Midwife, Ms B

A Report by the
Health and Disability Commissioner

(Case 12HDC01031)

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Executive summary

1. In 2012, Mrs A, who was 35 weeks pregnant with her second child, went into labour. Mrs A made two telephone calls to her Lead Maternity Carer (LMC) back-up midwife, Ms B, advising that she was experiencing back pain. Mrs A stated that she described to Ms B her painful, regular, contractions, but Ms B understood that Mrs A was experiencing "mild tightenings" that were no different from those she had been experiencing throughout her pregnancy.

2. After the second telephone call, Ms B advised Mrs A to go to a maternity unit for assessment.

3. Mrs A met Ms B at the maternity unit at approximately 6.45pm. Upon arrival, Mrs A was clearly in labour, and an ambulance was called to transfer her to the public hospital (the hospital).

4. Ms B took Mrs A into an assessment room to assess her and the baby and prepare her for transfer. Before Mrs A was able to get onto the bed, her uterine membranes ruptured and a large amount of straw-coloured liquor (amniotic fluid) was noted.

5. Ms B then listened to the fetal heart rate and inserted an IV luer. Ms B did not carry out an abdominal palpation or a vaginal examination or take any maternal observations.

6. At 7.12pm, Mrs A was transferred into the ambulance, which left the maternity unit at 7.27pm. Ms B accompanied Mrs A in the ambulance. The journey to the hospital takes approximately 20 minutes, but in an emergency may take only 10 to 15 minutes.

7. Shortly after leaving the maternity unit, Mrs A reported that she felt she needed to push. Ms B decided to return to the maternity unit.

8. Upon arrival at the maternity unit, Ms B had identified that Mrs A's baby was in a footling breech position. The maternity unit midwife Ms C then boarded the ambulance and ordered it to return to the hospital.

9. Ms C then carried out a vaginal examination and identified a cord prolapse. Mrs A was assisted onto her hands and knees, and Ms C applied pressure to the presenting part of the baby, while holding the prolapsed cord in order to keep it warm. Ms B continued to monitor the baby.

10. The ambulance arrived at the hospital at 7.47pm and was met by clinical staff. Mrs A was immediately transferred to theatre, where a Caesarean section was performed under general anaesthetic. Baby A was born at 7.57pm and immediately transferred to the neonatal unit, where brain cooling was commenced to try to minimise any damage caused by hypoxia.

11. At the time of discharge, Mrs A stated that she was given possible outcomes for Baby A, including possible brain damage, which may impact on her learning and development.

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Decision

12. Ms B failed to provide services to Mrs A with reasonable care and skill. In particular, when Mrs A initially contacted Ms B by telephone, Ms B failed to communicate adequately with Mrs A and, as a result, failed to elicit an accurate clinical picture.

13. Ms B inappropriately instructed Mrs A to go to the maternity unit for assessment. Even based on the assumption that Mrs A was not in labour, given her risk factors, Ms B should have instructed Mrs A to go to the hospital for assessment.

14. Ms B failed to assess Mrs A adequately following her arrival at the maternity unit and spontaneous rupture of membranes. Ms B should have conducted an abdominal palpation and vaginal assessment in order to assess the stage of labour, the presentation of the baby and whether the presenting part was in the pelvis, and to exclude cord prolapse.

15. When Mrs A started to push in the ambulance, Ms B should not have returned to the maternity unit. Even without knowing that she was dealing with a footling breech and cord prolapse, Ms B's decision to return to the maternity unit placed Mrs A and her baby in danger given Mrs A's risk factors.

16. I conclude that Ms B failed to provide services to Mrs A with reasonable care and skill for the following reasons: Ms B did not communicate adequately with Mrs A and therefore failed to elicit an accurate clinical picture when first contacted by telephone; Ms B inappropriately advised Mrs A to go to the maternity unit rather than the hospital for assessment; Ms B did not conduct an adequate assessment of Mrs A at the maternity unit; and Ms B inappropriately returned to the maternity unit in the ambulance when Mrs A started to push. Accordingly, Ms B breached Right 4(1)[1] of the Code of Health and Disability Services Consumers' Rights 1996 (the Code).

17. Ms B also breached Right 4(2)[2] of the Code for failing to document her telephone calls with Mrs A adequately.

18. Ms B has been referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

Complaint and investigation

19. The Commissioner received a complaint from Mrs A about the care provided to her by community-based midwife Ms B. The following issue was identified for investigation:

[1] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."
[2] Right 4(2) of the Code states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

The appropriateness of the care provided to Mrs A by Ms B in 2012.

20. An investigation was commenced on 22 August 2013.

21. The parties directly involved in the investigation were:

Mrs A	Consumer/complainant
Ms B	Provider, back-up Lead Maternity Carer

22. Information was reviewed from:

Ms C, staff midwife at the maternity unit
The District Health Board

Also mentioned in this report:
Ms D Midwife

23. Independent expert advice was obtained from midwife Robyn McDougal (Appendix A).

Information gathered during investigation

Background

24. In 2012, Mrs A was pregnant with her second child. Mrs A engaged community-based midwife Ms D as her Lead Maternity Carer (LMC).[3] Ms D works in a group midwifery practice of three self-employed community-based midwives.

25. Mrs A was at risk of intrauterine growth restriction and pre-eclampsia owing to a low PAPP-A.[4]

26. Mrs A elected to have a Caesarean section because she had had a Caesarean section with her first child. This was scheduled for a few days ahead of her estimated due date.

Ms B

27. Ms B is a registered midwife who was working in the same group midwifery practice as Ms D.

28. Ms B had met Mrs A previously during the birth of her first child. Ms B had been the back-up midwife and provided midwifery care during Mrs A's labour, prior to the decision being made to transfer her to secondary services for a Caesarean section because of her failure to progress.

