Health New Zealand|Te Whatu Ora Southern
Obstetrician and Gynaecologist, Dr A

A Report by the
Deputy Health and Disability Commissioner

(Case 19HDC02222)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the obstetric care provided to a woman by an obstetrician and gynaecologist at Health New Zealand|Te Whatu Ora (Health NZ) Southern. In 2017 the woman birthed her baby in hospital via a ventouse-assisted vaginal delivery with an episiotomy, performed by the obstetrician and gynaecologist.

2. The woman raised several concerns about the care she received, including standards of communication and the informed consent process for episiotomy and umbilical cord blood testing. Her complaint also raised concerns about whether culturally safe care was provided.

Findings

3. The Deputy Commissioner found that Health NZ Southern's systems allowed the baby's cord blood to be tested without the woman's consent. Accordingly, Health NZ Southern was found in breach of Right 7(10) of the Code. The Deputy Commissioner also found that Health NZ Southern's systems contributed to breaches of tikanga that surround the tapu of birth. She considered that Health NZ Southern's practices were not culturally safe and in breach of Right 1(3) of the Code.

4. The Deputy Commissioner found that the obstetrician and gynaecologist did not inform the woman that she could choose not to have an episiotomy, and the risks associated with that option. However, the Deputy Commissioner considered that in the particular circumstances of this case (including an urgent need to deliver the baby and the woman's apparent verbal agreement to the procedure), this omission did not amount to a breach of the Code.

Recommendations

5. Having considered the changes made since the events, the Deputy Commissioner made several recommendations, including that Health NZ Southern use this case as a basis for training; provide comment on how its cultural education programmes align with Tikanga Best Practice, the Waitangi Tribunal (Wai) 2575 and the aspirations of Te Aka Whai Ora; provide evidence of communication to staff regarding amendments to its policy regarding consent to cord blood testing; and provide the training framework for upskilling its Obstetric and Maternity services regarding PTSD and birth trauma.

Complaint and investigation

6. This report discusses the care provided to Mrs B by Health NZ Southern (formerly Southern District Health Board[1]). The following issues were identified for investigation:

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

- *Whether Health NZ Southern provided Mrs B with an appropriate standard of care.*
- *Whether Dr A provided Mrs B with an appropriate standard of care.*

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

8. The parties directly involved in the investigation were:

Dr A	Obstetric registrar
Mrs B	Complainant/consumer
Mr B	Consumer's husband
RM C	Private lead maternity carer
Health NZ Southern	District healthcare provider

9. Obstetrician and gynaecologist Dr F is also mentioned in this report.

10. Further information was received from:

RM D	Core midwife
RM E	Educator

Service Manager Women's and Children's Health
Acting Director of Midwifery
Associate Māori Health Strategy & Improvement Officer
Chief Māori Health Strategy & Improvement Officer
Pediatrics registrar

Background

11. For Mrs and Mr B, tikanga and practices of Te Ao Māori are a natural way of life for them, with their marae providing the traditional setting for their wider whānau, where tikanga is installed through the practices of kawa that surround Māori culture.

12. Mrs B received antenatal care from her lead maternity carer (LMC) Registered Midwife (RM) RM C. Mrs B's pregnancy was reasonably straightforward. In 2017 Mrs B gave birth to Baby B at the Hospital's maternity centre. Mrs B had an episiotomy and a ventouse (vacuum/suction cup) assisted birth.

13. Following the birth, Mrs B raised concerns with Health NZ around the care provided to her by staff at the maternity centre during the assisted delivery. Mrs B believed that the care provided to her during her delivery was 'unnecessarily aggressive', with no consideration given to the tikanga that surrounds the tapu of birth, or to her right to make an informed choice and give informed consent for the transfer of her care from RM C to Health NZ staff, and for the assisted delivery and the episiotomy.

14. Mrs B said that her feelings included powerlessness and hopelessness because of the trauma she experienced during the delivery. Unfortunately, the matter was unable to be resolved, and Mrs B raised her concerns with the Health and Disability Commissioner.

15. This report has two components:

- Part 1 discusses the transfer of care and concerns around communication.
- Part 2 discusses culturally safe care and complaint management.

Responses to provisional decision

16. Mrs B, Dr A, RM C, and Health NZ were given the opportunity to respond to relevant sections of the provisional decision. Their comments have been incorporated into this report where relevant and appropriate.

17. Mr B provided a statement corroborating Mrs B's recollection of events. He also stated:

> 'This whole debacle has changed [Mrs B] and me forever, and not in a good way, and I will never forget that day … [W]e documented everything that happened and sought answers from all those involved. We have an evident view of how our experience went. We know what happened, and it was appalling. [Mrs B] started this journey to improve the experience of birthing women in a hospital environment. Now, we seek accountability from those professionals that birthing women entrust to deliver an exceptional result for mother and baby.'

18. Health NZ stated:

> '[We] would like to apologise again to [Mrs B] and her whānau for the complexities they encountered during her health journey with us. This experience would have certainly been distressing for her and has clearly impacted her trust and confidence in our hospital.'

Part 1: Transfer of care and concerns around communication

Baby B's birth

19. In the early hours of the morning, Baby B was born at the maternity centre.

20. In addition to RM C, the following Health NZ staff were involved in the care of Mrs B during her delivery: Dr A, who was the on-call obstetrics and gynaecology registrar, RM E, RM D, and a paediatrics registrar.

Timeline leading up to delivery

Date/Time	Clinical notes
9.45pm	'Obstetric registrar [Dr A] updated as we are approaching 18 hours [since spontaneous rupture of membranes]. [Dr A] recommended commencing IV antibiotics if [Mrs B] consents and continuous CTG.'
9.57pm	'CTG commenced. Reviewed option for prophylactic antibiotics with [Mrs B] — declined at present. Maternal observations: BP [blood pressure] 120/70mmHg, HR [heart rate] 84bpm [beats per minute], T [temperature] 36.8°C, RR [respiratory rate] 12 breaths per minute.'
10.15pm	'Reduced variability (3–5bpm) on CTG, ?sleep trace, will continue to monitor. [Mrs B] comfortable in left lateral.'
10.35pm	'[Mrs B] back onto bed — forward leaning over bed. [Mrs B] requesting entonox.[2]'
11.18pm	'Maternal temperature 36.3°C.'
11.30pm	'[Mrs B] standing, FHR [fetal heart rate] Transducer moved.'
11.45pm	'Period of reduced variability noted on CTG (3–5bpm), will continue to monitor.'
12.15am	'FSE [fetal scalp electrode] applied following prolonged deceleration. ?hindwater leak since this morning a pinkish fluid draining in [increased] volume since application of FSE and head moved –1 station. Head remains ROP [right occiput posterior]. Cervix 6cm and is fully effaced once forewaters ruptured.'
12.35am	'Noticeable [increase] in intensity of contractions since FSE applied/forewaters ruptured.'
12.40am	'Onto hands and knees. Light meconium noted on bedding. Early decelerations with contractions with quick recovery to baseline. Baseline 120bpm, variability 5bpm.'
12.47am	'Reviewed option for antibiotics — [Mrs B] declines. Delivery trolley ready.'
12.55am	'[Mrs B] starting to feel a bit pushy, not yet an overwhelming urge.'
1.03am	'Variable decelerations continue with contractions but quick recovery. Baseline remains 120bpm with normal variability. Pink fluid draining.'

