HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

A Decision by the Deputy Health and Disability Commissioner

(Case 23HDC00977)

Introduction

1. This report 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. The report discusses the care provided to Mrs A by Health New Zealand | Te Whatu Ora Whanganui[1] (Health NZ Whanganui) and registered midwife (RM) B.

3. On 22 April 2022 Mrs A went into labour and was admitted to the maternity unit at a public hospital. Mrs A's care was handed over to locum community midwife[2] RM B. During the active stage of labour, Mrs A found that her pain relief was not being managed effectively. Postnatally, Mrs A experienced bleeding caused by retained placental tissue, which required surgical removal.

4. On 14 April 2023 Mrs A complained to HDC about the care Health NZ Whanganui and RM B provided to her in April 2022 when she was admitted to the maternity unit. Mrs A's complaint relates to the handover of her care to RM B, the management of her pain during labour, inadequate documentation, and inadequate escalation of her care to senior staff.

5. The following issues were identified for investigation:

- *Whether [Health NZ Whanganui] provided [Mrs A] with an appropriate standard of care in April 2022*
- *Whether [RM B] provided [Mrs A] with an appropriate standard of care in April 2022*

Information gathered during investigation

Summary of care provided

6. At 11.30am on 22 April 2022 Mrs A was admitted to the labour and delivery unit at a public hospital. Due to an unexpected shortage of staff on the maternity ward, a call-out to locum community lead maternity carers (LMCs) was made for an LMC to assist Mrs A during her labour and birth. At 2.10pm Mrs A's care was handed over to RM B.

[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 Health New Zealand | Te Whatu Ora.
[2] Locum midwives are midwives who provide cover for other midwives, and cover in emergency situations.

7. From approximately 2.30–3.30pm, Mrs A used Entonox[3] for pain relief. Mrs A also used the birthing pool to manage her pain. Mrs A became increasingly distressed and requested an epidural.[4] At approximately 3.30pm, RM B asked the obstetrician for an epidural for Mrs A, which was placed by an anaesthetist at 4.30pm. Mrs A was given a patient-controlled epidural analgesia pump[5] (PCEA), which enabled her to control the level of anaesthesia from the epidural.

8. At approximately 9.15pm, the epidural pump was stopped to encourage Mrs A to push. Entonox was also stopped. RM B documented that Mrs A expressed concerns that her contractions were becoming more painful and that she felt she was unable to push. At approximately 9.33pm, the epidural was re-commenced at Mrs A's request. RM B encouraged Mrs A to continue to push. However, Mrs A did not feel able to push as she was in pain, and Entonox was commenced again at her request.

9. At approximately 10.20pm, RM B consulted the obstetrician over the phone at Mrs A's request. The obstetrician recommended that Mrs A continue trying to push for another hour. Mrs A requested further pain relief as she found it difficult to push and to manage her pain. At 10.50pm, RM B asked the obstetrician to attend and review Mrs A as she had become very distressed. While waiting for the obstetrician to attend, Mrs A was using Entonox and the PCEA for pain relief. RM B documented that the PCEA did not appear to be working.

10. At 11.59pm, the obstetrician arrived to review Mrs A. An attempt was made to deliver the baby with forceps, but Mrs A was unable to tolerate the pain. The obstetrician noted that the epidural was no longer in situ. Mrs A requested that the epidural be re-sited before continuing with the assisted delivery, and the anaesthetist was contacted to re-site the epidural. The obstetrician proceeded with delivery of the baby with the assistance of forceps. At 12.32am, Mrs A's baby was born in good condition.

11. At approximately 12.39am, the placenta was delivered. In the days following Mrs A's labour and delivery, she experienced postpartum haemorrhage (PPH)[6] and pain. It was identified that Mrs A's PPH and pain symptoms were caused by retained placental tissue. On 27 April 2022 Mrs A was taken to theatre for an evacuation of the retained placental tissue.