[3] Ms D had also been Mrs A's LMC for her first pregnancy.
[4] Pregnancy-associated plasma protein (PAPP) is a protein complex shown to be linked to pregnancy complications.

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29. When Mrs A was 35 weeks' gestation, Ms B was working as the on-call back-up midwife because Ms D was on leave. Ms B advised HDC that the midwives in the practice met every Thursday morning to discuss their patients. Ms B said that Mrs A's care had been handed over to her, that she was aware of Mrs A's due date, and that an elective Caesarean had been planned. Ms B had seen Mrs A a few days earlier for a routine antenatal visit.

First telephone call

30. Mrs A told HDC that at approximately 3.40pm, she telephoned Ms B to advise her that she had pain down her leg and was experiencing regular painful contractions. Mrs A remembers thinking that she was in labour and had called her husband to come home early from work because she thought she might need to go to hospital. Mrs A said that she told Ms B this.

31. Mrs A said that Ms B told her that she was probably just having Braxton Hicks contractions,[5] and to take some Panadol and call her again if the pain became worse.

32. Mr A told HDC that he recalls his wife calling him to say that she was experiencing contractions unlike those she had been experiencing previously, and that she thought she was in labour.

33. In contrast, Ms B told HDC that Mrs A telephoned her at approximately 4.30pm. Ms B said that Mrs A described experiencing pain in her back that radiated into her buttocks and down the back of her legs. Ms B said that she asked Mrs A if she was having contractions, but Mrs A replied, "No," just mild tightenings no different from what she had been experiencing throughout her pregnancy. Ms B said that she asked whether the baby was moving, and Mrs A confirmed that it was.

34. During an interview with HDC, Ms B said that because she knew that Mrs A had experienced labour previously, and therefore knew what labour contractions felt like, she was reassured that Mrs A was not experiencing labour contractions. Ms B agrees that she advised Mrs A to take some Panadol and to call her again if the pain did not settle.

35. The only record of this conversation is a retrospective note written by Ms B at 11am the following day, which states:

> "[Mrs A] contacted me [at 35 weeks' gestation] at +/– 1630hs complaining of back pain that was radiating into her legs (the back of her legs). She reported good FM's [fetal movements]. She mentioned that she had some mild tightenings. I advised her at that stage to take two Panadol and rest, and to call me back if she was feeling worse and the pain worsened."

Second telephone call

36. Mrs A told HDC that the pain became worse, and that at approximately 6.20pm she telephoned Ms B again, advising her that she was now experiencing contractions

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[5] Sporadic uterine contractions that occur throughout pregnancy.

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every 2–3 minutes. Mrs A recalls that she told Ms B she thought she was in labour, and that Ms B advised her to go to the maternity unit[6] for an assessment.

37. In contrast, Ms B said that Mrs A called her back at approximately 6pm advising that her back pain was worse. Ms B said that she asked Mrs A to come into the maternity unit, which Ms B advised is about a 20–25 minute drive from Mrs A's home, so that she could assess her and investigate the cause of her back pain, such as whether Mrs A had a urinary tract infection. Ms B said that at that stage she did not think Mrs A was in labour, as she had given no indication that she was. Ms B denies that Mrs A told her that she was having contractions or that she thought she was in labour. Ms B stated:

> "Had [Mrs A] mentioned that she was in labour I would have advised her to go straight to the hospital, as she was a previous [Caesarean] Section and also at 35 weeks gestation. I was well aware that a woman in premature labour cannot birth at a Primary Birthing Unit (let alone a woman with a caesarean section birthplan). It is standard and expected practice that women in premature labour be transferred to hospital as there are increased risk factors associated with such labours including cord prolapse and breech presentation."

38. Ms B told HDC that when she asked Mrs A to meet her at the maternity unit, Mrs A said that she could not come in immediately because her husband had just come home and needed to eat his dinner, and that she also needed to prepare dinner for her older child. Ms B said that this was another reason she believed that Mrs A was not in labour.

39. Mrs A denies telling Ms B that she could not come in immediately. Mrs A said that her husband was already at home and that when she made the second telephone call to Ms B they were getting prepared to leave for the hospital.

40. Ms B made a retrospective record of this telephone call, documented at 11am the following day:

> "[Mrs A] called me back at 1800hs, saying that the Panadol had not worked and she was feeling worse with pain worsening. We agreed to meet at [the maternity unit] for an assessment."

41. Ms B then contacted staff at the maternity unit to advise that she was meeting Mrs A there for an assessment. Ms B spoke to the maternity unit midwife Ms C. In a statement to HDC, Ms C said:

> "I received a phone call from LMC [Ms B] at approximately 1800 hours to inform me that a woman was coming in with back pain and mild tightenings. I was also informed that the woman ([Mrs A]) had a previous emergency caesarean section for failing to progress and that this was [Mrs A's] second baby and she was currently 34 weeks gestation."

[6] The maternity unit is a primary maternity facility run solely by midwives. It does not provide emergency services or obstetric care.

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Arrival at the maternity unit

42. Mrs A arrived at the maternity unit at approximately 6.45pm.

43. Ms B recalls that she was sitting in the staff room, talking to Ms C, when Mrs A arrived by car with her husband. Ms B remembers Mr A driving into the ambulance bay, rather than parking around the front in the public car park. Ms B went to meet Mrs A and noted that she was "contracting strongly at this stage".