[2] Nitrous oxide gas.

1.10am	'Decelerations becoming slower to recover. Vaginal examination with consent; 9cm with anterior lip. Baby still feels ROP with head at –1. [Dr A] asked to review CTG.'
1.15am	'Obst Reg [Dr A] into room. FHR 83bpm. Fully dilated.'
1.25am	'Preparing for assisted delivery. Into lithotomy. Paed Reg notified to attend.'
1.29am	'[P]erineum infiltrated with 1% lignocaine — pudendal block. Kiwi cup applied.'
1.33am	'Cut to perineum.'
1.36am	'Live … infant delivered by Kiwi cup — meconium present.'
2.05am	'[C]alled for assistance as prolonged bradycardia was 9cm short time ago. ? ventouse. Average pushing, improved with encouragement and guidance. Advised LA [local anaesthetic] on perineum + [pudendal block] for kiwi cup assisted delivery mum agrees. Kiwi cup applied episiotomy cut baby delivered with 2–3 push/pull, hand to face, meconium liquid. Had to leave room prior to placenta delivery as emergency in other delivery suite.' ([Dr A's] notes made in retrospect.)

Transfer of care — decision for episiotomy and assisted emergency delivery

21. At around 1.10am, RM C contacted Dr A to ask them to review an abnormal CTG indicating that Baby B was in distress.

22. In response to the concerns raised around the transfer of care, RM C said that she must have called the emergency bell when the prolonged deceleration[3] was happening. RM C cannot recall whether Dr A came into the room in response to the bell, or whether RM D went to update Dr A, but Dr A was aware of the CTG and needed to triage care between Mrs B and another delivery suite room. RM C stated:

> 'From my perspective a transfer of care took place because you will quite clearly see that my last entry was at 0110hrs asking for a review of the CTG and then core staff took over documentation as per their secondary care role during an assisted birth. I do not write again until after the baby is born.'

[3] A decrease in fetal heart rate that lasts longer than two minutes.

23. In response to the provisional decision, Mrs B stated that she understood that RM C was seeking an obstetric consultation and stated that transfer of care could not legally occur without her consent.

24. In response to the provisional decision, RM C clarified that her initial request at 1.10am for review of the CTG was to seek an obstetric opinion about interpretation of the CTG, and that at that stage she was not requesting a transfer of Mrs B's care. RM C stated that in the five minutes between her request at 1.10am for obstetric review of the CT and Dr A's arrival into the room at 1.15am, the CTG had deteriorated 'therefore necessitating an urgent transfer of care upon Dr A's arrival to the room'. RM C also noted that at the time of Baby B's birth, Health NZ Southern had no policy regarding transfer of care. She stated:

> 'Whilst I don't recall the discussions/conversations around the birth, I do remember taking a step back so as to not get in the way and feeling uncertain of my role in this situation. I respectfully disagree that it was solely my responsibility to keep [Mr and Mrs B] informed about the birthing process as it unfolded given that I was not the only practitioner in the room.'

25. Dr A reviewed the CTG and determined that there was prolonged bradycardia (low heart rate), confirming that Baby B was in distress. Dr A examined Mrs B with her consent and found that Mrs B had made sufficient progress in labour to allow for assisted delivery. Dr A said that they counselled RM C and Mr and Mrs B about their findings and their recommendation to proceed to an assisted ventouse delivery using a local anaesthetic to the perineum. Dr A documented: '[M]um agrees.' There is no documentation of specific consent to an episiotomy or that this was specifically discussed with Mrs B.

26. Mrs B said that her labour was progressing slowly but well, until it came time to push. She stated that it was at this time that RM C requested assistance, and she was told by someone in the room that she was having an episiotomy and ventouse-assisted birth.

27. Mrs B said that she had no idea what was happening at the time. She stated that when the LMC requested assistance, people just appeared.

28. In response to the provisional decision, RM C stated that she is confident that prior to attaching the fetal scalp electrode she would have outlined the rationale for the intervention and sought consent from Mrs B. RM C said that it is 'extremely unlikely' that she would not have referenced the prolonged fetal heart rate deceleration in this discussion.

29. In Mrs B's complaint, she told HDC that she said 'no' to an episiotomy and ventouse-assisted birth. She also described saying 'okay' to the procedure not because she actually agreed, but because she couldn't talk and felt pressured by everyone.

30. Mrs B stated that Dr A then told her they were 'infiltrating with the numbing drugs', and then said, 'I am cutting the episiotomy now.' Mrs B told HDC that if Dr A had asked for consent to an episiotomy separately, she would have been able to say no. Mrs B stated: '[A]n episiotomy was cut and I was unable to refuse.' She said that when she was cut with

the scissors, she felt 'totally violated and ashamed' that she had let someone dominant do something she did not want.

31. RM C told HDC that she has no specific recollection of the conversations between Dr A and Mrs B around recommendation for assisted delivery, episiotomy, or pudendal block prior to delivery. However, RM C referred to Mrs B's antenatal 'Birth Choices' document under the heading of 'Medical Interventions and Referral process to Obstetric Team'. There are six sub-headings, including: epidural; CTG; IV cannula, fluids; ARM [4]; augmentation; ventouse/forceps/Caesarean section. In response to the six topics, Mrs B has written:

> '[W]hatever is decided is best I am happy for those to be done. I understand that decisions have to be made and nothing is a sure/predictable or controllable thing … [T]he cord blood[5] [and] placenta are the only things I would like to ensure are done.'

32. In response to the provisional decision, Mrs B stated that RM C had emailed her the Birth Choices document to complete and return. Mrs B said that 'it was a formality not a genuine plan we made together'. Mrs B also stated:

> 'I did understand that decisions have to be made and nothing is a sure/predictable or controllable thing. That doesn't mean that I wanted nor that it is legal for any medical professional to make that decision for me — I expected to be supported to decide. I don't have to write that in my birth plan, it is the law and I knew that.'

33. In response to the provisional decision, Mrs B also stated: 'None of the six topics in the birth plan discussed were episiotomy.'

34. In response to the provisional decision, RM C stated that while episiotomy is not included in the list of possible medical interventions, it is her usual practice to discuss episiotomy antenatally, and she cannot see why Mrs B's case would have been any different. RM C also stated that Mrs B never raised her views about episiotomy in their antenatal discussions, and noted:

> 'In the absence of [Mrs B] informing me of her position [regarding episiotomy] before [Baby B's] birth … I simply could not have advocated to uphold [her] preferences if I was not aware of them.'

35. Dr A said that as they normally do, Dr A would have mentioned that the other alternative for delivering a distressed baby (or if an instrumental delivery fails) is Caesarean section. Dr A acknowledged that there is no documentation for specific consent to the episiotomy, but Dr A's usual practice is to explain to a woman that sometimes an episiotomy is recommended to avoid tearing of the anal sphincter. Dr A stated that after applying the anaesthetic, they assessed the need for an episiotomy and judged it to be required. Dr A

[4] Artificial rupture of membranes.

