Midwife, RM C

Midwife, RM B

A Report by the

Deputy Health and Disability Commissioner

(Case 15HDC01534)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. Ms A was pregnant in 2013 and engaged registered midwife (RM) RM B as her LMC because RM B had attended the births of her previous children. However, following elective surgery, RM B handed over care of Ms A (at 37 weeks' gestation) to RM C. RM B told RM C that at Ms A's request she would be attending the birth as a support person only, although she hoped to be able to undertake postnatal visits. RM C saw Ms A twice antenatally following the handover of care.

2. At 8pm on 8 Month2[1], Ms A was admitted to a public hospital. Hospital records indicate that RM C arrived at 8.20pm. There is no record of RM B's arrival, which she says was at approximately 9.20pm. However, RM C said that RM B was already there when she arrived, and that she had provided initial midwifery care.

3. RM C had another client in labour during Ms A's delivery, and she was absent from Ms A's room for periods of time. The hospital staff were busy that night and unable to assist. Despite this, RM C did not arrange for a back-up midwife.

4. Throughout Ms A's labour, both RM C and RM B were involved in providing midwifery care to Ms A, although they disagree as to which midwife provided some aspects of the care, including the administration of drugs and vaginal examinations. Both midwives undertook observations, monitoring, and limited documentation throughout the labour.

5. CTG monitoring during Ms A's labour was inadequate, with no abdominal tocograph recorded to assist with assessment of fetal decelerations. When thin meconium-stained liquor was observed, RM C wanted to apply a fetal scalp electrode, but said that she was over-ruled by RM B. RM C considered that she was "not listened to" by either RM B or Ms A, because of their close personal relationship. RM B denied this and said that she was in a difficult situation owing to Ms A's increasing distress and RM C's absences from the room. RM B said that she was "forced to step in … and provide some limited midwifery care".

6. RM B suggested that Ms A be given a small dose of pethidine to assist with her distress. However, RM C disagreed and refused to administer it, saying that it was inappropriate because of the earlier presence of meconium in the liquor. RM B administered 25mg IV pethidine while RM C held Ms A still.

7. RM C documented that because the CTG monitoring was difficult to interpret, she made the decision to call for an obstetric review, but she did not document any reference to meconium or any concerns about the CTG, and there was no indication that the registrar was advised that there was any urgency or concern for the baby's well-being, and there was no paediatrician at the birth.

8. Baby A was born in poor condition with meconium aspiration and hypoxic ischaemic encephalopathy. His Apgar scores were 2 at one minute, 5 at five minutes and 6 at ten minutes. He was transferred to a neonatal unit in a main centre, and then to another hospital before being discharged home.

[1] Relevant months are referred to as Months 1 and 2.

Findings

9. RM C accepted the responsibility as LMC from RM B, and therefore held overall responsibility for the midwifery care provided to Ms A. The Deputy Commissioner found that RM C should have been more conscientious in her discussions with Ms A and RM B about her role as LMC, and should have ensured that both her role and RM B's role were clearly defined and documented appropriately. The Deputy Commissioner found that RM C failed to ensure adequate monitoring of Ms A and the fetal heart rate (FHR), and failed to recognise developing symptoms of fetal distress over a period of almost two hours. This failure resulted in RM C not requesting an earlier obstetric review or ensuring that there was paediatric support at the birth. Accordingly, RM C failed to provide services to Ms A with reasonable care and skill, in breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[2]

10. RM B handed over responsibility as LMC to RM C. The Deputy Commissioner considered that aspects of the transfer of care were not managed appropriately or, if they were, they were not documented clearly. The Deputy Commissioner found that RM B provided midwifery care to Ms A during labour, and that as a midwife RM B had a responsibility to advocate for adequate monitoring of the FHR and to recognise and respond to the developing symptoms of fetal distress. The failure to do so resulted in neither midwife requesting an earlier obstetric review or ensuring that there was paediatric support at the birth. Accordingly, RM B failed to provide services to Ms A with reasonable care and skill, in breach of Right 4(1) of the Code.

Recommendations

11. It was recommended that RM C and RM B provide a written apology to Ms A.

12. It was recommended that RM C and RM B complete a course in fetal surveillance.

13. It was recommended that the Midwifery Council of New Zealand (MCNZ) consider using this case to develop guidelines for midwives who wish to act as a support person for a woman in labour.

Complaint and investigation

14. The Midwifery Council of New Zealand referred a complaint to the Commissioner about the services provided by RM C, to Ms A. During the assessment of the care provided, the following issues were identified for investigation:

- *Whether RM C provided Ms A with an appropriate standard of care in 2013.*
- *Whether RM B provided Ms A with an appropriate standard of care in 2013.*

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

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

16. The parties directly involved in the investigation were:

Ms A	Consumer/complainant
RM B	Registered midwife/provider
RM C	Registered midwife/provider

Also mentioned in this report:

RM D	Midwife

17. Information from the Accident Compensation Corporation (ACC) was also reviewed.

18. Independent expert advice was obtained from a registered midwife, Ms Stephanie Vague **(Appendix A)**.

Information gathered during investigation

Background

19. Ms A, 38 years old at the time of these events, was pregnant. Before the pregnancy and birth that is the subject of this report, Ms A had one birth by Caesarean section, while her other babies were normal vaginal births. This pregnancy was without complication other than one admission at 37 weeks + 2 days' gestation for an investigation for proteinuria[3] and an irregular maternal heartbeat. Ms A's contractions commenced at 40 weeks' gestation and she was admitted to the public hospital. Following a four-hour labour, Baby A was born in a poor condition with severe meconium aspiration[4] and hypoxic ischaemic encephalopathy.[5] He was transferred to a neonatal unit in a main centre, and then to another hospital for extracorporeal membrane oxygenation[6] for eight days, before being discharged home.