44. Ms C said that she was present when Mrs A arrived, and she observed that Mrs A was obviously in labour. Ms C immediately called an ambulance to transfer Mrs A to the hospital. Ms C said that this was before Mrs A's waters broke.

45. Ambulance service records show that a call was received from Ms C at 6.48pm.[7]

Spontaneous rupture of membranes

46. Mrs A advised that when she arrived at the maternity unit, Ms B came out to the car to meet her, and assisted her into an assessment room. Mrs A said that before she could sit down on the bed, her waters broke. She recalls a "huge gush of water" the colour of straw with some blood.

47. Ms B stated:

> "There was a copious amount of liquor, far more than is normal — it took approximately 4 towels to soak up the liquor."

48. Ms C advised that "[Mrs A]s] membranes ruptured soon after admission — blood stained polyhydramnios …"[8]

49. The records documented by Ms C at 7.10pm state: "SROM [spontaneous rupture of membranes] — Blood stained liquor at 1900hrs." Ms B said that Ms C and one other midwife were present by that time and assisted with cleaning up. Ms B advised that she made the decision to transfer Mrs A to hospital, and asked Ms C to call an ambulance.

Assessment

50. Ms B stated that Mrs A was "in considerable pain and distressed", and that after her membranes broke they had to wait for her to breathe through a contraction before they were able to assist her onto the bed. Ms B said that while they awaited the arrival of the ambulance, her priority was to check that the baby was well. She said that she listened to the fetal heart rate (FHR) using the cardiotocograph (CTG) for several minutes and was assured that the baby was well. Ms B then inserted an IV luer into Mrs A's hand and took some bloods.

51. Initially Ms B advised that the sequence of events before the ambulance arrived prevented her from performing an examination to assess whether Mrs A was dilated

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[7] The ambulance service advised that the call was assigned a code meaning urgent patient transfer, and assigned a Priority 1, ie, "lights and siren".

[8] An excessive volume of amniotic fluid.

HDC

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or not. Ms B noted, "We were all busy preparing for the transfer." In a later response to HDC, Ms B said that she did not carry out an abdominal examination or vaginal examination because Mrs A was too distressed. Ms B stated that Mrs A was "very distressed and was barely able to remain calm enough for me to carry out the examination I did". In response to the provisional opinion, Ms B said that both of these factors, the fact that Mrs A was distressed coupled with the fact that everything progressed very quickly, prevented her from carrying out an abdominal assessment. Ms B said that her priority was to get Mrs A to the hospital. Ms B stated that had they been staying at the maternity unit she would have carried out an abdominal palpation, but that Mrs A's "habitus"[9] would have made it difficult to identify a breech presentation in any case.

52. In contrast, Mrs A does not recall being overly distressed at that stage. She recalls that her contractions were painful but tolerable. She said that her young daughter was present in the room throughout, and is sure that she would not have been "out of control" knowing that her daughter was in the room.

53. Mrs A's recollection is supported by that of Mr A, who told HDC that after being shown to the assessment room he went back out to the car to get something. When he returned, he noticed water on the floor, which staff were trying to clean up. Mr A said that he remembers his wife being very controlled throughout. He said that although he could see that she was clearly in pain, he was amazed at how well she was managing it.

54. Similarly, Ms C recalls that although Mrs A was in pain with her contractions, she remained quite calm and was responsive to everything she was asked to do.

55. The patient records, written by Ms C at 7.10pm, state:

> "[Mrs A] invited into [the maternity unit] for assessment pains in back that go down the legs at 1855. …
> [On examination] [Mrs A] contracting 1:2–3 mins
> SROM — Blood stained liquor at 1900hrs
> CTG on
> Delivery suite ch m/w [charge midwife] phoned — to inform of transfer. …"

56. Ms C commented that from the point of Mrs A's arrival at the maternity unit, everything flowed quite quickly, and by the time they had contacted the hospital to advise staff of the transfer, and had put in place an IV luer, the ambulance had arrived.

Ambulance delay

57. At 7.06pm the ambulance service called the maternity unit and spoke to Ms C, to advise that there was a delay with the ambulance because of the availability of a unit. The ambulance service records show that the ambulance arrived at 7.12pm.[10]

[9] The physical characteristics of an individual such as physique and body build.
[10] The patient records document the ambulance arriving at 7.18pm.

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Transfer to the hospital

58. Mrs A was then transferred into the ambulance, and it left for the hospital. The ambulance was manned only by the driver. Ms B accompanied Mrs A in the back of the ambulance.

59. The ambulance service records show that the ambulance left the maternity unit at 7.27pm.

60. Mrs A recalls that approximately five minutes after leaving the maternity unit she felt something "fall out" of her vagina during a contraction, and asked Ms B to take a look. Mrs A said that when Ms B looked, she told the ambulance driver to return to the maternity unit because she could see the head.

61. In contrast, Ms B said that approximately one minute after departing the maternity unit, Mrs A reported feeling a need to push. Ms B said that because at that stage the ambulance was only at the entrance to the maternity unit, she immediately told the driver to turn around and return to the maternity unit. Ms B said that she made this decision because she felt that it was safer to deliver the baby at the maternity unit, where there was support, rather than on her own in the back of an ambulance.

62. After giving instructions to the ambulance to turn around, Ms B telephoned the maternity unit to advise that they were returning. Ms B said that she did not perform an assessment in the ambulance, and that "[she] didn't even look".

63. Ms C said that when one of the other midwives informed her of this change of plan she immediately telephoned the ambulance call centre to ask the ambulance to proceed to the hospital as planned. Ms C stated:

> "Within a few minutes [of leaving the maternity unit] LMC [Ms B] phoned back and spoke to my colleague to say that baby's vertex was on view, [Mrs A] was pushing and that they were returning to the maternity unit. I considered that this was an unsafe decision because of [Mrs A's] previous and present antenatal and birth history. I rang the ambulance call centre to ask them to proceed as planned, to the hospital but by this time the ambulance was back at the maternity unit."