[5] This relates to Mrs B's decision for cord blood banking and is not related to the testing of Baby B's cord blood that occurred shortly after his birth. Cord blood banking is the practice of collecting and storing umbilical cord blood to preserve stem cells.

said that if a woman agrees, usually Dr A advises the woman if and when they are performing the episiotomy. Dr A said that they have had women decline episiotomies previously, understanding the risk of a tear. Dr A stated that often the need for an episiotomy to protect the perineum and expedite the baby's birth becomes evident only during the birth process and has to be done quickly. Dr A said that they never proceed with any obstetric intervention without a woman's consent.

36. Dr A stated:

> 'I am sorry that in my well-intentioned actions I was making them feel so disempowered and traumatised … In obstetrics, we look after two people, mum and baby, and often need to balance the urgency and emergency nature of a situation in which the baby's wellbeing is at risk, with allowing time for discussion with the parents, questions and informed consent.'

37. Dr A documented that the baby was delivered 'with 2–3 push/pull motions and that there was meconium liquor (an indicator of fetal distress and compromise in addition to the prolonged bradycardia)'.

38. Once Baby B was born, Dr A documented that they had to leave the room to attend an emergency in another delivery room. Dr A stated: 'I made sure the episiotomy had not extended to a tear and that [Mrs B] was not bleeding significantly.' Dr A documented that they returned to the room at 2.05am to repair Mrs B's episiotomy, at which stage RM E offered to do the repair so that Dr A could attend to the other emergency.

39. Health NZ said that Dr A's clinical assessment was that the situation was urgent and the best way to ensure a good outcome was to expedite the delivery, but 'unfortunately in those situations there may be limited time for detailed explanations'.

40. In response to the provisional decision, Dr A provided the opinion of an obstetrician and gynaecologist Dr F. Following review of the provisional decision, Dr F opined:

> '[Dr A] believed that [they] had verbal consent for an assisted delivery and episiotomy, on the other hand [Mrs B] felt that she was pressured and that she was not given any options or informed of the necessity for an episiotomy before episiotomy was performed. This misunderstanding is a result of the situation. An obstetric emergency for fetal distress, the registrar meeting the patient for the first time, with everyone stressed can explain the potential for misunderstanding.'

41. Dr F advised that it would be 'harsh' to expect that Dr A had the time to fully explain the options of episiotomy versus tearing in the ten minutes from entering the room to commencing the procedure. He noted that during this time Dr A had to introduce themself, assess the CTG, perform a vaginal examination, reassess the situation, discuss the need for delivery, discuss the possibility of Caesarean section, explain that an assisted delivery was the delivery method of choice and prepare for the procedure. Dr F also advised that the decision to perform an episiotomy can be made only as the delivery is occurring, when an assessment of the risk of damage to the anal sphincter by tearing can be made.

42. Health NZ considered that Dr A provided the best possible care for Mrs B and her unborn baby in an emergency situation. Health NZ referred to the written clinical notes and the verbal account provided, which support Dr A's attempts to communicate effectively and provide the necessary information and consent. Health NZ stated: 'As a service we take responsibility for the concerns raised by [Mrs B] of which we have already or will be acting upon.'

43. In response to the provisional decision, Health NZ provided a statement from the Acting Clinical Director of Obstetrics & Gynaecology at the Hospital, who stated:

> 'In [New Zealand] there is no routine provision of information regarding the potential need for specialist interventions during labour and delivery … Research has confirmed antenatal classes in [New Zealand] and NZCOM[6] do not proffer this eventuality which has significant bearing on women's expectations … [Health NZ] and regional [districts] do not have a policy of informing women booked in their facility that information regarding possible procedures and prior consent before labour be required.'

Perinatal trauma

44. In Mrs B's complaint, she speaks of her birth experience and the trauma that she experienced. Mrs B spoke of how ineffective and damaging the strategies staff used to 'motivate' her to deliver her baby were, led by Dr A, and said that she felt totally violated and like a complete failure.

45. Mrs B stated that while she was not able to recognise the trauma at the time, in the weeks following Baby B's birth she was able to piece together the traumatic moments surrounding the assisted-delivery phase of the birth.

46. Mrs B said that she was not given any debrief or information for herself or support people to monitor whether she had a post-traumatic stress disorder (PTSD) mental injury. She stated:

> 'I asked what happened on the way back to the ward and was told we could talk about it tomorrow and just to rest. There was no awareness by staff that debriefing and spending time helping me regulate my nervous system was very important.'

47. There is no mention of a 'debrief' in Mrs B's clinical records while she was an inpatient. At 7.50am, following transfer to the ward, it is noted: '[Mrs B] appears generally well.'

48. Mrs B told HDC that the transfer of legal care back to RM C would have been a good time to have a debrief. However, Mrs B said that she was not aware of when the transfer of care process took place and stated:

[6] New Zealand College of Midwives.

> 'We would have been aware of this if we were also involved or communicated with when care was transferred back to [RM C], this process was also not something we were a part of.'

49. In Mrs B's antenatal records, RM C noted discussions and monitoring of Mrs B's emotions and feelings, with a recommendation of support options for Mrs B to consider if she felt that she was developing postnatal depression.

50. In response to the provisional decision, RM C stated that she facilitated a debrief with Mrs B at four weeks' postpartum, as documented in Mrs B's postnatal notes: 'Debriefed the birth as [Mrs B] has had some sad feelings about this.' RM C noted that she is not appropriately qualified to counsel women regarding potential birth trauma or PTSD. She stated that the most appropriate action would have been to refer Mrs B to an appropriate counsellor but there were no specific services for this in the region at the time. RM C referred to the postnatal notes, which document that at five weeks postpartum Mrs B's score on the Edinburgh postnatal depression scale indicated 'possible depression'. RM C documented: 'In depth discussion regarding postnatal depression. Options from here: follow up with GP +/- counselling.' RM C stated (original emphasis):

> 'I note [Mrs B's] references to peri-natal trauma and PTSD have only come up during correspondence **after** I discharged her from my care. I was actively monitoring [Mrs B's] mental wellbeing as part of her postnatal care. She had features of postnatal depression and I made appropriate recommendations.'

51. Health NZ acknowledged that the way in which the delivery of Mrs B's son was expedited could have been difficult for Mrs B.

ACC

52. Mrs B's claim for a treatment injury involving the episiotomy and its repair and for PTSD was accepted by ACC. The ACC advisor reviewed the facts of the case for ACC and emphasised the importance of effective communication between mother and support staff during labour. The ACC advisor stated:

> 'There is a general assumption that childbirth is a joyous occasion and that the arrival of a healthy child is all that matters. Women who have had a difficult time are expected to simply accept it. While it is understandable that some births do not go according to plan, good communication between the mother and the birth attendants might go a long way towards mitigating negative experiences. Many women still complain of being treated like the mere vessel of delivery rather than a person with rights and feelings.'