12. Health NZ Whanganui undertook a Maternal Morbidity Review in relation to the 3rd degree perineal tear[7] and postpartum haemorrhage (PPH) Mrs A experienced. The review found that Mrs A experienced heavy PPH due to retained placental tissue. The review noted that

[3] Entonox is a gas mixture of nitrous oxide and oxygen that is used for pain relief during labour. It is inhaled via a face mask during a contraction.

[4] Epidurals are used mainly in a main maternity hospital as they require insertion by an anaesthetist. A small plastic tube is inserted into the lower back under local anaesthetic. Pain-relief medication is injected into this tube during labour.

[5] Patient Controlled Epidural Analgesia (PCEA) enables the patient to self-administer a 'top-up' bolus of a predetermined amount of epidural infusion solution whilst their infusion continues at the prescribed rate.

[6] PPH is defined as blood loss greater than 500ml and continuing.

[7] A third-degree tear involves the vaginal tissues, perineal skin, and perineal muscles that extend into the anal sphincter.

the placenta and membranes were documented as 'complete' but that it had an 'odd shape'. It is unclear whether or when information regarding the appearance of the placenta was passed on to staff/the O&G team by RM B, and whether a second opinion was sought at the time of placenta/membranes checking in view of its unusual shape.

13. A treatment injury claim for Mrs A was accepted by the Accident Compensation Corporation (ACC) for 'secondary postpartum haemorrhage requiring surgery and blood transfusion'. To assess this claim, ACC obtained independent advice from a registered midwife, who identified concerns relating to the documentation of the placenta, and whether the odd shape of the placenta and membranes was communicated to other staff involved in Mrs A's care. The independent advice also noted that the staff caring for Mrs A in the subsequent four days following her labour and delivery did not review the summary to check for the integrity of the placenta in light of the presentation of Mrs A's symptoms.

Summary of concerns

Epidural management

14. Mrs A told HDC that she is concerned that RM B did not hold an epidural qualification or follow Health NZ Whanganui protocols for epidural care. Mrs A said that RM B did not undertake any of the routine checks, failed to insert an indwelling catheter,[8] and failed to recognise that the epidural catheter had become dislodged.

15. RM B told HDC that at the time of the events, she was not epidural certified. RM B said that in circumstances where a midwife is not epidural certified, it is usual practice and a common arrangement at the public hospital for the core staff to be responsible for the epidural. RM B stated that she informed core staff in the midwifery office that she was not epidural certified and would be unable to provide epidural cares for Mrs A.

16. In response to the provisional decision, Health NZ Whanganui told HDC that it refutes RM B's statement that it is 'usual practice and a common arrangement in [the public hospital] for the core staff to be responsible for the epidural'. Health NZ Whanganui told HDC that this statement is incorrect and that this practice approach is not supported, encouraged, or taught at the hospital. It is deemed unsafe to fragment or portion out a labouring woman's care as it increases the risks of missed care episodes, adverse outcomes, and poor patient satisfaction.

17. RM B documented in the clinical notes: '… epidural okay'd … core staff advised. Core midwife [RM C] to support with epidural cares.' RM B said that she was reassured that an epidural-certified midwife would manage the epidural care. RM B assumed that core staff who were epidural certified and accepted to manage the epidural care would have initiated any checks related to the epidural. During the second stage of labour, RM B considered that Mrs A's back pain was likely due to the position of the baby. RM B said she explained to Mrs A that sometimes the epidural is not able to remove all or some of the back pain during the second stage of labour. RM B told HDC that at the time, she was unsure whether Mrs A's pain and discomfort were due to the low position of the baby or whether the epidural was no longer

[8] A flexible tube inserted into the bladder to drain urine from the body.

effective. RM B said that since becoming epidural certified, she would now consult with the anaesthetist to review the woman.

18. RM B said that she did identify that the epidural catheter may have become dislodged, and she recorded this in the clinical notes. RM B documented (during the second stage of labour): 'Epidural [site] checked? not in properly …' In her response to HDC, RM B advised that one of the core midwives who was epidural certified checked the epidural site at her request. The epidural site did not appear to be dislodged as there was no significant pooling in the dressing. However, RM B documented that when Mrs A attempted to use the PCEA for pain relief, it '[did not] appear to be working. ?no longer in situ …'. RM B's documentation queried whether the catheter had dislodged, as Mrs A did not appear to be receiving any pain relief through the PCEA pump.