Transfer of midwifery care

20. RM B and RM C are both independent registered midwives who, at the time of these events, were part of a midwifery practice. RM B had been the lead maternity carer (LMC) for Ms A's previous pregnancies, and Ms A engaged her again as LMC for this pregnancy. However, RM B underwent elective surgery, and when Ms A was 36 weeks' gestation, RM B transferred Ms A's care to RM C, and then attended the birth as a "support" person for Ms A.

21. The transfer of care or any discussions about it are not recorded in the clinical notes, and there are numerous factual discrepancies between the accounts of the two midwives, particularly in relation to the timing and other details of the transfer of care arrangements, as outlined below.

[3] Protein in the urine.
[4] Inhalation of amniotic fluid mixed with meconium (a baby's first stool), during or before delivery.
[5] Brain damage caused by oxygen deprivation. Hypoxic ischaemic encephalopathy can lead to severe developmental or cognitive delays, or motor impairments that become more apparent as the child continues to develop.
[6] Extracorporeal membrane oxygenation (ECMO) is treatment that uses a pump to circulate blood through an artificial lung back into the bloodstream. It provides enough oxygen to the baby while allowing time for the lungs or heart to rest or heal.

RM B

22. On 6 Month1, RM B had her final appointment with Ms A. RM B told HDC that she had discussed the transfer with RM C previously, and RM C had agreed to the transfer. RM B said that she considered that the transfer would take effect from 7 Month1 onwards. RM B introduced Ms A to RM C on 6 Month1, and said that she had no knowledge of any antenatal care given to Ms A after this date.

23. RM B said that she was aware that RM C did not formally register the transfer of LMC care, but that this "was not unusual in midwifery partnerships as we often give care to each other's clients when another midwife has time off".

24. RM B said she told Ms A that, as a result of her surgery, she (RM B) would not be able to provide any further antenatal or labour care, but that she hoped to undertake some of the postnatal visits. Ms A asked RM B to attend the delivery as a support person, and RM B said she agreed to do so because Ms A was a friend and she was aware that Ms A was feeling vulnerable as a result of family matters.

RM C

25. RM C disputes RM B's account of the handover of care arrangement. RM C stated:

> "Previously it has been implied that I was LMC for [Ms A] from 36 weeks and that all midwifery decisions from this point and during labour were my responsibility. This is not correct … [RM B] continued to be LMC throughout the pregnancy, labour and postnatally."

26. However, RM C also said:

> "[T]he LMC ([RM B]) had arranged with her client, [Ms A], that she ([RM B]) would be present at the birth for support. I understood the support role would be simply that."

27. In response to the provisional opinion, Ms A said that RM C told her: "I will be your midwife and be carrying out midwifery care until [RM B] is able to get back to work."

28. RM C said that she met with Ms A twice prior to Ms A going into labour. However, RM C said that she did not hold Ms A's notes, which were kept by RM B. RM C further said that RM B did not divert her telephone to her (which was RM B's usual practice unless RM C was overseas).

29. RM C told HDC that she did not see Ms A after 27 Month1 until called into the delivery suite by RM B.

30. Following Ms A's delivery, RM C invoiced RM B for two antenatal visits (dated 20 Month1 and 27 Month1) and for partial reimbursement of the delivery fee.

Commencement of labour

31. On the evening of 8 Month2, at 40 weeks' gestation, Ms A said that she and her husband decided to go to hospital after her contractions had commenced and had become too painful. Initially Ms A advised that she did not recall telephoning either midwife, but in response to the provisional opinion, Ms A said that they contacted RM C first and she advised them to go

to hospital, and said that she would meet them there. Ms A further stated that RM B did not assess her on the day of her labour.

32. RM B said that RM C telephoned her to say that Ms A was in labour and that she was going into hospital. However, RM C said that RM B telephoned her to advise that following a call from Ms A, who thought she was in labour, RM B had assessed her and made the decision to transfer Ms A from home to the public hospital. In contrast, RM B stated that she did not hear from either Ms A or RM C until Ms A was in the hospital.

33. RM C said that RM B asked her to telephone the delivery suite to advise that they were coming in, which she did at 7.33pm and again at 7.56pm. The hospital clinical notes confirm a call from "the LMC" (name not stated) at approximately 8pm.

34. RM C said that she tried to call back RM B on her home landline at 7.57pm and 7.58pm, but there was no response. RM C provided her telephone records, which corroborate these outgoing calls.

35. The admission record states that Ms A was admitted at approximately 8pm, already in labour. Her husband was with her. Ms A said: "[RM C] was there to meet us [at the hospital] and then my support person [RM B] … arrived later."

36. However, RM C stated that she arrived at the hospital at 8.20pm, and the hospital clinical notes state: "[RM C] back-up LMC arrived at approx[imately] 8.20pm to provide intrapartum care."

37. RM C noted retrospectively: "[W]hen I arrived, [RM B] had already put in a luer,[7] taken and sent bloods and administered Benzyl Penicillin IV[8]." However, RM C had documented in the clinical records at 8.30pm: "[P]lan to give Benzyl penicillin 2.4g as per new hospital protocol." The medication chart indicated RM B signed for the penicillin at 8.45pm. RM C said that at that point she did not realise that RM B had already administered the antibiotic, and that she should have corrected the entry in the clinical notes retrospectively.