Opinion: Dr A

Discussion around assisted delivery and episiotomy — adverse comment

53. Dr A was the obstetrics and gynaecology registrar who attended Mrs B at the request of her LMC, RM C, to review an abnormal CTG indicating fetal distress. I have no concerns with Dr A's technical expertise in opting for, and performing, an assisted ventouse delivery. Mrs B's concern is that she was neither told about the situation with Baby B, nor given an opportunity to consider what was best for herself and her baby. The issues I address below relate to Dr A's communication and discussion with Mrs B about what the delivery would entail.

54. Right 7(1) of the Code of Health and Disability Services Consumers' Rights (the Code) states that services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of the Code provides otherwise. One of the accepted exceptions to obtaining comprehensively informed consent is the doctrine of necessity. That is, in emergency situations it is not always reasonable, practicable, or possible to obtain fully informed consent of the kind that may be possible in non-emergency situations.

55. Right 6(1) of the Code requires providers to inform consumers of information that a reasonable consumer, in the consumer's particular circumstances, would expect to receive. Emergency circumstances will affect how much information can reasonably be provided. However, the Royal Australasian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) guidelines for instrumental vaginal delivery[7] (the RANZCOG guidelines) state: 'Safe instrumental vaginal birth requires a careful assessment of the clinical situation and clear communication with the mother …' The RANZCOG guidelines also state:

> 'The time spent obtaining consent for instrumental birth during labour may be determined by the urgency of the situation. Verbal consent should be obtained and the discussion documented in the clinical record.'

56. At the time Dr A assessed Mrs B, Baby B was in distress, and it was necessary to deliver Baby B before any harm eventuated. Dr A arrived at 1.15am and preparations for assisted delivery began at 1.25am. Dr A had 10 minutes in which to discuss matters with Mrs B briefly. In my view, the relevant information to be discussed included a clear explanation of the situation, the need for an assisted delivery, and a choice about whether to have an episiotomy to expedite the baby's birth and protect the perineum, or risk uncontrolled tearing.

57. It is clear from the evidence that Mrs B understood that her labour was progressing slowly but well, and that when it came time to push, RM C requested assistance. Mrs B said that she would have been able to accept the need for assisted delivery if someone had explained to her what was happening. However, she also recalls being told that her delivery was not progressing and that she needed an episiotomy and ventouse-assisted birth. She recalls first

[7] RANZCOG, 'Instrumental vaginal delivery', March 2016.

saying 'No' but then saying 'okay' after someone told her that her baby needed to be born. She told HDC that she felt pressured and that she was not given any options or informed of the necessity for an episiotomy before the episiotomy was performed. She also recalls that Dr A explained what they were doing as they administered the local anaesthetic and cut the episiotomy.

58. RM C cannot recall the discussions. Dr A stated that they advised Mr and Mrs B of their findings in relation to prolonged bradycardia and the need for Baby B to be delivered urgently by ventouse delivery, which included administration of local anaesthetic to the perineum. Dr A documented that 'mum agreed'. Dr A acknowledged that Mrs B's consent to an episiotomy is not documented specifically but said that it is their usual practice to explain the need for an episiotomy to avoid tearing, and that Dr A never proceeds with an intervention without a woman's consent. Dr A also said that local anaesthetic is applied in anticipation of the need for episiotomy, to reduce the risk of significant perineal trauma. Although Dr A documented discussing local anaesthetic for the purpose of an episiotomy, the clinical records do not refer to a discussion between Dr A and Mrs B or Mr B (Mrs B's support person) around the options and risks associated with an episiotomy.

59. Based on the above evidence, I am satisfied that Dr A did inform Mrs B of the situation (that Baby B was in distress and that delivery needed to be expedited), and that Dr A intended to perform a ventouse delivery with local anaesthetic.

60. However, I do not consider that Dr A informed Mrs B that she could choose not to have an episiotomy, that is, she could opt to tear naturally, and the risks associated with choosing that option. I agree with Mrs B that this is information that she could reasonably expect to receive. In my view, Dr A's care of Mrs B could have been improved by informing Mrs B of these options and associated risks, and it is regrettable that this was not done.

61. That said, I accept that the discussion around the assisted delivery occurred in circumstances where there was a small window of time to discuss matters with Mrs B and an urgent need to deliver Baby B as soon as possible. As outlined by Dr F, in the ten minutes from entering the room to commencing the procedure, Dr A had to introduce themself, assess the CTG, perform a vaginal examination, reassess the situation, discuss the need for delivery, discuss the possibility of Caesarean section, explain that an assisted delivery was the delivery method of choice, and prepare for the procedure. I am also mindful that Mrs B did say 'okay' after being told that her delivery was not progressing and that she needed an episiotomy and ventouse-assisted birth. For this reason, in the particular circumstances of this case, I consider that the omission to offer an alternative to episiotomy and discuss the risks does not amount to a breach of the Code.

62. I acknowledge that Mrs B was left feeling traumatised by the experience. Her complaint made it clear that she did not feel respected or heard during the delivery phase of her labour. The ACC advisor highlighted the importance of communication between the mother and the birth attendants and suggested that this may go a long way towards mitigating negative experiences at birth — a sentiment I share.

Opinion: RM C

Transfer of care — adverse comment

63. The New Zealand College of Midwives Standards of Practice outlines the need for continued assessment of the woman and baby and progress of labour, and states that if the woman or midwife feel that progress is not being made, mother and baby should be reassessed regularly for factors that may indicate whether additional care should be considered. Standard two states: '[T]he midwife upholds each woman's right to free and informed choice.'

64. From the information gathered it is evident that Baby B was experiencing some distress during birth, with the presence of light meconium at 12.40am and bradycardia noted, and that this prompted RM C to seek assistance from the on-call registrar.

65. I note Mrs B's comments that she had no idea what was happening at the time. Mrs B stated: '[W]hen the LMC requested assistance, people just appeared … [S]omeone said, your baby has to be born.' RM C did not document that she told Mrs B about the need to seek assistance from the on-call obstetrician at that point. Mrs B raised concern that she understood that RM C was seeking an obstetric consultation rather than a transfer of care and that transfer of care should not have occurred without her consent. In response to the provisional decision, RM C clarified that her initial intention was to seek Dr A's opinion only, but by the time Dr A arrived in the room the clinical picture had deteriorated, necessitating an urgent transfer of care.

66. RM C referred to Mrs B's prenatal notes, which indicate that in general Mrs B was happy for 'medical interventions' to be undertaken when it was decided that they were for the best (as set out in more detail in paragraph 31 above).

67. I acknowledge the importance of a prenatal discussion about medical interventions, but these discussions should not have been a substitute for ensuring that Mrs B was adequately informed at the time about her baby being distressed and the need for further assistance and transfer of care.