64. The patient records, written in retrospect by Ms C, state: "Phone call from [Ms B] to say vertex on view and returning to [the maternity unit]. I did not take the call so rang Ambulance to tell them to get to [the hospital] stat as is 34 weeks."

65. The ambulance service records state: "[C]rew adv was required by midwife to turn back because baby crowning …"[11] At 7.38pm, the records state: "[The maternity unit] called to advise ambos to keep going towards hospital and not turn back."

Identification of footling breech

66. Ms B said that before unloading Mrs A she performed a visual examination, and it was then that she noted a foot and leg protruding from the vagina. Ms B stated:

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[11] This entry was written retrospectively at 1.13am the following day.

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> "When we got to the maternity unit I lifted the covers of [Mrs A] just to assess by inspection, as to whether she was actually pushing, when I noticed a fetal foot and leg, sticking out of the vagina."

67. Ms B advised that, at the same time, Ms C approached the ambulance and "yelled that [they] should be enroute to the hospital".

68. Ms B recalls that she then told Ms C what was happening, and that Ms C came on board the ambulance and instructed it to go to the hospital.

69. Ms C recalls that when she realised that the ambulance had arrived back at the maternity unit, she went outside and met Ms B coming out of the ambulance, and Ms B told her that it was a footling breech presentation.

70. Ms C said that she then got into the ambulance and told it to go to the hospital.

71. Mr A recalls that after driving a little way out of the maternity unit he saw an ambulance drive back in the opposite direction. Mr A became a little concerned but was unsure whether or not it was his wife. Mr A remembers turning the car around, and was sitting at some lights when an ambulance went past very fast, with lights and siren going. He then received a telephone call from Ms B to say that they were on their way to the hospital. Mr A cannot recall the content of the conversation.

Journey to the hospital

72. Ms C carried out a vaginal examination in the ambulance. It was at this stage that she noticed a large loop of umbilical cord extending out of the vagina by approximately 20cm. Ms C asked Ms B to listen to the FHR, but no FHR could be heard. Ms C recalls that she thought she could feel a very faint pulse in the cord, so decided to assess whether delivering the baby was an option. Ms C then asked Mrs A to push with the next contraction to assess the descent of the baby. However, because no descent was felt she told Mrs A to stop pushing.

73. Ms C then assisted Mrs A to turn over onto her hands and knees in an attempt to reduce the pressure on the cord. Ms C kept her hand on the cord to try to keep it warm. With her other hand she applied pressure to the baby's presenting part in an attempt to keep any pressure off the cord.

74. Ms B then telephoned the charge midwife at the hospital to update her on the situation.

75. Mrs A stated in her complaint that by that stage she knew that things were serious. She said that Ms C had taken over, and that she did exactly what Ms C told her to do.

76. In her statement, Ms C advised that after they had turned Mrs A over, she thought that she could hear a faint FHR of about 50bpm.

Arrival at the hospital

77. The ambulance arrived at the hospital at 7.47pm and was met by clinical staff. Mrs A was immediately transferred to theatre.

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78. In theatre, the obstetrics consultant made the decision to perform an emergency Caesarean section.

79. Mrs A was given a general anaesthetic, and Baby A was delivered at 7.57pm.

Postnatal care

80. Baby A was immediately transferred to the neonatal unit, where brain cooling was commenced to try to minimise any damage caused by hypoxia.[12]

81. Baby A was subsequently diagnosed with grade 2 hypoxic ischaemic encephalopathy.[13]

Ongoing care

82. Baby A was discharged from the Neonatal Unit two weeks later, with follow-up with the Child Development Service.

83. Mrs A stated that at the time of discharge, she and her husband were given the possible outcomes for Baby A, including her having suffered brain damage that may impact on her learning and development.

84. Baby A continues to be monitored through the Child Development Service. She has been assessed as having "largely age appropriate" gross and fine motor skills, but has demonstrated delayed communication and social skills.

85. Mrs A told HDC that Baby A is receiving ongoing therapy.

Response to provisional opinion

Ms B

86. In response to the provisional opinion, Ms B reiterated her view that the maternity unit was the safest place to deliver the baby, and that her decision to return to the maternity unit was appropriate in the circumstances. Ms B stated:

> "I still believe that [the maternity unit] was the best place for me to deliver a baby that was preterm (35 weeks) irrespective of whether it was a breech or not. It is definitely a far safer place than the back of an ambulance. Also the staff support at [the maternity unit] was far greater as they were all skilled midwives. I was alone in the ambulance."

Mrs A

87. In response to the provisional opinion, Mrs A said that she does not wish to receive an apology from Ms B, as she does not believe it would be "an honest, remorseful apology".

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[12] Oxygen deficiency.
[13] Disturbed neurological function secondary to hypoxia.

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Opinion: Ms B — Breach

Timing and advice provided during telephone calls — Breach

88. Mrs A made two telephone calls to Ms B between 3.40pm and 6.20pm. The exact timing of these calls is unclear; Mrs A said that they occurred at 3.40pm and 6.20pm, while Ms B said they occurred at 4.30pm and 6pm. While I note that Ms B's recollection that the second telephone call occurred at 6pm is supported by the records written by Ms C in the maternity unit clinical records, I do not consider that the timing of the calls had a major impact on the following events. I therefore do not consider that I need to make a factual finding in relation to the timing.