19. RM B told HDC:

> 'I consider that I worked within my scope of practice and did not at any time manage the epidural … I consulted accordingly when things became more complex, however, I also feel I was not supported as it would have been expected as a new graduate midwife in this space despite my multiple attempts at seeking support and guidance from a senior care midwife during this labour and birth.'

20. In Health NZ Whanganui's response to Mrs A's complaint, it outlined that an internal review of Mrs A's health record indicated the following:

> '[T]here were significant gaps in care and monitoring whilst you had an epidural in situ. Block levels (dermatomes) as well as your basic observations; blood pressure, pulse respiratory rate and pain score were not well recorded hourly. Insertion of an indwelling catheter should have occurred for fluid balance monitoring as you were unable to mobilise to the toilet. Additionally, hourly position change should have been the opportunity to check the epidural dressing and site.'

21. Health NZ Whanganui's response to Mrs A also stated: 'She [RM B] understands that as soon as she was aware of your epidural request, she should have discussed options regarding on going care with the shift coordinator.'

22. In response to the provisional decision, Health NZ Whanganui stated that when RM B received Mrs A's request for an epidural, the practice was for the LMC to inform the woman that she was not certified to provide this care and to hand over the woman's care to core midwifery staff. At this point, the shift coordinator would have been contacted and arrangements made for another on-call midwife to come in. Health NZ outlined that the Regional Analgesia and Anaesthesia for Labour and Birth: Lead Maternity Care (LMC) guidelines state:

> 'LMC midwives who choose not to be epidural certified must notify maternity services when applying for their access agreement and also inform their women/people at booking of any intention to hand over should the woman/person require an epidural …'

23. RM B's response and documentation indicates that she had informed core staff that she was not epidural certified. However, this information was not relayed to Mrs A by midwifery staff.

Retained placenta

24. Mrs A told HDC that she is concerned that RM B failed to advise senior staff about the odd appearance of the placenta. Mrs A said that had this information been passed on to staff, her postpartum bleeding could have been managed differently.

25. RM B stated that the placenta appeared complete, but she noted the odd shape in her documentation. On the 'labour and birth summary', RM B circled 'complete' for the placenta and wrote that it had an 'odd shape'. RM B also drew a diagram of the odd shape.

26. RM B advised that when she handed Mrs A's care back to the core staff, she asked a senior midwife to look at the placenta to understand her concerns about its shape. However, RM B said: '[T]he request was declined, and they suggested they would monitor for bleeding as they would with any postnatal mother on the ward …'

27. RM B told HDC that despite the odd appearance of the placenta, any blood loss that was outside of normal should have been managed with the appropriate pathway. While RM B acknowledged that retained placental tissue found, she said that this was not obvious on inspection of the placenta post birth, 'due to [the] abnormal shape of the placenta'.

Handover of care to RM B

28. Mrs A told HDC that she did not choose RM B on an informed basis and feels that she did not have a choice. Mrs A said that she was unaware that RM B was a new graduate midwife. Mrs A expected that her labour and birth care would be provided by core staff.

29. Health NZ Whanganui's direct response to Mrs A's complaint noted that Mrs A was the third patient to present to the maternity unit. At the time, the acuity on the maternity unit was high, as there was a complex case that required a higher intensity of care than normal. As such, there was a shortage of staff. To ensure that the maternity unit would be able to provide Mrs A with a level of continuity and consistency of care, the Clinical Midwife Manager (CMM) sought assistance from all local LMCs. Health NZ said that this was not unusual practice, but it should have been a collaborative and inclusive process to enable full knowledge and informed consent.

30. RM B told HDC that at the time of Mrs A's admission she was a new graduate midwife and had had a few months in practice. RM B said that she agreed to be contracted by Health NZ Whanganui to assist Mrs A. RM B agreed to provide care under the agreement that the woman was established in her labour and consented to her providing care, being a new graduate. RM B told HDC: 'I subsequently discussed and confirmed the consent with [Mrs A] and also discussed my new graduate status with [Mrs A] during the first stage of her labour.'