68. The Ministry of Health Guidelines for Consultation with Obstetric and Related Medical Services 2012 (Referral Guidelines) applied at the time of Baby B's birth in 2017. The Referral Guidelines outline the process in situations requiring emergency transfer of clinical responsibility. The Referral Guidelines state: 'The transfer of clinical responsibility must be clearly established and documented at the time or as soon as practicable once the situation has stabilised.' The Referral Guidelines also state:

> 'Effective communication with the woman and her [whānau] is essential in an emergency. The LMC must provide as much information as possible to the woman and her [whānau], and to others responding to the emergency. It is expected that the LMC will have discussed the management of obstetric emergencies with the woman prior to the occurrence of such an emergency.

> Communication with the woman may be difficult in some cases due to the nature of the emergency. Although the woman retains the right to decline treatment or transport and also the right to receive complete information, the situation may mean that a comprehensive discussion of benefits, risks and options is not possible.'

69. I appreciate that RM C's first response was to ensure a safe delivery for Baby B by seeking assistance with an emergent situation. However, RM C also had a responsibility to ensure a safe transfer of care to Dr A, which involved informing Mr and Mrs B about what was happening. As such, I am disappointed in the apparent lack of communication by RM C — a health professional who had an established relationship with Mrs B and Mr B as the support person — to ensure that they were kept informed about the birthing process as it unfolded.

70. However, the responses from RM C and Dr A indicate that their priority was to ensure a safe delivery, and, when Dr A attended and assessed the situation, Dr A told Mrs B that her baby was in distress and an assisted delivery was required.

Antenatal discussions — adverse comment

71. As discussed in more detail above, one of Mrs B's key concerns is that she was not informed that she could choose not to have an episiotomy — that is, she could opt to tear naturally — and the risks associated with choosing that option.

72. RM C noted that Mrs B's antenatal notes captured their discussions about 'Medical Interventions and Referral process to Obstetric Team'. These topics included CTG; IV cannula, fluids; ARM[8]; augmentation; and ventouse/forceps/Caesarean section. Mrs B wrote on the form that she was happy for whatever was decided as best to be done.

73. In my view, these antenatal discussions would have been an appropriate time specifically to discuss an episiotomy (and the associated risks and alternatives, such as tearing naturally) with Mrs B. This aligns with the RANZCOG 'Instrumental vaginal birth' guidelines, which state:

> 'Because instrumental vaginal birth including possible episiotomy is such a common outcome of labour, women should be informed about instrumental birth, and when it may be required during antenatal care.'

74. In addition, the New Zealand College of Midwives Practice Standard 5 states: 'Midwifery care is planned with the woman.'

75. In response to the provisional decision, RM C stated that it is her usual practice to discuss episiotomy antenatally and she cannot see why Mrs B's case would have been any different. On the other hand, Mrs B stated that episiotomy was not one of the topics discussed in her birth plan and that, in any case, RM C had emailed her the form to complete and this was a 'formality not a genuine plan we made together'. In considering this information, and noting that there is no documentation of a discussion about episiotomy in the antenatal notes, on

[8] Artificial rupture of membranes.

balance I find it more likely than not that RM C did not discuss the possibility of episiotomy with Mrs B in their antenatal discussions.

76. In my view, if RM C had discussed the potential for an episiotomy and the associated risks and alternative options, and had documented these discussions, she may have been better able to work in partnership with Mrs B during labour and, where appropriate, advocate for her wishes surrounding the episiotomy. This also may have meant that Mrs B was better informed and prepared to make the decision about the instrumental birth and episiotomy when it became evident that Baby B needed to be delivered urgently. I encourage RM C to ensure that she discusses these matters with women antenatally and, where women have preferences, to ensure that those are documented in the birth plan, and that she communicates those preferences to other clinicians who may be involved in the woman's care during labour and birth, for example in emergency situations.

Perinatal trauma — educational comment

77. Mrs B said that following Baby B's birth, she was not given any debrief or information for herself or her support people to monitor whether she had a PTSD mental injury. I note that Mrs B considers that a good time for a debrief would have been when her care was transferred back to RM C. However, Mrs B said that she did not know when the transfer of care happened, as there was no communication with her about this.

78. In Mrs B's postnatal records from the weeks following Baby B's birth, RM C notes discussions with Mrs B around her emotions and feelings, with a recommendation for further support if Mrs B felt that she was developing postnatal depression. While I acknowledge that those discussions occurred, and that RM C stated that she was actively monitoring Mrs B's mental wellbeing in the postpartum period, in my view it would have been beneficial for Mrs B to have had an opportunity to debrief in the early period immediately following Baby B's birth and prior to Mrs B's discharge from hospital. As LMC, and a health professional with whom Mrs B had an established relationship, RM C was in an ideal position to provide Mrs B with that opportunity. I encourage RM C to reflect on the timing of her postnatal discussions with her clients and their whānau in circumstances where there were complications and events did not proceed as originally planned — for example, following an assisted birth.

Opinion: Health NZ

Perinatal trauma — educational comment

79. The RANZCOG guidelines[9] outline the need for postnatal discussion regarding birth, and state:

> 'Women should be given the opportunity to discuss the reason for operative birth, the management of any complications, and the prognosis for future pregnancies. This

[9] RANZCOG guidelines, 'Instrumental vaginal birth', March 2016.

> discussion should occur in the early postnatal period if possible, and ideally should be led by the clinician who performed the birth. Instrumental vaginal delivery has been associated with a fear of subsequent birth, and in a severe form has manifested as post-traumatic stress-type syndrome.'

80. Following Baby B's birth, Dr A had to leave the room to attend an emergency in another delivery room. Dr A returned to Mrs B's room at 2.05am to repair Mrs B's episiotomy. At this stage, RM E offered to do the repair so that Dr A could attend to the other emergency. There is no evidence that in the immediate postnatal period, staff engaged in a discussion with Mrs B about her experience of assisted delivery.

81. Health NZ acknowledged that the way in which the delivery of Mrs B's son was expedited could have been difficult for Mrs B. Dr A, as the senior registrar on shift at the time, was managing several emergency situations that presented in rapid succession. I encourage Health NZ to reflect on whether there were safe staffing levels in the unit at the time, and whether staffing levels affected Dr A's ability to be present for sufficient time, without distraction, to provide Mrs B and Mr B with a full debrief.

82. In my view, it would have been helpful for Mrs B to have been supported by staff present at the delivery, and to have been provided with an opportunity to debrief and work through the events of the delivery. Had Health NZ taken the time for this postnatal discussion, as outlined in the RANZCOG guidelines, Mrs B could have had the opportunity to work through the clinical decisions that were made, supporting her process of healing from these traumatic events.

83. I am cognisant of the Acting Clinical Director's remarks at paragraph 43 about the current situation in New Zealand relating to the information routinely given to women antenatally about the potential need for specialist interventions during labour and delivery. I invite the parties concerned to consider the merits of further work in this area.

Part 2: Culturally safe care and complaint management

Opinion: Health NZ — breach

Consent to cord blood testing — breach

84. Right 7(10) of the Code states that no body part or bodily substance removed or obtained in the course of a healthcare procedure may be stored, preserved, or used otherwise than with the informed consent of the consumer.