38. RM B denied having inserted the luer, and said that it had been done prior to her arrival. She said that she arrived at the hospital at approximately 9.30pm, and that RM C had been in the delivery room for some time before she got there. Ms A also recalled RM B arriving after RM C and, in response to the provisional opinion, said that RM B did not insert a luer.

39. RM B said that she cannot explain the discrepancy between the time she thought she arrived and the time of signing for the drugs, but commented: "I believe I would have signed for the drug at [RM C's] request and/or because the labour was in such a chaotic state when I arrived at the hospital." In response to the provisional opinion, RM B said she thinks that the drugs were dispensed at 8.45pm, and that she signed for them retrospectively.

40. RM B stated that on arrival at the hospital she explained to the staff midwives that she was there as a support person, and not in the capacity of a midwife. She had her arm in a sling, and she said that she believed the staff understood her position.

[7] A device for administration of intravenous fluid.
[8] Ms A had tested positive for Group B streptococci and, as per the hospital policy, once labour was established she was offered appropriate intravenous antibiotics.

Labour and birth

41. Both RM C and RM B documented in Ms A's clinical notes during her labour.

42. At 8.30pm, RM C documented in the clinical notes that she had assessed Ms A and performed a vaginal examination (VE):

> "Cervix 3–4cm dilated, very favourable, soft, stretchy, [Cervix] fully effaced. Bulging forewaters felt and left intact."

43. The next entry in the clinical notes at 9.20pm states that 500ml of normal saline was administered. RM B signed for the saline, and RM C said that it was administered by RM B, and that it was something she would not have done, as her usual practice is to administer Plasmalyte 148[9] 1000ml for quick rehydration.

44. The clinical records note that at 9.45pm the fetal heart rate (FHR) was 130–145, and at 10pm the FHR was 150–165.

Commencing CTG without tocograph recording

45. 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 baby's heart rate in relation to the contractions, and is used to identify fetal distress.

46. Usually two abdominal belts are applied, with one holding an ultrasound transducer to pick up the baby's heartbeat and the other holding a pressure-sensitive transducer called a tocodynamometer (abdominal tocograph transducer), which measures the duration of the uterine contractions and the interval between them. In some circumstances, if the external monitoring of the heart rate is not proving reliable, the baby's heart rate may be recorded by placing a smaller lead from the CTG machine inside the woman's vagina to attach a fetal scalp electrode (FSE) to the baby's head.

47. At 10.25pm, RM B documented in the clinical notes:

> "FHR dropped to 80bpm during contractions, good recovery.
>
> CTG continuous
>
> VE by [RM C]
>
> [Cervix] 8cm dilated –1
>
> ARM[10] consent given
>
> ARM — meconium liquor — thin."

48. At this time the CTG was recommenced, but the abdominal tocograph transducer was not recording, and therefore there was no record of the uterine contractions. RM C said that as Ms A was on her hands and knees, the monitoring was difficult, and so the abdominal tocograph transducer was not attached.

[9] Plasmalyte 148 is a glucose infusion solution, administered intravenously, and is a source of water, electrolytes, and calories.
[10] Artificial rupture of membranes.

49. The clinical notes do not indicate a reason for the ARM, and in her complaint Ms A stated:

> "[RM C] broke my waters. I have no idea why [she] broke my waters other than to speed the labour up?
>
> …
>
> When she (RM C) saw meconium was in [the amniotic fluid] no call was made and it was pretty much brushed off as something that happens often and not to worry."

50. RM C denied that she performed the vaginal examination at this time, and stated that it was RM B who performed the vaginal examination and had the discussion with Ms A about an ARM. RM C stated that her usual practice is that if she conducts a vaginal examination she will write it up herself (as she did later in the labour). However, RM B denies that she performed the vaginal examination at this time, and documented that RM C had carried it out. In addition, in her response to the provisional decision Ms A said that the only time RM C did a vaginal examination was towards the end of the labour.

51. RM C advised that in her view, "thin meconium on its own would not have warranted assessment under Code 5018 Referral Guidelines". The Ministry of Health *Guidelines for Consultation with Obstetric and Related Medical Services* (*Referral Guidelines*, 2012) Code 5018 require that a midwife recommend a consultation with an obstetrician if there is moderate or thick meconium.

52. From time to time RM C left the room at the request of hospital staff to attend to another client. These absences from the room are not documented. RM C says that she was absent "only for short periods[11]"; however, RM B considers that RM C was gone for "an extended period", and that she became concerned that normal midwifery checks were not being done. Ms A said: "At one point [RM C] was gone for an hour."

53. Both midwives state that the hospital staff were busy that night. RM C told MCNZ that she and RM B discussed calling in a back-up midwife, but "the progress of [Ms A's] delivery did not give [them] time to arrange alternative cover".

54. Following the ARM, CTG monitoring was recommenced, but then discontinued at approximately 10.56pm when Ms A went to the toilet. Just before the CTG was stopped, there was a deceleration from a baseline of 155bpm to 70bpm, which did not recover to its former rate before CTG monitoring was discontinued. This is not documented in the clinical notes, but RM C made brief annotations on the CTG tracing indicating Ms A's mobilisation and position.

55. RM B said that, due to her surgery and in the absence of RM C, she was unable to replace the CTG monitor bands. RM B further stated:

> "When I rang the bell to call the hospital staff, they told me they were busy with [RM C's] other client. I told them [Ms A] needed [RM C] to come back.

[11] RM C is unable to locate her midwifery notes for the other client. HDC has received limited hospital records in an attempt to verify the periods RM C was absent from Ms A's room, but the lengths of the absences remain unclear.