31. The clinical notes contain no documentation by core staff or RM B regarding any discussions with Mrs A regarding the handover of her care to RM B.

Management of care during second stage of labour

32. Mrs A told HDC that she did not have any problems with the care provided during the first stage of labour. However, in the second stage of labour, she started to feel a significant amount of pain. Mrs A said that she was repeatedly told by RM B that the pain was due to the position of the baby. Mrs A alleged that RM B disconnected the Entonox as RM B considered that it was interfering with her ability to push. Mrs A felt that RM B was fixated on her pushing out the baby. Mrs A told HDC that she made multiple requests for pain relief medication and a review of her pain by the obstetrician and anaesthetist, but this was declined by RM B.

33. Health NZ Whanganui told HDC that there is no documentation in Mrs A's clinical records to indicate whether RM B sought advice or consulted with a senior member of the core midwifery team on duty regarding pain management for Mrs A.

34. RM B told HDC that she did not physically disconnect the Entonox. However, she said that she suggested to the core midwife that Entonox be discontinued to allow Mrs A to push more effectively.

35. RM B told HDC that she left the room on multiple occasions to request additional support when Mrs A became more distressed, but on two occasions she was told, '[S]he just needs to push her baby out.' RM B said that no further guidance or support was provided, nor was there any review of Mrs A's epidural, and no suggestion was made regarding Mrs A's pain relief. RM B stated that due to her inexperience at the time, she thought that this must be a normal response. She acknowledged that in hindsight, informing Mrs A of her efforts to communicate with staff would have assisted Mrs A to understand the situation better.

36. There is no documentation of RM B's discussions with the senior midwife regarding the management of Mrs A's pain relief during the second stage of labour. There is also no documentation by the senior midwife of any advice or guidance provided to RM B.

Lithotomy position during second stage of labour

37. Mrs A told HDC that that her legs were placed in the 'lithotomy position and held down by [RM B] and the other core midwife against [her] will'. Mrs A alleged that RM B and the core midwife 'kept physically "man-handling" [her] legs back into the position they felt [she] needed to be in'. Mrs A said that she kept pulling her legs down from the stirrups as they were too high for her and caused her lower back to lift off the bed, which increased her discomfort. Mrs A is concerned that there is no documentation that she was placed in the lithotomy position.

38. RM B told HDC that she and the core midwife suggested multiple changes to Mrs A's legs and position, to help her with pushing and to optimise her pelvis. This included using the foot supports, placing Mrs A's feet on their hips, and, on one occasion, attempting the lithotomy position. RM B said that they attempted to place one leg up, but Mrs A was distressed and found it uncomfortable, so they removed her leg from this position and placed it down, as they had at any stage when Mrs A became uncomfortable or unhappy with the supported leg position.

39. RM B denied that she and the core midwife were 'man-handling' Mrs A. RM B stated: 'I recall we were speaking at all times with [Mrs A] about the proposed manoeuvres and she appeared to work with us without objection or questions.'

Responses to provisional opinion

Health NZ Whanganui

40. Health NZ Whanganui responded to the provisional decision. Health NZ Whanganui's comments have been incorporated above.

RM B

41. RM B advised that she accepted the provisional findings.

Mrs A

42. Mrs A was given an opportunity to respond to the information gathered during the investigation part of the provisional decision. She advised that she remains concerned about RM B's practice and whether she is practising safe midwifery care. Mrs A stated that there is a lack of accountability by RM B and the midwives involved in her care.

43. Mrs A considers that assistance should have been provided by more senior midwifery staff. She remains of the opinion that RM B failed to escalate her care in a timely manner, and that RM B did not take appropriate steps to ensure that her epidural was being managed adequately.

44. Mrs A also stated that RM B's documentation does not accurately reflect the events that occurred during her labour and delivery.