85. Mrs B told HDC that the blood of the umbilical cord was tested for pH[10] without her understanding, knowledge, or permission. She stated:

> 'We had no knowledge this was done until much later in our journey … The first we heard of the cord blood being tested was [Dr A] calling across the room the pH level and saying "Good call!".'

86. Dr A told HDC:

> 'When clamping the cord to enable cord blood sampling, I noted there was a true knot in the cord. The baby was handed to the Paediatrics registrar present at the time of delivery for assessment. The documented Apgar score was 5 at 1 minute and the cord arterial blood pH was 7.02. Both results are in keeping with a compromised baby.'

87. Health NZ told HDC that it is not usual process to obtain consent to cord blood testing, as the taking of cord blood is considered the appropriate standard of care for the baby and is used to inform ongoing care of the neonate. Dr A said that this is often a conversation in the room, normally while waiting for the placenta to be delivered. The procedure is explained to parents, including how and why the cord bloods are taken, and how results are used to direct care. Dr A stated: 'It is not usual practice to gain formal consent in such emergent situations.'

88. In response to the provisional decision, Mrs B noted that at the time the cord blood was taken 'it was not at all an emergency'. She stated: 'The fact that it is not usual practice to get informed consent, in my opinion, is the problem.'

89. Health NZ's response shows a lack of understanding of its obligations under the Code. For having systems that allowed the cord blood to be tested without Mrs B's informed consent, I find that Health NZ breached Right 7(10) of the Code.

Cultural safety and respect — breach

Cord blood testing

90. In Te Ao Māori, the mother, the child, and the whenua (placenta) are tapu and must be attended to properly. The umbilical cord, often referred to as tāngaengae, is the vital link between the child and the placenta, and practices surround observing the rules of tapu, which often includes reciting appropriate karakia.[11] As noted above, Mrs B was not afforded an opportunity to consent to the cord blood being tested.

Communication and environment

91. Mrs B's complaint raised concerns around the lack of dignity and cultural respect shown to her during her labour, and the breach of tikanga that surrounded Baby B's birth. Mrs B referred to an aggressive nature that surrounded the delivery of her baby. She described

[10] Umbilical cord blood gas analysis, performed for the evaluation of the newborn's acid-base status immediately after delivery, is an objective way of assessing newborn condition at birth and may help in the management of neonatal care.

[11] Mead, Hirini, *Tikanga Māori: living by Māori*. Wellington: Huia Publishing (2003).

the hospital staff, led by the obstetrician, screaming and yelling at her to push. She also described the obstetrician hitting her firmly on the perineum on or near the site of the episiotomy and telling her to push at that site.

92. Mrs B said that RM E came around to her ear and, when she had her contractions, RM E gave her calm and clear instructions to push baby. Mrs B stated: 'I couldn't feel [the contractions] without her help until I was able to calm down.'

93. Mrs B accepted that the interventions were necessary but raised concerns around the need for tikanga of manaakitanga. She stated:

> 'My baby was born screaming, which was a surprise to us. [Baby A] did not need to go to NICU. I am not saying I wanted to risk not having the assisted birth, but there was time to be kind, respectful and calm, actually I believe it would have been faster. My baby was born in a feeling of chaos.'

94. In response to Mrs B's complaint, Dr A 'totally rejected' Mrs B's claim that Dr A hit Mrs B or yelled at her to push at a specific site. Dr A stated that they had not, and would never, hit any woman in labour nor at any other time, and that they will guide women how to push by indicating that they should push in the area where Dr A is touching while examining the vagina. Dr A noted that this was an emergency situation, with a baby suffering from fetal distress, and decisions needed to be made quickly. Dr A stated that their tone of voice may have reflected that urgency, and is sorry that Mrs B was upset by that. Dr A acknowledged that they have a loud clear voice, which they considered important in an emergency situation. Dr A stated: 'I assessed the situation to be one that risked significant harm for the baby, I felt my actions could expedite the baby's delivery and reduce the risk.' Dr A acknowledged that Mrs B found this stressful and aggressive.

95. In response to the provisional decision, Mrs B stated that Dr A's instruction for pushing was not helpful or skilful. She stated that she found Dr A's statements concerning because if a woman is required to 'forcefully push' during labour, the force of pushing is controlled from the breath and the diaphragm. Mrs B emphasised that the best way to manage an assisted birth is to work with the birthing woman.

96. RM E told HDC:

> '[Dr A] is an experienced registrar who, unfortunately does not have a quiet voice and in an emergency does tend to get louder, which can be taken as unsympathetic in a situation such as this.'

97. RM C told HDC:

> 'I do not recall [Dr A's] tone and manner being any different from my interactions with [Dr A] since. There is nothing unusual about this birth that has stayed in my mind.'

98. RM D stated:

> 'As I do not remember the night in question, I cannot comment on what was said or how it was said. I do believe that if I had witnessed behaviour that I thought was inappropriate, I would have said something at the time. I am truly sorry that [Mrs B's] birth experience was something that she needed to heal from rather than celebrate, and I am thankful for her words which have been a very pertinent reminder to me of the power health professionals have to influence that experience.'

99. Health NZ recognised that at times of stress it can be very difficult to attend to the finer points of communication, especially when difficult decisions of great importance must be made immediately in situations where clinical conditions can deteriorate quickly. Health NZ stated: 'We sincerely apologise that [Mrs B] found communication inadequate.'

100. Health NZ Southern Māori Health Leadership Team met with Mrs B and her whānau, following on from previous contact made by Health NZ Southern Executive Director Māori Health. At this meeting, Mr and Mrs B shared their story and discussed the impacts on their whānau following the events, which were acknowledged by Health NZ Southern Māori Health Leadership Team. Health NZ said that it would continue to work with Mr and Mrs B to improve the quality and delivery of appropriate and timely culturally safe maternity services. Further actions taken as a result of Mrs B's concerns are discussed further below.

My opinion

101. I acknowledge the follow-up actions taken by Health NZ following Mrs B's initial complaint and the commitment to recognise the need to improve staff members' understanding of cultural safety and the pathways to identify and uphold cultural beliefs for whānau surrounding maternity care.

102. When considering medical procedures and internal examinations at childbirth, for Māori women this can be culturally and physically invasive, where 'cultural safety' is not always understood.[12] The role of 'cultural safety' and the sanctity of a woman's body was outlined in the Cartwright Inquiry (1988), which stated:

> 'The implications of the sacredness of the genital area for Māori women cannot be underestimated … Any doctor conducting a vaginal examination, needs a sympathetic understanding that the genital tract is a sacred part of a woman's body which should be treated with respect, examined in total privacy, and under conditions which enable the woman to respond with trust and communicate her views, symptoms and feelings as an equal.'

103. Māori refer to the maternal body as 'whare tangata', where women are believed to be the custodian of the next generation and the mana of the whānau. Mrs B's complaint described the 'spiritual realm', in which Māori belief is that the birth canal runs between the realms of

[12] Simmonds, NB, 'Honouring our ancestors: reclaiming the power of Māori maternities'. In H. Tait Neufeld & J. Cidro (Eds.), *Indigenous Experiences of Pregnancy and Birth*. Ontario, Canada: Demeter Press (2017).