89. The details of what was discussed during these telephone calls are also unclear. In particular, Mrs A said that during the first telephone call she told Ms B that she was experiencing what she thought were regular painful contractions that were associated with radiating pain down her leg. In contrast, while Ms B agrees that Mrs A told her that she was experiencing pain that radiated into her leg, Ms B recalls that Mrs A described having "mild tightenings" that were no different from what she had been experiencing for the last few weeks. Ms B told HDC that she did not consider Mrs A to be in labour at that stage, and was reassured that Mrs A knew what a labour contraction felt like, having experienced them during the birth of her first child.

90. Mrs A advised that during the second telephone call she told Ms B that the pain was getting worse, and that she thought she was in labour. In contrast, Ms B recalls that Mrs A told her that the back pain was getting worse but denied that she thought she was in labour. Ms B said that if at any stage she had thought Mrs A was in labour, she would have told her to go to hospital immediately.

91. I note that while Mrs A's version of events is backed up by her husband's recollections, Ms B's version of events is supported by what she documented in the clinical records, albeit retrospectively. This is also consistent with the contemporaneous records written by Ms C, which note that Ms B was coming into the maternity unit to assess a woman with "back pain and mild tightenings".

92. In light of the fact that Ms B's recollections are supported by the clinical records, I accept that it was Ms B's belief that Mrs A was not in labour. However, clearly there was a breakdown in communication between Mrs A and Ms B. In my view, it was Ms B's responsibility to obtain an accurate clinical picture from Mrs A. This is a basic clinical skill. By failing to obtain an accurate clinical picture, Ms B failed to exercise reasonable care and skill.

Decision to assess Mrs A at the maternity unit — Breach

93. During the second telephone conversation, Ms B asked Mrs A to come into the maternity unit for assessment. Ms B said that this was so she could assess the cause of Mrs A's pain, such as a urinary tract infection.

94. I have accepted that Ms B believed that Mrs A was not in labour. Therefore I must consider the appropriateness of Ms B's decision to assess Mrs A at the maternity unit, rather than at the hospital, based on this belief.

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95. The maternity unit is a primary maternity facility, so does not have any facilities to cope with emergency situations, nor does it provide any obstetric services. My expert advisor, Robyn McDougal, advised:

> "The ability to perform a full medical assessment at this primary unit is limited and considering [Mrs A's] previous history of caesarean section, the assessment would have been more appropriately performed at the hospital based on the unclear diagnosis of the back pain."

96. I accept Ms McDougal's advice that the decision to assess Mrs A at the maternity unit, even based on an assumption that she was not in labour, was inappropriate given Mrs A's risk factors. Having accepted this, I consider that Ms B's decision to assess Mrs A was inappropriate and, accordingly, Ms B failed to provide care to Mrs A with reasonable care and skill.

Assessment in the maternity unit — Breach

97. There is no dispute that when Mrs A arrived at the maternity unit she was in labour.

98. While there is a slight discrepancy in relation to who made the decision to transfer Mrs A to hospital (Ms B stated that she asked Ms C to call an ambulance for transfer to hospital, whereas Ms C stated that as soon as she saw Mrs A she called the ambulance because she considered immediate transfer was required), there is no dispute about the need for transfer. Clearly there was a common view that transfer was warranted. I do not consider it material who first made the decision to call the ambulance.

99. While awaiting the arrival of the ambulance, Mrs A's membranes ruptured spontaneously. A "copious amount of liquor" was noted. Ms B then listened to the FHR and inserted an IV luer in preparation for transfer to hospital. Ms B initially advised HDC that the sequence of events prevented her from performing an abdominal palpation and vaginal examination before the ambulance arrived, noting that they were all busy preparing for the transfer. Later, Ms B stated that she did not carry out an abdominal assessment or vaginal examination at that time because Mrs A was so distressed she was barely able to lie still. In response to the provisional opinion, Ms B stated that both of these factors, the fact that Mrs A was distressed coupled with the fact that everything progressed very quickly, prevented her from carrying out an abdominal assessment. Further to this, Ms B stated that, in any case, Mrs A's "habitus" would have made it difficult to identify a breech presentation.

100. In contrast, Mrs A does not recall being overly distressed at that stage. This is supported by both Mr A and Ms C, who recall that although Mrs A was in pain, she remained quite calm and responsive to instructions throughout.

101. I do not accept Ms B's account that Mrs A was too distressed for an abdominal or vaginal assessment to be carried out. If that was her assessment, then she should have documented it in the clinical records. As this Office has frequently emphasised, it is through the records that healthcare providers have the power to produce definitive proof of a particular matter, and health professionals whose evidence is based solely

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on their subsequent recollections (in the absence of written records offering definitive proof) may find their evidence discounted.[14]

102. I note Ms McDougal's advice that an abdominal assessment would have been appropriate in order to assess fetal descent. Furthermore, Ms McDougal advised that in light of the fact that Mrs A had experienced a spontaneous rupture of membranes with a large amount of straw-coloured liquor noted, a vaginal examination was also indicated in order to assess cervical dilation, fetal presentation, and station of the presenting part. This was in order to ascertain Mrs A's progress, but also to eliminate the possibility of other labour risks. In particular, Ms McDougal advised that polyhydramnios is a classical risk factor for cord prolapse, especially if the presenting part is not engaged in the pelvis. I note that the midwives caring for Mrs A were aware of the excess liquor, as Ms C had referred to the amount of liquor as polyhydramnios, and Ms B advised that there was a "copious amount of liquor, far more than normal".