Relevant standards

45. The Whanganui District Health Board 'Pain Management Options in Labour guidelines' (dated 12 December 2019) state:

> '… The care of labouring women with epidural analgesia and the administration of an epidural infusion can only be performed by a registered midwife who has current WDHB epidural analgesia certification …'

46. The Regional Analgesia and Anaesthesia for Labour and Birth Workbook for Midwives for Central Region (updated May 2020) states:

- 'For the region of … only Midwives who are epidural certified may care for women/people receiving epidural analgesia.'
- 'Blood pressure, heart rate, respiratory rate, pain score and block height should be measured hourly and recorded on the epidural chart as well as the partogram …'
- 'Assess level of epidural block (dermatome) hourly — with ice.'
- 'If the woman has an epidural infusion running she will also require an IDC to avoid over-distension of the bladder due to reduced mobility and infrequent voiding …'

- 'The epidural catheter should be watched for migration by checking for movement of the depth markings, and the site should be checked for any leakage, redness or swelling …'

47. The Ministry of Health Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines) (February 2012) state:

- 'Transfer of clinical responsibility is a negotiated three-way process involving the woman, her Lead Maternity Carer and the practitioner to whom clinical responsibility is to be transferred …'
- 'Communication between all practitioners involved with the woman will include her, and will be open, clear, timely and appropriately documented …'
- 'Practitioners are responsible for appropriately documenting their decisions, including any variation from the Referral Guidelines or other guidelines, and the circumstances of any such variation …'

Opinion: Health New Zealand Whanganui — breach

Introduction

48. Under Right 4(2)[9] of the Code of Health and Disability Services Consumers' Right (the Code), Health NZ Whanganui had a duty to ensure that the services Mrs A received at the public hospital complied with legal, professional, ethical, and other relevant standards, and to ensure that its staff were similarly compliant. This included the care provided by RM B and the core midwives who were employees of Health NZ Whanganui at the time of the events.

49. Under Right 6(1)[10] of the Code, Health NZ Whanganui also had a duty of care to ensure that Mrs A was adequately informed about the circumstances of the transfer of her care to RM B, and the management of her epidural.

50. Having carefully considered the information gathered, I conclude that the issues raised by Mrs A are attributable to Health NZ Whanganui at an organisational level, and I find Health NZ Whanganui in breach of Right 4(2) and Right 6(1) of the Code. The reasons for this decision are set out below.

Epidural care and monitoring — breach

51. I acknowledge that the maternity unit at the public hospital was short staffed on 22 April 2022 when Mrs A was admitted to the labour and delivery unit, and that the core midwifery team wanted to provide Mrs A with a level of continuity and consistency of care throughout her labour and birth experience. I accept that there was an expectation that Mrs A's epidural would be managed and monitored by an epidural-certified midwife. However, this did not eventuate because of the acuity of the birthing unit. I am critical that the epidural care

[9] Right 4(2) states: 'Every consumer has the right to have services provided that comply with legal, professional, ethical and other relevant standards.'

[10] 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 …'

provided to Mrs A by Health NZ Whanganui was contrary to the relevant guidelines and therefore did not meet the expected standard.

52. The 'Whanganui District Health Board Guideline — Pain Management Options in Labour' and the 'Regional Analgesia and Anaesthesia for Labour and Birth: Workbook for Midwives for Central Region' both outline that for the region, only midwives who are epidural certified may care for women/people receiving epidural analgesia. Based on these guidelines, RM B was not certified to provide epidural care for Mrs A. Health NZ Whanganui's response to Mrs A's complaint states that RM B ought to have discussed options regarding ongoing care with the shift coordinator when Mrs A requested an epidural. RM B's response and documentation indicate that at the very least, she had informed core midwifery staff that she was not epidural certified and therefore would be unable to provide epidural care for Mrs A. RM B told HDC: '[It] is quite common in … for uncertified midwives to provide care whilst core staff manage the epidural, and this is done on an agreed individual midwife–midwife basis.' The documentation indicates that core midwife RM C agreed to provide support with the epidural care, but it is otherwise unclear how this arrangement would work whilst RM B was the LMC supporting Mrs A.