Te Po and Te Ao Marama.[13] For Mrs B, the concerning behaviour demonstrated by staff at the time of Baby B's delivery meant that tupuna heard every word and felt every action, and this was what their son was being handed into.

104. Because Mrs B and her whānau were not supported in their right to exercise their cultural beliefs, the mana and wairua for Mrs B and her whānau were diminished. As stated in 'Te Ha o Whanau: A culturally responsive framework of maternity care':

> 'Manaakitanga is tikanga that aligns with Article 1 of the Treaty of Waitangi — kawanatanga. In the healthcare context, acting with manaakitanga will ensure the environments where cultural practices and values are respected to have a contributory role in the health and wellbeing of whānau.'[14]

105. 'Tikanga left at the front door' is a term heard all too often in the healthcare setting. I note that Mrs B's complaint mentioned that her first encounter with the staff who were to support the assisted delivery was when she was told that she was having an episiotomy and ventouse-assisted birth. When whakawhanaungatanga is avoided, Māori tend to feel unconnected to the place and people within that place.[15] Mrs B complained that not only was no connection made with the staff who entered her birthing room for the delivery, but she needed to submit and retreat mentally, as coping mechanisms in response to what she felt was being done to her.

106. In my view, there was still time to practise manaakitanga. This is evident in Mrs B's comments about RM E's calm and clear approach in guiding her during delivery, compared to Mrs B's description of loud yelling by other staff present at the time of delivery.

107. Health NZ had an obligation to enable culturally safe practices. While I appreciate the urgent nature of the circumstances surrounding Baby B's delivery, this should not have been at the detriment of Mrs B and her whānau's cultural beliefs.

108. Many aspects of Health NZ's response to Mrs B's complaint focused on justifying the clinical decisions made during the delivery of Baby B. Mrs B made it clear in her complaint that her concerns were not about the clinical decisions made, but rather the implications on her and her whānau when their right to participate in the decisions for their whānau — rangatiratanga — were taken away.

109. Mrs B expressed deep gratitude for the birth of a healthy baby, but said:

> '[I also felt disappointment] regarding the impact on my mental and emotional health due to the "care" I received by the hospital staff who performed the ventouse extraction of my baby.'

[13] The 'perpetual night' and the 'world of light and life'.
[14] Stevenson, K, Filoche, S, Cram, F, and Lawton B, 'Te Hā o Whānau: A culturally responsive framework of maternity care'. NZMJ 133:1517 (2020).
[15] Ibid p 69.

110. Mrs B stated that she did not want to risk not having the assisted birth, but she felt that there was time to be kind, respectful, and calm.

111. The Māori Health Strategy, He Korowai Oranga, was developed to address health inequities while delivering effective services that support Māori aspirations for health and wellbeing — Pae Ora.[16] Health NZ had an obligation to ensure that its staff were 'culturally safe' and provided services that took into account Mrs B's cultural beliefs. I see Health NZ's inability to recognise the practices of tikanga that surround the tapu of birth — the sanctity of 'whare tangata' and the tikanga that surrounds the tapu of blood — as contributing factors that affected Mrs B and her whānau's ability to uphold their cultural beliefs.

112. I consider these breaches of tikanga as systemic issues within Health NZ Southern. In my view, it is not enough that Health NZ staff had an awareness of the 'different cultural requirements' surrounding birthing practices; tikanga must be practised at all times. I consider that Health NZ's practices were not culturally safe and a breach of Right 1(3) of the Code.[17]

Health NZ's complaint process — adverse comment

113. Mrs B referred to the complaint process with Health NZ as long and disjointed, and said that not only was the initial response unclear, it was 'offensive and harmful'.

114. When Mrs B first received Health NZ's response to her complaint, initially she thought it was a mistake. Mrs B said that Health NZ's subsequent response ten days later not only did not answer the questions she had raised, it re-traumatised her. She stated that she sent feedback to empower herself to let it go and to speak up for herself, so that her experience of the 'unacceptable standard of care' might improve another woman's experience without the support or confidence to do what she had done.

115. Mrs B met with a Health NZ Māori worker, who acknowledged Mrs B's feedback and her concerns around cultural issues. However, there was no further communication with Mrs B about actions taken following this meeting.

116. As Mrs B's concerns were not resolved, she responded to Health NZ outlining many aspects of its response about which she was deeply concerned, including Health NZ's response to the episiotomy. Mrs B said:

> 'The most traumatic thing I read was the episiotomy was not necessary. I thought there must have been some reason why I had to have one because I didn't understand. I did not have one during my last assisted birth and the natural tear was so much easier to recover from … To read that it was a choice that was made for me was actually just too much.'

[16] He Korowai Oranga — Māori Health Strategy 2014.
[17] Right 1(3) states: 'Every consumer has the right to be provided with services that take into account the needs, values, and beliefs of different cultural, religious, social, and ethnic groups, including the needs, values, and beliefs of Māori.'

117. Mrs B met with Health NZ's Quality Manager and Women's and Children's Representative, where actions around increasing staff awareness of trauma and Māoritanga were agreed. However, following this meeting, Mrs B did not receive any updates.

118. As mentioned previously, Health NZ Māori Executive Team met with Mr and Mrs B at Mrs B's request. At this meeting, Mr and Mrs B's beliefs from a Māori perspective were shared, and Health NZ extended its sincere apologies to Mr and Mrs B.

119. Following this meeting, Mrs B felt that many aspects of her complaint had still not been resolved by Health NZ, and Mrs B made a complaint to the Healthy and Disability Commissioner.

120. In Health NZ's response to HDC around concerns raised by Mrs B about Health NZ's complaint process, Health NZ apologised and acknowledged that its complaint process was not satisfactory. Health NZ stated: 'The original response was not entirely satisfactory, mainly because it was fragmented and poorly-coordinated.'

121. Health NZ also said that 'three individual letters provided, created an inconsistent response that lacked clarity', and that the complaint responses should have involved all Health NZ staff involved and should have been integrated into a summary document that addressed the concerns identified and understood by the complainant.

My opinion

122. Right 10 of the Code provides that every consumer has the right to complain about a provider in any form appropriate to the consumer. The provider must facilitate the fair, simple, speedy, and efficient resolution of the complaint.

123. In my view, Health NZ's response to Mrs B's initial complaint was met with some resistance and became about justification of the actions taken on the day. Mrs B's complaint was an opportunity for Health NZ to consider any relevant areas for improvement and find resolution. Instead, Mrs B was left feeling re-traumatised.

124. Mrs B had a right to a simple, speedy process of resolution. However, Health NZ's 'fragmented and poorly-coordinated' complaint process at the time meant that Mrs B had to spend many hours re-telling her trauma and concerns surrounding the delivery of her son. I agree with Health NZ's comment that its response was 'poorly composed'. No individual should come away from a complaint process feeling re-victimised.