> I felt very conflicted at this point. I could not just sit and do nothing. My training took over and I did what I could, in my physical condition. I managed to get a monitor on [Ms A]."

56. It is unclear as to what time RM C returned to Ms A's room. However, RM B stated: "[RM C] finally came back in and was confronted with a frantic, loudly verbal woman thrashing around dangerously." Ms A denied that she was "thrashing around".

57. The clinical notes (in RM C's handwriting) state that at 11.00pm Ms A was experiencing involuntary urges to push with contractions.

58. At 11.06pm the CTG tracing was recommenced, again without the abdominal tocograph transducer recording, and RM C documented it as "reassuring". However, because Ms A was becoming increasingly distressed, and moving about on her hands and knees, RM C said that she expressed a wish to apply a fetal scalp electrode (FSE),[12] particularly in view of the presence of meconium liquor. She said that RM B disagreed, saying that it would be difficult to apply because Ms A was not lying on her back. RM C said that RM B stated that she "did not think it was necessary".

59. By 11.42pm, Ms A was extremely distressed and was asking for an epidural and a Caesarean. RM B suggested that Ms A be given a dose of pethidine[13] to "help her calm down", but RM C disagreed. RM C stated:

> "[RM B] said that [Ms A] was wanting Pethidine and I disagreed … it was an inappropriate time for Pethidine, and [I was] not keen following meconium liquor, and with a previous Caesar[ean], we needed an obstetric review … I told [RM B] I would write up the Pethidine but I refused to give it. My words were 'If you want it given you give it yourself, and sign for it'."

60. RM B's recollection is that following her suggestion to give Ms A a small dose of pethidine, RM C asked her to collect it from the staff midwife while she (RM C) stayed with Ms A. RM B said that although the staff midwife was able to check out and prepare the pethidine, she did not have time to administer it.

61. RM B said that she was in a dilemma because the staff midwife could not assist. She told MCNZ:

> "[RM C] was not able to administer pethidine on her own because of [Ms A's] flailing movements. So [RM C] held [Ms A] still while I administered the pethidine. I wrote this into [Ms A's] notes."

62. In RM B's response to HDC, she said:

> "I was a midwife in a difficult situation, I gave 20mg IV … [RM C] asked me to help in a difficult situation where no other help was available. I could not just be a support

[12] The FSE is an electronic transducer connected directly to the fetal scalp to assess the fetal heart rate pattern when external monitoring cannot be used or when the signal quality is poor.
[13] Pethidine is a widely used narcotic analgesic.

> person. As a midwife, I am responsible to give any assistance I am able to if the situation requires it. At that moment I needed to be a midwife."

63. RM C said that RM B was fully involved in the decision-making. RM C said that because of RM B's strong personal relationship with Ms A, any discussion about the labour and ongoing care was between RM B and Ms A, and that she (RM C) was "not listened to".

64. The clinical notes (written by RM B) state that 25mg IV pethidine was administered at 11.42pm. At this point, there is no further comment in the notes about fetal or maternal distress (other than noting that Ms A wanted a Caesarean section).

65. RM C stated that "the CTG tracing was a challenge to interpret due to maternal positioning". She made the decision to call the obstetric registrar to review the labour progress, but noted that the registrar was unable to attend immediately. The clinical notes written by RM C at 11.52pm state:

> "Obs satis [observations satisfactory]. Phoned Reg to assess as VE high head OP[14] Asynclytic[15] 8cm dilated. Asked to come in to assess as previous LSCS[16] & findings. Entonox[17] + IV Pethidine helped her relaxation, sudden involuntary urges to push & BD [bear down]. Intermittently sucking Entonox if needed only. FHR=125–132bpm — reassuring. Well baby at present."

66. A notation on the CTG monitoring record at this time states:

> "Registrar called unable to come in as in [operating theatre at] present. Will come ASAP."

67. RM C also told HDC that because Ms A was still on her hands and knees, the abdominal tocograph transducer was not on, so they "were unaware of the relation of the heart rate to the contractions, other than what [they] could hear". However, RM C further stated:

> "The FHR in-between contractions were clearly heard and appeared normal in-between contractions. Head compression decelerations were present."

68. RM C stated that RM B said that it was "OK not to have the FSE because she could hear the baby and [Ms A] didn't want one". Ms A denied saying that she did not want the FSE to be attached.

69. At 11.58pm, the baby's FHR was recorded as 120–140bpm, and his head was visible. CTG tracing was noted as "continuous".

70. RM C said that a staff midwife (RM D) had been called and was present, but no further obstetric or paediatric support was requested at this time. RM C stated:

[14] The OP (occiput posterior) position is a cephalic presentation of the fetus with its occiput (back of the head) toward the mother's sacrum.
[15] The presentation of the fetal head during childbirth with the axis oriented obliquely to the axial planes of the pelvis.
[16] Lower segment caesarean section.
[17] Nitrous oxide used in labour for pain relief.

> "The DHB midwife was present in the room for at least 5 minutes prior to delivery and they are usually the ones to initiate a phone call to paediatricians to attend delivery or [RM B] herself could have called. I accept my responsibility for not having insisted that they be called."

71. The clinical notes (written by hospital midwife RM D) state that she answered the emergency call bell at 00.06am.

72. The clinical notes (written by RM D at 00.07am) state: "Head out thin mec[onium] present +++ (in excess)."

73. At 00.08am, Baby A was born pale, floppy, and "stunned". His birth was documented as "precipitate" and his response as "poor". His Apgar score was 2 at one minute, 5 at five minutes and 6 at ten minutes.