53. In its response to HDC, Health NZ Whanganui refuted RM B's statement about the arrangement in place for 'non-certified' midwives. Health NZ Whanganui advised that the practice was for the LMC to inform the woman that she was not certified to provide epidural care and to hand over the woman's maternity care to core midwifery staff, and the shift coordinator would contact an on-call core midwife to come in. However, as noted above, that did not occur on this occasion, and no arrangements were made by core midwifery staff to hand over Mrs A's maternity care to another midwife who was epidural certified.

54. The Ministry of Health 'Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines)' outline that when there is a transfer of clinical responsibility, this is to be a negotiated three-way process involving the woman, her LMC, and the practitioner to whom clinical responsibility is to be transferred. Communication between all practitioners involved with the woman will include the woman, and it will be open, clear, timely, and documented appropriately. Mrs A's complaint and the lack of documentation of such discussions indicate that this did not occur. I am critical that there was no clear discussion with Mrs A that RM B was not epidural certified, and that her epidural management and monitoring would be undertaken by one of the core midwives.

55. The 'Regional Analgesia and Anaesthesia for Labour and Birth: Workbook for Midwives for Central Region' (updated May 2020) outlines the expected management and monitoring of an epidural, which includes recording basic observations,[11] assessment of pain scores and dermatomes, and checking of the epidural dressing and site. Health NZ Whanganui's response to Mrs A outlined that a review of the health records indicates that this expected management and monitoring did not occur. In addition, there is inadequate documentation of the epidural care provided. The guidelines outline that the epidural-certified midwife

[11] Basic observations include blood pressure, pulse, respiratory rate.

(who is providing epidural care) is expected to manage, monitor, and document the epidural care provided.

56. I consider this to be a failure of Health NZ Whanganui's systems. Health NZ Whanganui said that at the time of this event, there was no 'arrangement' in place for 'non-certified' midwifes, and in practice the maternity unit did not have in place a formal process or guideline that set out the respective responsibilities of both the epidural-certified core midwife and the midwife who was not epidural certified to ensure that there was continuous oversight and appropriate monitoring of the epidural and to ensure that it was working effectively for the woman throughout her labour and birth experience.

Conclusion

57. While I acknowledge that individual midwives were involved in the provision of care to Mrs A over the course of her labour and birth experience, in my opinion Health NZ Whanganui was responsible for ensuring that an epidural-certified midwife was available to provide Mrs A's epidural cares. Because this did not happen, Mrs A's care was not provided in accordance with the relevant epidural guidelines. This meant that Mrs A's epidural was not monitored appropriately, and she was subject to unnecessary pain, which had a significant impact on her birth experience. Accordingly, I find that Health NZ Whanganui failed to provide services that complied with relevant guidelines and therefore breached Right 4(2) of the Code.

Lack of informed consent — breach

58. Health NZ Whanganui acknowledged that Mrs A was not informed that her care would be handed over to an LMC who was a new graduate midwife and who was not epidural certified. Health NZ Whanganui advised that there should have been a three-way discussion between the core midwives, the LMC, and Mrs A regarding the handover of Mrs A's care. In addition, these conversations and their outcomes should have been documented in the clinical records clearly, which in Mrs A's case did not occur. I note that this is contrary to the 'Ministry of Health: Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines)'.

59. Health NZ Whanganui advised that the 'Regional Analgesia and Anaesthesia for Labour and Birth: Lead Maternity Care (LMC)' guideline advises that 'midwives who choose not to be certified must notify maternity services when applying for their access agreement and also inform their women/people at booking of any intention to hand over should the woman/patient require an epidural'. I acknowledge that the guideline states that it is the responsibility of the LMC to inform the patient that they are not epidural certified. However, taking into account that RM B was not the LMC throughout Mrs A's pregnancy, there was a shortage of core midwifery staff on the ward, and RM B had informed core staff of her lack of epidural certification, I consider it reasonable to expect that Health NZ Whanganui would have informed Mrs A of this in these particular circumstances.