103. The New Zealand College of Midwives publication *Standards of Midwifery Practice* (2008) identifies the actions required to ensure the maintenance of the midwifery partnership with the woman. Standard Three states that the midwife collates and documents comprehensive assessments of the woman's and/or baby's well-being.[15] Furthermore, the second decision point in labour in the New Zealand College of Midwives publication *Handbook to Practice* (2008) suggests the need for a full assessment, including assessment of the lie, presentation and descent of the baby, and discussion of the need for vaginal examination.

104. Having found it more likely than not that Mrs A was not too distressed to have an abdominal or vaginal examination performed, and despite Ms B's submission that Mrs A's "habitus" would have meant that a breech presentation would have been difficult to palpate, I conclude that Ms B did not carry out an adequate assessment of Mrs A. Had she done so, Ms B would likely have assessed the fact that the baby was in a breech position, and observed the presence of a cord presentation or cord prolapse earlier and taken appropriate emergency action, including transfer to the hospital with a second midwife. Accordingly, Ms B did not assess Mrs A adequately.

105. I note Ms McDougal's advice that Ms B did not provide basic midwifery care and assessment, which led to "a cascade of serious complicated events that in all probability could have been avoided". Ms McDougal considered that Ms B's failure to carry out these standard midwifery assessments was a serious departure from midwifery standards.

Return to the maternity unit — Breach

106. Initially Mrs A left for the hospital accompanied only by Ms B. Ms B stated that when Mrs A advised that she needed to push, she (Ms B) asked the ambulance to return to the maternity unit. Ms B said that she was not aware that the baby was in a footling

[14] See Opinion 08HDC10236, available at www.hdc.org.nz.

[15] Standard Three states: "The midwife collects information using all sources in consultation with the woman" and "The midwife documents her assessments and uses them as the basis for ongoing midwifery practice."

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breech position at that stage, and she made the decision to return to the maternity unit because she considered this to be safer than delivering the baby in the ambulance.

107. In contrast, Mrs A recalls that shortly after departure from the maternity unit she felt something "fall out" of her vagina and asked Ms B to look. Mrs A said that when Ms B looked she told the ambulance to turn around immediately.

108. I note that both the ambulance service records and the maternity unit records note that Ms B asked the ambulance to return to the maternity unit because the baby's head was visible. Furthermore, I note that the ambulance service records confirm that the ambulance originally left the maternity unit at 7.27pm. Ms C's telephone call asking that the ambulance continue to the hospital as planned is recorded as being received at 7.38pm.

109. In light of the supporting documentation, I accept that it is more likely than not that Ms B carried out a visual assessment in the ambulance. However, it appears that Ms B was not aware at that time that she was looking at a footling breech presentation but believed that delivery was imminent.

110. Ms B submitted that the maternity unit was the safest place to deliver the baby irrespective of whether or not it was breech. I remain of the view that Ms B's decision to return to the maternity unit was unwise. As noted above, the maternity unit is a primary maternity facility, so does not have any facilities to cope with emergency situations, nor does it provide any obstetric services. The hospital was approximately 10–15 minutes away when travelling by ambulance (with lights and siren). As noted by my expert, Mrs A had a number of risk factors, including being pre-term and having had a previous Caesarean section. Therefore, having emergency services immediately available was important.

111. In my view, even accepting that Ms B was not aware that the baby was in a footling breech position and believed delivery to be imminent, Ms B's decision to return to the maternity unit was clinically inappropriate, and a departure from the accepted standard of care.

Transfer after identification of footling breech — No breach

112. By the time the ambulance arrived back at the maternity unit, Ms B had identified that the baby was in a footling breech position. Ms B communicated this to Ms C, who was coming out to meet the ambulance. Ms C subsequently boarded the ambulance and ordered it to return to the hospital.

113. Shortly after departure from the maternity unit, Ms C identified a cord prolapse and assisted Mrs A to turn onto her hands and knees. Ms C applied pressure to the presenting part of the baby while holding the loop of the prolapsed cord to keep it warm. Ms B continued to monitor the FHR.

114. Ms McDougal advised that the management of the footling breech once it was identified was appropriate. Therefore, I am satisfied that this aspect of the care was reasonable in the circumstances.

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Documentation — Breach

115. Ms B did not record contemporaneous records of either her telephone conversations with Mrs A or of her subsequent assessment of Mrs A at the maternity unit. I accept that it was reasonable for Ms B to focus on assessment and caring for Mrs A while at the maternity unit. However, Ms B should have taken detailed notes of her telephone conversations with Mrs A.

116. Clinical records are central to ensuring safe, effective and timely care, and are a requirement of midwifery practice. Competency 2.16 of the New Zealand College of Midwives publication *Midwives Handbook for Practice* (2008) requires that a midwife provide "accurate and timely written progress notes and relevant documented evidence of all decisions made and midwifery care offered and provided".

117. Ms B's failure to document her telephone conversations with Mrs A contemporaneously was a departure from professional standards.

Conclusions

118. In my view, Ms B failed to provide services to Mrs A with reasonable care and skill.

119. When Mrs A initially contacted Ms B by telephone, Ms B failed to communicate adequately with Mrs A and, as a result, failed to elicit an accurate clinical picture.

120. Ms B inappropriately instructed Mrs A to go to the maternity unit for assessment. Even based on the assumption that Mrs A was not in labour, given her risk factors, Ms B should have advised Mrs A to go to the hospital to be assessed.

121. Ms B failed to assess Mrs A adequately following her arrival at the maternity unit and her spontaneous rupture of membranes. Ms B should have conducted an abdominal palpation and vaginal assessment in order to assess the stage of labour and the presentation of the baby. Ms McDougal advised that this was a serious departure from accepted midwifery standards.