74. RM C said that she cut the umbilical cord and clamped it before passing Baby A to RM B and RM D for towel stimulation and resuscitation. RM C said that she rang the emergency bell and telephoned the paediatric team at 00.10am.

75. In contrast, RM B told MCNZ:

> "[T]he hospital staff midwife came into the room seconds before [Ms A] delivered [Baby A]. Straight away I knew there was a problem. When I saw meconium liquor I took it upon myself to call the p[a]ediatric doctor on call."

76. By 00.12am the paediatrician had arrived. Baby A was resuscitated and stabilised before being transferred to the special care baby unit (SCBU) with severe meconium aspiration[18] and hypoxic ischaemic encephalopathy.[19]

77. The clinical documentation (in RM C's handwriting) states: "0010 Paeds called, promptly arrived. Baby stabilised and transferred to SCBU by paeds and SCBU staff."

78. RM C stated that she continued to care for Ms A and to deliver the placenta, and "tried to give reassurance where [she] could". Once Ms A was showered and dressed, she went to see Baby A in SCBU.

79. Later that morning, Baby A was transferred to the neonatal unit in a main centre, and then to another hospital for extracorporeal membrane oxygenation treatment for a further eight days, before being discharged home.

Further information

RM C

80. In her response to HDC, RM C stated:

[18] Inhalation of amniotic fluid mixed with meconium (a baby's first stool), during or before delivery.

[19] Brain damage caused by oxygen deprivation. Hypoxic ischaemic encephalopathy can lead to severe developmental or cognitive delays, or motor impairments that become more apparent as the child continues to develop.

> "It was never clear from [RM B] that I was solely responsible for the labour; it was not documented in the hospital notes and there was no forwarding of phone calls. There were no clear parameters discussed, just a presumption from me that [RM B] was in support, but this was not borne out by the events of the evening.
>
> …
>
> I went in for the birth expecting to be in charge, but in reality [RM B] overrode my decision making and I was unable to lead and do things my way."

81. RM C further commented:

> "On reflection of the LMC situation, I feel the situation was far from ideal. There were grey areas regarding the roles between the LMC 'support person' and myself as locum/back up … Due to me being called to a client next door on occasion, and the situation with the LMC being present for labour, I feel that both [Ms A] and her [partner] frequently relied on [RM B's] decision making and her advice.
>
> …
>
> In hindsight, and after much reflection, I believe I should have been more assertive in ensuring roles were clear.
>
> …
>
> I should never have allowed another midwife … to attend a labour, as it clouded judgments and responsibilities."

82. In relation to the need for obstetric assistance, RM C said:

> "[I]n hindsight, I now consider obstetric input should have been requested earlier, in view of the fetal base line and decelerations."

83. She also stated:

> "The documentation is well below par and well below my usual documentation standard for a labour, likely created by poor judgment of who was in control."

RM B

84. In her statement to MCNZ, RM B said:

> "I believe that in these specific circumstances it turned out to be advantageous that [Ms A's] support person was a professional qualified midwife.
>
> However, in my view it can be problematic to have a support person who is well known to the hospital staff and woman's midwife, because the professional boundaries can be blurred. For that reason I was reluctant to be [Ms A's] support person, even though we are very close.
>
> …

> [Baby A] has been affected by a traumatic birth, but I cannot say that it was the result of his standards of midwifery care … what I can say [is] that I believe the midwifery care for [Ms A] was suboptimal in this case. I contributed by being there, which seems to have reduced the level of care provided by [RM C] …"

85. In her response to HDC, RM B advised that in her view it was clearly understood that Ms A's care had passed to RM C and that "there was no grey area about this". RM B further stated:

> "[Ms A] was distressed because [RM C] wasn't available. I understand a key reason for the break in the therapeutic relationship was [RM C's] divided attention. This meant that I was forced to step in and fill the gaps and provide some limited midwifery care.
>
> …
>
> I do agree that there is an inherent problem with midwives attending in a supportive role only. I have learned from this case and I will not attend a birth in a supportive capacity for a former patient or family or friend in the future. I do not wish to be forced into a position again where I am compelled to provide care against my better judgment.
>
> I was professionally compromised by [RM C's] irregular management of [Ms A's] case. I provided only limited, discrete midwifery care at times throughout the labour. Much of this care was at [RM C's] direction. Overall responsibility for the planning, management and clinical decision-making lay with [RM C].
>
> Had I not stepped in and provided care then the outcome may have been much worse for [Ms A]. I feel like I was in a 'damned if I do, damned if I don't' type situation."

Response to provisional opinion

86. Ms A, RM C and RM B were given the opportunity to comment on relevant sections of the provisional opinion. The responses have been incorporated into the report where appropriate. Further responses are outlined below.

Ms A

87. Ms A considers that RM C was fully responsible for the midwifery care provided. Ms A is concerned about the disputed facts as set out, and advised that she supports RM B's version of events. In addition, Ms A stated that RM C was out of the room for long periods of time, and that when she returned she asked RM C for updates and advice, and that without RM B's input the outcome would have been worse.

RM C

88. RM C told HDC that she accepts the Deputy Commissioner's decision. RM C asked for her response letter to be attached to the final report.[20]

RM B

89. RM B considered that the disputed facts should be resolved in her favour, and that it would be unfair to rely on RM C's account without clear justification.

[20] See Appendix A.

90. RM B advised that she was compelled to act because RM C was absent, and submitted that the expert advice supports a finding that she had no choice other than to provide midwifery care to Ms A. RM B agrees that she assumed some responsibility later on in the labour "as the situation went downhill", but says that this was secondary to RM C's responsibility.