60. It is clear from the information gathered that Mrs A was not informed that the oversight and management of her epidural would be provided by one of the core midwives, and not by RM B. Mrs A's complaint indicates that she was not informed that RM B was not epidural certified. RM B told HDC that she does not recall that either she or the core midwives informed Mrs A of the respective separate roles they would take in relation to the

management of her epidural. I further note that there is no documentation of any discussions with Mrs A about the oversight and monitoring of her epidural by the core midwives.

Conclusion

61. Under Right 6(1) of the Code, Health NZ Whanganui had a duty to ensure that consumers receiving services at its hospital were provided with the information they needed to make informed choices about their care. I consider that information relating to RM B taking over Mrs A's care, including that she was a graduate midwife and was not epidural certified, and that the management of the epidural care would need to be by a different midwife, was information that a reasonable consumer in Mrs A's circumstances needed to make an informed choice about her care.

62. An epidural is not an uncommon choice for women in labour, and, in my view, Mrs A should have been made aware from the outset that if she chose to have an epidural, this part of her care could not be managed by her proposed lead maternity carer. In failing to ensure that Mrs A was provided with this information, I find that Health NZ Whanganui did not provide her with the information that a reasonable consumer in Mrs A's circumstances would expect to receive, and, accordingly, that Health NZ Whanganui breached Right 6(1) of the Code.

Other comment

Retained placenta and PPH

63. The Maternal Morbidity review undertaken by Health NZ Whanganui found that it is unclear whether or when information regarding the odd appearance of the placenta and membranes was communicated to the core staff/obstetrics and gynaecology (O&G) team by RM B, and whether a second opinion was sought at the time of the placenta/membranes checking in view of its unusual shape.

64. RM B told HDC that the placenta and membranes appeared complete but had an odd shape. She said that she sought a second opinion from a senior midwife, but her request for a review of the placenta was declined. She was advised that any PPH would be managed as per the usual process. However, RM B did not document these discussions.

65. There is no documentation in the clinical records to indicate whether staff who managed Mrs A's PPH in the days after her labour and delivery checked the information RM B had documented about the placenta in the Labour and Birth summary.

66. Based on the information gathered, I am unable to make a finding on whether or not core midwifery staff were made aware of RM B's concerns about the odd appearance of the placenta. I am also unable to make a finding on whether staff were made aware of, but failed to act on, RM B's concerns about the appearance of the placenta.

67. While I acknowledge that there could have been earlier identification of the retained placental tissue and therefore earlier intervention to resolve the PPH, the clinical records indicate that the postnatal management of Mrs A's PPH was in line with the 'Whanganui District Health Board Management of Postpartum Haemorrhage Guideline (2021)'.

Lithotomy position

68. Mrs A alleged that RM B and the core midwife forcibly held down her legs in the lithotomy position against her will during the second stage of labour. Mrs A told HDC that the stirrups were too high for her, which caused more pain and discomfort.

69. RM B told HDC that she and the core midwife suggested multiple changes to Mrs A's legs and position to assist her with pushing and optimising her pelvis. This included attempts at placing Mrs A in the lithotomy position. RM B said that at any stage when Mrs A became distressed or uncomfortable, her legs were placed down. RM B recalls that she and the core midwife always spoke with Mrs A about proposed manoeuvres.

70. While I do not wish to mitigate Mrs A's recollection of the event and her reported discomfort, I am unable to resolve her concern that she was 'man-handled into the lithotomy position'. I am unable to determine specifically the communication that occurred between Mrs A and RM B and the core midwife. However, if excessive force was used when moving Mrs A's legs into different positions to assist her labour, this would have been inappropriate given the significant distress and pain Mrs A had been experiencing throughout the active stages of labour.

Opinion: RM B — adverse comment

71. I acknowledge that at the time of the events, RM B was a new graduate midwife. RM B told HDC, and documented in the clinical notes, that she had informed core midwifery staff that she was not epidural certified. It is apparent from the information obtained that as a new graduate midwife, RM B did not receive adequate support from Health NZ Whanganui, which in turn affected the care provided to Mrs A.