122. Ms B should not have returned to the maternity unit once in the ambulance when Mrs A started to push. Even without knowing that she was dealing with a footling breech presentation, Ms B's decision to return to the maternity unit placed Mrs A and her baby in danger given Mrs A's risk factors.

123. Ms McDougal advised that these failures were a moderate departure from expected standards.

124. I conclude that for: failing to communicate adequately with Mrs A and elicit an accurate clinical picture when she first contacted her by telephone; inappropriately advising Mrs A to go to the maternity unit rather than the hospital for assessment; failing to conduct an adequate assessment of Mrs A at the maternity unit; and inappropriately returning to the maternity unit in the ambulance when Mrs A started to push, Ms B failed to provide services to Mrs A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

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125. Ms B failed to comply with professional standards by failing to document her telephone calls with Mrs A adequately and, accordingly, also breached Right 4(2) of the Code.

Recommendations

126. I recommend that the Midwifery Council of New Zealand consider whether a competency review of Ms B is warranted.

127. I recommend that Ms B undertake further training with regard to communication with clients, assessment of women in labour, and documentation. Ms B should provide a report to this Office within three months of the date of this report, confirming her attendance at, or enrolment in, relevant training.

Follow-up actions

128.
- Ms B will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.
- 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 Midwifery Council, the New Zealand College of Midwives, and the District Health Board, and they will be advised of Ms B's name.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

The Director of Proceedings decided not to issue proceedings as appropriate resolution had been obtained.

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Appendix A — Independent midwifery advice to the Commissioner

The following preliminary expert advice was obtained from midwife Robyn McDougal:

"Thank you for the opportunity to review this complaint about [Mrs A] during her labour & birth period.

I have received:

- [Mrs A's] original complaint;
- [Ms B's] response to [Mrs A's] complaint, dated 19th September 2012;
- [Mrs A's] midwifery notes;
- [Mrs A's] records from [the ambulance service];
- [Mrs A's] clinical notes from [the] DHB.

I have read the guidelines for the Expert Advisor and can declare I have no personal or professional conflict in this case.

I will retain these copies of clinical records and related information sent to me, maintaining confidentiality and safety, until I am advised that my involvement with this case is no longer needed.

You have asked that I review this information to consider whether the care received by [Mrs A] from her back up midwife, [Ms B], was adequate. I am also to specify if there are any departures from the expected standards of practice and to also report whether these departures are mild, moderate or severe in nature.

The Complaint:

The substance of the complaint is about [Mrs A's] concerns related to the unsafe midwifery management of her early labour, resulting in an emergency caesarean section which led to the multiple intensive treatments, inclusive of brain cooling treatments for their baby in the Special Care Baby Unit (SCBU).

[Mrs A] went into labour at 35 weeks gestation at around 16.30 hours. Two phone calls were made to her midwife (back up midwife) to state she was having regular contractions. When [Mrs A] finally reached [the maternity unit] for assessment, her membranes ruptured and [Ms B] decided to transfer [Mrs A] to [the hospital] due to the need for caesarean section as planned in the antenatal period with the Obstetrician. Unfortunately [Mrs A's] experience became an obstetric emergency; footling breech with a cord prolapse. There was some redirection of the ambulance with emergency measures in place until they reached [the hospital]. Due to the time taken to get to theatre, the compression on the prolapsed cord and presentation of a breech baby, the baby needed extensive resuscitation at birth and then brain-cooling techniques were administered to help prevent any further nerve damage.

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I believe that there are three departures from expected standards of midwifery practice that are related to:

1. The phone conversations in early labour care: moderate departure
2. The initial acute assessment at [the maternity unit]: serious departure
3. Right 4, part 1 of Health and Disabilities Service, Consumers Rights

I will now cover the pertinent points made in the letter of complaint from [Mrs A].

1. <u>Phone Conversations:</u>

The conversations between [Ms B] and [Mrs A] were very contradictory, not only when looking at the time of the calls but the content of the conversations. The difficulty with a written account of conversations that contradict each other is that the full picture of events is difficult to interpret.

The template below shows the contradictions related to times and content of the conversations.

<u>Conversations between [Mrs A] & [Ms B].</u>	
[Mrs A]	[Ms B]
3:40hrs (15.30): [Ms B] was rung by [Mrs A] to say she was in pain and having regular contractions. [Mrs A] said a second time that she was very sore.	4.30hrs (16.30): [Mrs A] contacted [Ms B] complaining of pain in her back stating the pain radiated down her back to her buttocks and down her legs. [Ms B's] recommendation was to rest and take Panadol.
6.20 (18.20): [Ms B] was phoned again to be informed by [Mrs A] that she was in intense pain and the contractions were now 2–3 minutes apart.	6:00hrs (18:00): [Mrs A] rang to say the pain in her back was worse.

It seems from the letter of complaint that [Mrs A] was in a lot more pain than [Ms B] was able to acknowledge and recognise in the initial phone conversation. The Midwifery handbook for practice has decision points to guide midwifery practice; 'The decision point one in labour — when a woman or her support person first lets her midwife know she is in labour' goes on to say: 'this timing allows the midwife to determine the woman's need for assessment and ongoing midwifery care' (NZCOM, p34, 2008). Due to [Mrs A's] previous pregnancy history of caesarean section (C/S) in 2011 there is a strong implication of risk for both [Mrs A] and her baby if commencement of labour is ignored. The risk of perinatal death due to rupture of uterine scar as a result of labour is 1.4 per 1000 births (Pairman, Tracey, Thorogood & Pincombe, 2010). The risk of a uterine rupture increases with a pregnancy interval of 5–12 months to 4.8% and then drops to 0.9% with an

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interval of 36 months (Boyle, 2011, Nahum, 2012). [Mrs A's] risk could have been seen as very close to a 4.8% chance of uterine rupture due to a 13 month pregnancy interval; previous C/S was in June 2011 and this experience is 13 months later.