91. In addition, RM C considers it to be inconsistent to make a finding that she blurred the lines of the responsibility, while also finding that she ought to have done more to recognise and respond to the developing fetal distress. RM B stated that the breach findings are not supported by the facts or by the expert advisor, and that they unfairly overstate her degree of responsibility for the labour and birth. She believes that she should not be found in breach for acting only in her role as a support person.

Opinion: RM C — breach

Introduction

92. Ms A engaged RM B as her LMC but, following elective surgery, RM B handed over care of Ms A (at 37 weeks' gestation) to RM C. The transfer of LMC care was not formally registered, but my expert advisor, Ms Stephanie Vague, said that it is not uncommon for there to be a verbal agreement in place between midwives rather than registering a transfer of care.

93. There are factual discrepancies in the accounts of the handover of care from RM B to RM C, and these are addressed below. My midwifery expert, Ms Stephanie Vague, stated that a formal change of LMC may have made the lines of responsibility and communication clearer to all parties. I acknowledge that handing over care without registering the change is accepted practice. However, I am critical that the decision to transfer Ms A's care was not clearly and fully documented in the clinical records.

94. Regardless, it is clear that RM C accepted the role as LMC for Ms A's labour, and that she was aware that RM B would be attending the birth as a support person for Ms A.

Admission

95. On 8 Month2, Ms A's labour contractions commenced, and she was admitted to the public hospital at approximately 8pm. Due to the lack of contemporaneous documentation, it is unclear as to who communicated with Ms A initially, and who provided the initial cares for Ms A, or the extent of the discussions between the midwives and Ms A. I am critical of both the conflicting accounts of what happened and the lack of accurate contemporaneous documentation.

Labour care

96. The clinical notes state that at 10.25pm the fetal heart rate (FHR) dropped to 80bpm during contractions, with good recovery. At this point the CTG was recommenced but the abdominal tocograph transducer was not recording. Therefore, there is no record as to when the FHR dropped in relation to the contractions. RM C advised that she could hear the fetal heart clearly in between contractions and, in her view, it appeared normal with head compression decelerations present.

97. The notes (written by RM B) record that RM C performed a vaginal examination and that consent was given for an ARM. No reason was documented for the ARM. RM C denied that she performed the VE at this time, and stated that it was RM B who performed the VE.

98. However, both RM B and Ms A state that RM C performed the ARM, following which the presence of thin meconium liquor was noted. Ms A stated in her complaint: "[RM C] broke my waters. I have no idea why [she] broke my waters other than to speed the labour up?"

99. The contemporaneous notes state that consent was given, but I am critical that Ms A did not understand the reason for the ARM, and that RM C did not document the reason and the details of her discussion with Ms A.

100. I note that from time to time, RM C was called to attend to another client, leaving RM B with Ms A. RM C's absences from the room were not documented, but were described by RM B and Ms A as an "extended period" and "for an hour". Despite having received limited information from the public hospital about the periods of time RM C left Ms A in the care of RM B,[21] I am unable to make a statement of fact as to the length of time Ms A was out of RM C's care.

101. Both midwives state that the hospital staff were busy that night. RM C told MCNZ that she and RM B discussed calling in a back-up midwife, but "the progress of [Ms A's] delivery did not give [them] time to arrange alternative cover". My midwifery expert, Ms Vague, advised that in her opinion, as Ms A was in the delivery suite for four hours from the time of admission until the birth, this allowed plenty of time for RM C to call for back-up assistance. As LMC, RM C had primary responsibility for the management of Ms A's labour and birth and, taking into account RM B's limited physical capabilities, I am critical that RM C did not arrange back-up midwifery assistance.

102. At 10.55pm the CTG monitor was discontinued to allow Ms A to go to the toilet, despite a fetal heart deceleration to 70bpm that had not recovered before the recording was stopped. Ms Vague stated that "it would be most unusual for a midwife to stop a CTG while the fetal heart was showing evidence of a significant deceleration". At 11.00pm RM C made the following entry in the clinical notes: "FHR satis[factory] 145bpm. CTG — reassuring trace." Ms Vague has advised that this deceleration without adequate recovery is concerning, and I am critical that RM C did not recognise this.

103. The CTG was recommenced at 11.06pm and appeared satisfactory until approximately 11.30pm. RM C said that at about this time Ms A was becoming increasingly distressed and moving about on her hands and knees. RM C said that she wanted to apply an FSE, particularly because of the earlier show of meconium. However, she said that RM B disagreed, saying it would be difficult to apply given Ms A's vigorous mobility, and that RM B "did not think it was necessary".

104. Ms Vague commented: "[I]f a CTG is warranted, it is because close monitoring of the baby is required and it is imperative that a midwife find a way to obtain this … In my experience,

[21] HDC has been unable to confirm the periods of time RM C was absent from Ms A's room while attending another client.

most women will agree to the placement of a fetal scalp electrode in order to get a better trace of the baby's heart rate if there is concern."

105. The clinical notes do not indicate whether or not Ms A refused to have an abdominal tocograph transducer on or whether it was simply left off. Ms Vague stated:

> "Whatever the reason for the absence of the abdominal transducer, it would not be regarded as acceptable practice, particularly in the presence of meconium stained liquor. In my opinion, [RM C's] actions would be regarded as a moderate departure from accepted practice by her peers."

106. I am critical that RM C failed to recognise the importance of applying an abdominal tocograph transducer at this point in Ms A's labour and that, despite her preference for an FSE to be applied, she did not recognise that it was her responsibility to overrule RM B when she understood RM B to say that she "did not think it was necessary", and to offer that option and the reasons for it to Ms A.