125. While I find Health NZ's initial response to Mrs B's complaint disappointing, I am encouraged by Health NZ's apology and acknowledgement of its handling of the complaint, and the changes it has made as a result of the concerns raised by Mrs B. The development of programmes to increase Health NZ's staff competency around informed choices, consent, and cultural safety shows an organisational commitment to ensure that whānau experience positive health outcomes.

Opinion: RM C

Cultural safety — other comment

126. Standard one of the midwifery practice standards provides: 'The midwife works in partnership with the woman' and 'applies the principles of cultural safety to the midwifery partnership', where unsafe practice is defined as 'any action that diminishes or disempowers the cultural identity and wellbeing of an individual'. The standards also refer to the need for midwives to 'ensure all plans address the woman's cultural needs' throughout the pregnancy.

127. Mrs B's antenatal appointments should have included discussions about the cultural considerations that were important to her and her whānau to support culturally safe practices.

128. In response to the provisional decision, RM C identified two occasions in the antenatal period that facilitated the opportunity for discussion with Mrs B about her cultural preferences.

129. First, RM C stated that she and Mrs B completed the maternity centre's booking form together, as is documented in the midwifery clinical notes. RM C said that it is her usual practice to go through the form in detail with the woman. She noted that the booking form asks: 'Do you have any religious, personal or cultural beliefs, preferences/sensitivities about which we should be aware to help us meet your needs?' and that the only preference Mrs B disclosed to RM C was that she 'want[ed] to keep the placenta'. RM C stated that this demonstrates that discussion around cultural preferences was had. She noted that no other cultural preferences were documented and that Mrs B signed the booking form.

130. Secondly, RM C stated that there was opportunity for a discussion around cultural safety and preferences in preparation for labour and birth when Mrs B completed the Birth Choices form. RM C noted that Mrs B wrote on the Birth Choices form: '[T]he cord blood [and] placenta are the only things that I would like to ensure are done.' RM C stated: 'If there were additional cultural preferences to be considered, they have not been brought to my attention.'

131. In response to the provisional decision, RM C also referred to a letter written by Mrs B following Health NZ's response to Mrs B's initial complaint. In this letter, Mrs B wrote:

> '[RM C] respected our choices … She understood tikanga without us having to explain it and when [a] hospital midwife made her [negative] comment about our choice to keep the placenta[,] [RM C] corrected her without her or us losing face, which is a skilled and culturally appropriate way to correct a mistake of that nature.'

132. Mrs B had a right to have her cultural beliefs and practices upheld during her labour. The handover of care to Dr A would have been an appropriate time to acknowledge Mrs B's cultural beliefs (as discussed in detail above) to support a culturally safe transfer of care.

133. I acknowledge that the booking form and the birth choices form presented opportunities for discussion about Mrs B's cultural beliefs and practices. However, in my view such discussions require more than a box in a form. As noted by Mrs B in her response to the provisional decision, she felt that the Birth Choices form was a 'formality'. In my view, antenatal discussions are the appropriate time for midwives to facilitate discussions about cultural beliefs and practices to support culturally safe care.

Changes made

134. I am encouraged by Health NZ's efforts made as a result of the concerns raised by Mrs B, including communication and values-based workshops — 'Speak-Up', 'Get Dotted', and 'Compassionate Communication'. I encourage Health NZ to continue to reflect on its organisational response and continuous improvement of effective communication with all individuals who come under its care.

135. As a result of Mrs B's complaint, Health NZ also implemented the following changes:

a) An education session on 'The Code and You' was held with obstetric teams in Dunedin and Southland, in partnership with the HDC advocacy service, focusing on principles of informed decision-making and consent.

b) An information leaflet on the right to make choices in childbirth was developed and is provided to women upon booking at the maternity centre.

c) A transfer of clinical responsibility A3 project resulted in education for obstetric providers about referral guidelines, and clearer communication with women and between care providers about who is clinically responsible for care. The project also provided a birth plan template. As part of this project, the topic 'referral guidelines/transfer of care/three-way conversation' has been added as an agenda item for the Primary Maternity Settings Hui[18] and the Southern Maternity interface forum.[19]

d) A formal MIDAS document for Clinical Transfer of Care between Obstetrics and Midwifery was completed.

e) The Māori Health Directorate implemented the Māori Health proposal for change. Mr and Mrs B's feedback from the meeting was included in the decision-making and realignment of Māori Health services.

f) Two new Pou Takī Educators positions were created, developing Māori cultural education programmes across Health NZ Southern. The education content is reflective of the feedback provided by Mr and Mrs B and includes the exploration of staff

[18] The Primary Maternity Settings Hui takes place quarterly and is for staff working in primary maternity units across the Southern district (including managers, midwives, nurses and lactation consultants).
[19] The Southern Maternity interface forum will take place twice a year from 2024 and is for obstetricians, registrars working in maternity, paediatricians, midwifery leaders and managers, LMCs, maternity staff, patient safety staff, and consumers (when appropriate).

members' own cultural values and beliefs and how these impact on the care patients and their whānau experience in alignment with Tikanga Best Practice and the Waitangi Tribunal (Wai) 2575.

g) A dedicated Kaiawhina position working with Health NZ Southern Maternity Services commenced in 2020.

h) In early 2023, a midwifery performance appraisal tool, Hua Oranga, was implemented. It encompasses a cultural self-assessment and wellbeing self-assessment, which provides midwives the opportunity to reflect on cultural safety and how they support Māori whānau.

i) Cultural safety training was added to the mandatory annual midwifery training in 2022 and 2023.

136. Following review of HDC's recommendations in the provisional decision, Health NZ Southern amended its policy on cord blood testing to include the consumer's right to informed consent prior to cord blood being taken for testing.

Recommendations

137. I recommend that Health NZ Southern:

a) Incorporate an anonymised version of this case as a basis for training staff at the Hospital. This is to be provided to HDC within three months of the date of this report.

b) Provide HDC with a copy of its Māori cultural education programmes, outlining how the programmes align with Tikanga Best Practice and the Waitangi Tribunal (Wai) 2575. Health NZ is also to provide comment on how this framework aligns with the aspirations of Te Aka Whai Ora considering the elements of Pae Ora. This is to be provided to HDC within nine months of the date of this report.

c) Provide HDC with evidence of the directive to all relevant staff identifying the policy change with respect to cord blood testing and consumer consent, within three months of the date of this report.

d) Provide HDC with the training framework that surrounds the Obstetric and Maternity services upskilling for staff regarding PTSD and the impact of trauma during and following birth, within six months of the date of this report.

e) Provide HDC with an update on the 'MIDAS document for Clinical Transfer of Care between Obstetrics and Midwifery', within three months of the date of this report.

138. I recommend that Dr A report to HDC on any refresher training they have taken in relation to informed consent in the past three years, within three months of the date of this report.

Follow-up actions

139. A copy of this report with details identifying the parties removed, except Health NZ Southern, will be sent to the Medical Council of New Zealand, and it will be advised of Dr A's name in covering correspondence.

140. A copy of this report with details identifying the parties removed, except Health NZ Southern, will be sent to Te Tāhū Hauora|Health Quality & Safety Commission, NZCOM, and the Royal Australian and New Zealand College of Gynaecologists, and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.