms A's large baby was identified in the 35-week growth scan.

b) In regard to the weight range of Ms A's baby, there are no established guidelines or evidence to suggest that earlier intervention is effective in improving obstetric outcomes.

c) It was reasonable to allow Ms A to labour spontaneously at 41 weeks' gestation.

d) With regard to the labour, Dr G noted that Ms A was 7cm dilated for 12 hours and had an obstructed labour with a prolonged first stage. Dr G advised that Ms A's obstructed labour was neither recognised nor managed adequately by RM B.

e) Syntocinon was indicated at 2.00pm (5 hours earlier) and an emergency Caesarean would have been performed at 4.00–5.00pm (7 hours earlier) and if the delivery had been expedited in this way, a peri-partum hysterectomy may have been avoided.

f) Ms A suffered a major post-partum haemorrhage. Dr G considers that the post-partum haemorrhage was managed competently and that the hysterectomy performed was a lifesaving procedure.

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Appendix E: RANZCOG guideline

RANZCOG's *Induction of Labour in New Zealand: A clinical practice guideline (2019)* states:

> "Good Practice Points:
>
> …
>
> For women with suspected macrosomia, in the absence of pregnancy complications, consider expectant management."

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Appendix F: Ministry of Health guidelines

The Ministry of Health's *Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines)* (2012) state that the guidelines previously appended to Section 88 of the Maternity Services Notice 2002 are to be used in conjunction with the Primary Maternity Services Notice 2007.

The *Referral Guidelines* p 25 Code 4013 state: "Large for gestational age [condition] Birthweight > 97th percentile on customised growth chart [description] Consultation [referral category]."

Consultation [Referral Category] p 3 states:

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

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