Documentation

72. I am concerned that RM B did not document key discussions with core midwifery staff when she sought advice and guidance regarding Mrs A's epidural, pain management, and the odd appearance of the placenta.

73. RM B told HDC that she sought advice and guidance from a senior midwife regarding Mrs A's pain and discomfort on at least two occasions. RM B said that she was told: '[S]he just needs to push her baby out.' She stated that no further guidance or suggestions were provided by the senior midwife, and there was no review of the epidural. RM B said that due to her inexperience, she thought that this was the 'normal response'. RM B did not document any of her discussions with senior staff when she sought advice and guidance on Mrs A's pain management.

74. RM B also told HDC that when she handed Mrs A's care back to one of the core senior midwives following the birth of the baby, she requested that the midwife look at the placenta to understand her concerns regarding its odd shape. However, RM B said that her request was declined, with the senior midwife advising that any PPH would be managed as per usual for all women who experience PPH. RM B documented that the placenta appeared complete and that it had an odd shape. However, RM B did not document her discussions with the senior midwife regarding the odd shape of the placenta.

75. Due to the lack of documentation, I am unable to assess adequately what communications occurred between RM B and the core staff on the unit. However, I remain critical of RM B's documentation. RM B should have ensured that all discussions pertaining to Mrs A's care were documented in the clinical records.

Changes made since events

Health NZ Whanganui

- LMCs are offered education for initial epidural certification and for ongoing recertification.
- A Midwife Clinical Coach was appointed to offer clinical and pastoral support to any new graduate midwives.
- When variance response management responsibilities necessitate the Midwifery Manager to request an LMC(s) to take over the care and responsibility of a woman booked under the unit, she will ensure that a three-way conversation occurs between core midwives, LMCs, and the woman, and that these conversations and their outcomes are documented clearly in the woman's health record.
- A list of current epidural-certified midwives is now attached to the epidural trolley for anaesthetists and midwives to check who is credentialled.
- The Midwife Manager will ascertain an LMC's epidural certification status prior to commencing discussions regarding taking over care of unit clients.

RM B

76. RM B told HDC:

> 'I apologise to [Mrs A] that she had a negative experience and for any role I had in that. This was never my intention. Every mother deserves to feel safe and cared for and most certainly does not deserve to feel negatively about her labour and birth.'

77. RM B also advised:

> 'I have carried out considerable reflection of this labour and birth. I identified gaps in my knowledge and considered how to better prepare myself for situations that can arise like this and how I manage this now. As a result, I am now epidural certified and more confident and assertive asking senior colleagues for help.'

78. The Midwifery Council undertook a competence review of RM B's practice in light of Mrs A's complaint. The Midwifery Council stated:

> 'The Council discussed the support available to [RM B] from her colleagues and [the public hospital's] obligation to support new graduates … the consequences of staff shortages and the incident that occurred in [RM B's] first year of practice. The Council considered that it seems [the public hospital] let [RM B] down …

> [T]he Council identified that there were opportunities for education … As a result, the Council has requested that [RM B] engages in a competence programme comprising of documentation and record keeping education …'

79. The Council advised HDC that RM B has since completed the requirements of the competence programme, and they are reassured by RM B's progress in her midwifery practice.

Recommendations

80. I recommend that Health NZ Whanganui:

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

b) Develop/implement a policy/documented process to guide midwives who are not epidural certified, on the expected management of an epidural, and the support they can expect to receive from an epidural-certified midwife on the maternity unit. Health NZ Whanganui is to provide HDC with a copy of the policy/process within three months of the date of this decision.

c) Provide a copy of the new protocol for Variance Response Management for the maternity unit when variance necessitates the Midwifery Manager to request an LMC(s) to manage the labour and birth of a woman booked under the unit. Health NZ Whanganui is to provide HDC with a copy of the protocol within three months of the date of this decision.

Follow-up actions

81. A copy of this report with details identifying the parties removed, except Health NZ Whanganui, will be sent to the Midwifery Council and Health NZ and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.