107. At 11.30pm there was a further deceleration to 80bpm. Ms Vague advised that from this time there was obvious fetal distress, with the FHR being grossly abnormal with frequent variable decelerations and reducing baseline variability. Ms Vague stated that, had Ms A been reviewed by the obstetric team shortly after 11.30pm, then, in her view, at the very least a fetal scalp blood sample could have been taken to determine how compromised the baby was by the labour.

108. However, RM C stated that the FHR in between contractions was heard clearly and appeared normal in between contractions. She added that head compression decelerations were present, although this is not documented. I am critical that the fetal distress developing over this period appears not to have been recognised by RM C, and that obstetric advice was not sought.

109. At 11.42pm RM B suggested that Ms A be given a dose of pethidine to "help her calm down". Initially RM C disagreed, but because of Ms A's obvious distress, RM C agreed to the pethidine being given but refused to be the one to administer it.

110. Although the clinical notes do not state who administered the pethidine, both midwives agree that while RM C attempted to keep Ms A from moving, it was RM B who administered the injection. RM C said that she raised the need for an obstetric review at this time, but did not action it until 11.52pm.

111. Ms Vague noted that although the dose of pethidine was not high, it is a narcotic drug that can depress a baby's respiratory centre of the brain if given close to birth. As the CTG indicated that the baby was already showing signs of potential oxygen deprivation, this meant that there was an increased risk of possible delay in establishing respirations after birth. For this reason, Ms Vague considers that paediatric support was warranted at the birth, and that RM C should have anticipated this. Her failure to do so would be regarded as a moderate departure from accepted practice.

112. At 11.52pm, RM C performed further observations and noted these as "satisfactory". RM C also documented that the obstetric registrar had been called, but the clinical notes state that

the referral was for a previous LSCS, slow progress, and the malposition of the baby's head. There was no reference to meconium or any concerns about the CTG, and no indication that the registrar was advised at that time that there was any urgency or concern for the baby's well-being.

113. Ms Vague considers that RM C's inability to recognise episodes of fetal distress over a period of approximately two hours, and therefore her delay in seeking an obstetric review and her failure to request a paediatrician attend the birth, would be regarded as a moderate to severe departure from accepted practice.

114. RM C later reflected on this and commented: "[I]n hindsight, I now consider obstetric input should have been requested earlier, in view of the fetal base line and decelerations."

115. Baby A was born at 00.08am, "stunned, floppy and barely responsive". I note that Ms Vague considers that RM C's actions following Baby A's birth were appropriate, as was her post-delivery care of Ms A, and I accept that advice.

Inadequate documentation

116. I am critical of RM C's failure to document clearly the transfer of Ms A's care to her. In addition, I note that the documentation throughout the labour was poor. A midwife is required to provide "accurate and timely written progress notes and relevant documented evidence of all decisions made and midwifery care offered and provided". Ms Vague advised that most midwives would make an entry approximately every 30 minutes to record midwifery cares and assessments, and this did not happen.

117. I accept RM C's reflection that her documentation of the care provided to Ms A on 8 Month2 was poor and, by her own admission, below her usual standards. I note that the Midwifery Council of New Zealand required RM C to undertake documentation, training, and self-audit exercises, and that these have now been completed.

Conclusion

118. This was an unusual labour situation involving the woman in labour, her original LMC who was present during the labour and birth as a personal friend and support person, and the LMC, who was originally the back-up LMC.

119. Clearly RM C had taken over the responsibility as LMC from RM B. However, it is evident from both midwives' version of events that there had not been a definitive discussion between them prior to the labour, to establish their respective roles. None the less, despite RM B's involvement in the labour being more than that of a support person, RM C held overall responsibility for the midwifery care provided to Ms A.

120. I agree with Ms Vague's observation that "[a]s LMC, [RM C] was responsible for the provision of midwifery care and should have ensured that both Ms A and RM B were clear about this". I consider that had RM C been more conscientious in her discussions with Ms A and RM B about her role as LMC, then some of the communication problems that occurred during Ms A's labour may have been avoided.

121. I am critical that RM C failed to ensure that Ms A's contractions and the FHR were monitored adequately, despite Ms A's mobility and distress, and that RM C failed to

recognise the developing symptoms of fetal distress over a period of almost two hours. This failure resulted in RM C not requesting an earlier obstetric review or ensuring that there was paediatric support at the birth.

122. In these circumstances, I find that RM C failed to provide services to Ms A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

Opinion: RM B — breach

Handover of care

123. Ms A engaged RM B as her LMC for this pregnancy, and midwifery cares were carried out by RM B until her elective surgery, when Ms A was approximately 36 weeks' pregnant.

124. The transfer of care was not formally registered, although my expert advisor, Ms Stephanie Vague, said that it is not uncommon for there to be a verbal agreement in place between midwives, rather than registering a transfer of care. I acknowledge that this is accepted practice, but I am critical that the decision to transfer Ms A's care was not documented clearly.

125. There was not a clear handover of care between the two midwives. While RM B considered that she had fully handed over the LMC responsibility to RM C until the post-partum period, RM C appears to have understood the arrangement to have been a more casual one in which she was "filling in", primarily for the labour.

126. Ms Vague said:

> "A transfer of midwifery care such as this case entailed, is dependent on the quality of communication between the two midwives and the woman so that there is a clear understanding of the roles and responsibilities of each midwife. This ensures that the woman also knows who is responsible for her midwifery care when labour starts."

127. It is evident that from the outset the quality of communication between the two midwives responsible for Ms A's care was lacking. As Ms A's original LMC, RM B had a responsibility to ensure that the handover of care to RM C was adequate, clearly understood, and appropriately documented. I am critical that aspects of the transfer of care were not managed appropriately or, if they were, they were not documented clearly. However, it is clear that RM C accepted the role as LMC for Ms A's labour and that she was aware that RM B would be attending the birth as a support person for Ms A.

Labour

128. On 8 Month2, Ms A's labour contractions commenced, and she was admitted to the public hospital at approximately 8pm. Due to the lack of contemporaneous documentation, the extent of any discussions between the midwives and Ms A is unclear. I am critical of the lack of accurate contemporaneous documentation. While RM B may have intended being present at the labour solely as a support person for Ms A, it is clear from the documentation and from RM B's responses that, despite her limited physical capabilities, she took an active role in

providing midwifery cares for Ms A. None the less, despite RM B's involvement in the labour being more than that of a support person, RM C held overall responsibility for the midwifery care provided to Ms A.

129. Both midwives state that the hospital was busy and they discussed getting a back-up midwife. As LMC, RM C had the responsibility to arrange assistance. However, I am critical that RM B, aware of her own limited physical capabilities, did not take it upon herself to insist that a back-up midwife be called to assist.

130. RM B stated that as a midwife she was in a difficult situation. She said that she could not be just a support person and, as a midwife, it was her responsibility to give any assistance she was able to if the situation required it. However, from early on in the labour, RM B contributed to providing midwifery cares, well before there was any cause for concern.

131. In response to the provisional opinion, RM B advised that she was compelled to act because RM C was absent, and submitted that the expert advice supports a finding that she had no choice other than to provide midwifery care to Ms A. I acknowledge that RM B's actions were partially a result of RM C being absent from the room at times and that, towards the end of the labour, the situation actively required RM B's midwifery assistance. However, I remain of the view that in "supporting" Ms A, RM B at times blurred the lines of responsibility, causing confusion for Ms A and also undermining RM C.

132. The Midwifery Council of New Zealand generally advises that a midwife not act as a support person because the boundaries become blurred. However, the Midwifery Council advised me that in the event that a midwife does act as a support person, the midwife "must act if she sees a deteriorating situation and cannot say 'I am here as a support person only'. The midwife is not able to remove themselves from a detrimental situation, but must act as a midwife."

133. In response to the provisional opinion, RM B stated that it would be inconsistent to make a finding that she blurred the lines of the responsibility, while also finding that she ought to have done more to recognise and respond to the developing fetal distress. I do not consider such a finding to be inconsistent, and instead believe that this demonstrates the inherent and conflicting boundary issues in such a situation, and why the Midwifery Council advises that a midwife not act as a support person.

134. Ms Vague stated that the presence of RM B at the delivery "illustrates the inherent problem with midwives trying to adopt a clinically passive role and being present in a supportive capacity only". Ms Vague further stated:

> "[RM B's] actions may have served to hinder the relationship between [Ms A] and her new LMC [RM C]. In any event, her presence and her subsequent involvement in care, suggest … that [RM B] must also assume some responsibility for the outcome of this labour."

135. I agree with Ms Vague. I acknowledge RM B's submission that my breach finding unfairly overstated her degree of responsibility for the labour and birth, and that she should not be found in breach for acting only in her role as a support person. However, my view remains the same, that not only did RM B provide midwifery care to Ms A, she also had a responsibility as a midwife in the room to advocate for adequate monitoring of the FHR and

to recognise and respond to the developing symptoms of fetal distress. This failure resulted in neither midwife in the room requesting an earlier obstetric review or ensuring that there was paediatric support at the birth.

136. I remain of the view that RM B failed to provide services to Ms A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

Recommendations

137. I recommend that RM C provide a written apology to Ms A for her breach of the Code. The apology should be provided to this Office for forwarding to Ms A within three weeks of the date of this report.

138. I note that RM C has provided evidence of further training relating to documentation and prescription writing.

139. I recommend that RM C complete a course in fetal surveillance, and report back to this Office within three months of the date of this report.

140. I recommend that RM B provide a written apology to Ms A for her breach of the Code. The apology should be provided to this Office for forwarding to Ms A within three weeks of the date of this report.

141. I note that RM B does not hold a current practising certificate. However, should she return to practice, I recommend that she complete a fetal surveillance course and report back to this Office within three months of recommencing practice.

142. I recommend that the Midwifery Council of New Zealand use this report in considering the development of guidelines for midwives who wish to act as a support person for a woman in labour, and report back to this Office on the outcome of its consideration.

Follow-up actions

143. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Midwifery Council of New Zealand and the district health board.

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

Appendix A: Letter from RM C

24 May 2018

Health and Disability Commissioner

Attn: Rose Wall, Deputy Health and Disability Commissioner

Dear Ms Wall,

Complaint by – Response to Provisional Report

I refer to your letter dated 7 May 2018 and your provisional report in relation to the above matter (the Provisional Report).

While I am naturally disappointed at the decision reached in the Provisional Report, I am willing to accept that decision in all of the circumstances.

I appreciate how difficult the complications with birth would have been for and the rest of their family, and for that I am truly sorry. I recognise that having both myself and present at his birth clouded all judgment and understanding of duties and responsibilities, and I sincerely apologise for the difficult position that that left in. I really feel for and her family for having to go through such a rough time, including recovery in the aftermath. I am also very thankful and relieved that I have seen running around the fields; it was a joy to see him now able to be active and enjoy life.

I will certainly provide with a written apology and attend a fetal surveillance course in conjunction with the Midwifery Council of New Zealand.

Yours faithfully,