Standard Six of the handbook of practice also states 'Midwifery actions are prioritised and implemented with no midwifery action or omission placing the woman at risk' (NZCOM, p 20, 2008). Due to the threat of labour at 35 weeks gestation with a history of previous C/S, the first phone call from [Mrs A] should have alerted [Ms B] to the need for immediate assessment, consultation and transfer of care to a secondary facility.

[Ms B] makes a statement on the bottom of page one of her report, about [Mrs A] needing to stay at home due to family needs. [Ms B] had decided that this would be an indication that [Mrs A] was not in labour. The midwifery handbook for practice has decision points to guide midwifery practice; 'The decision point one in labour — when a woman or her support person first lets her midwife know she is in labour' goes on to say: 'this includes encouraging the woman to stay at home, *if appropriate*, until labour has established' (NZCOM, p34, 2008). While there is always a difficult decision to make about the establishment of labour, there are basic midwifery skills such as abdominal palpation and hands on her abdomen to feel for the strength length and frequency of contractions tightening under the midwife's hand to assess for labour (Pairman, Tracey, Thorogood & Pincombe, 2010). While [Ms B] felt [Mrs A] was not in labour, [Mrs A] asked a second time in the first phone call for confirmation from her backup midwife. Again [Ms B] felt that labour had not established. An assessment, including abdominal palpation and vaginal examination at home could have been offered at the very first phone call and may have been more prudent in the initial instance. Thorpe and Anderson discuss this in relation to the first decision point in labour; 'If a midwife is not certain of the progress of labour, then a home visit should be made before a woman is advised to come to a maternity unit' (Thorpe & Anderson, p 488, 2010). Early labour can be confusing and of course in the reverse, if the woman is not reassured by the phone conversation with the midwife, a home visit would be appropriate. This early assessment could have pre-empted the subsequent events entirely if labour or possibly even the footling breech had been diagnosed initially.

[Ms B] states in her report that 'at no stage did she ([Mrs A]) state she was having contractions' in the conversations with [Mrs A]. This is another contradiction in conversations. While [Mrs A] stated in her letter of complaint that she had told [Ms B] she was having contractions at 1630hrs, the phone calls to [Ms B] did not reassure [Mrs A] and therefore the midwife's responsibility to her client in this instance were not completed with regard to midwifery standards of practice.

[Ms B] has demonstrated a moderate deviation in midwifery standard of practice when [Ms B] did not attend [Mrs A's] need for assessment as soon as she had rung to say she was having contractions.

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2. Initial assessment at [the maternity unit]

[Ms B] asked for [Mrs A] to meet her at [the maternity unit].

1850 hours (hrs); [Mrs A] was in [the maternity unit]

1900 hrs: spontaneous rupture of membranes (as recorded in hospital delivery summary)

1926 hrs: [Ms B] & [Mrs A] left in the ambulance

1949 hrs: Arrived in theatre

1957 hrs: baby born at [the] hospital via C/S

67 minutes from [the maternity unit] to birth of the baby at [the hospital].

The second phone call to [Ms B] initiated a request to assess [Mrs A] at [the maternity unit]. The maternity unit is a primary maternity facility where there are no obstetric services available, unlike [the hospital] which has a secondary maternity facility (Health Point, 2013). It appears by [Ms B's] report at 1850hrs, upon greeting [Mrs A] at [the maternity unit], that [Mrs A] was recognised to be in established labour; 'she was contracting strongly at this stage' and then shortly after arrival at [the maternity unit] [Mrs A's] waters or membranes had ruptured. [Ms B] stated she felt that it was necessary to transfer [Mrs A] straight away and made preparations to do so.

I note that [Ms B] had started electronic monitoring of the baby's heart rate with a cardio toco graph (CTG) and listened for several minutes; page 2 of [Ms B's] report. However there was no attempt to assess [Mrs A] by abdominal assessment for foetal decent in the pelvis, nor had there been a vaginal examination to assess for cervical dilation, foetal presentation, and station/descent of the presenting part in the pelvis prior to departure in order to ascertain labour progress but also to eliminate the possibility of other labour risks.

[Ms B] chose to insert an intravenous cannula for [Mrs A] while 'other midwives in [the maternity unit] were there helping to clean up the floor and attend to [Mrs A]; page 2 of [Ms B's] report.

With the rupture of membranes and the huge amount of straw coloured liquor expelled; (as noted by [Mrs A] in her letter of complaint) possible presence of meconium in the liquor, a vaginal examination to assess for cord prolapse would be safe midwifery practice based on those cues (Pairman et al, 2010). Polyhydramnios is a classical risk factor for cord prolapse especially if the presenting part is not engaged in the pelvis (Thorgood, 2010). Even although polyhydramnios was not a diagnosed risk for this pregnancy, there was a note made by [Ms B] that the amount of liquor was remarked on as 'copious amount, more than normal' page 2 of [Ms B's] report. Engagement of the presenting part in the pelvis was not known as there had not been any assessment for this.

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While [Ms B] listened for several minutes to the CTG, there would have been a good opportunity to discuss and gain consent for initial basic midwifery assessment: abdominal palpation and vaginal assessment. [Ms B] was not working in isolation and some of the tasks she had chosen to perform could have been performed by the other midwives while she assessed [Mrs A] herself. These are decision points discussed in Decision Point Two of the Handbook to practice (NZCOM, 2008).

I believe that [Ms B] has demonstrated a moderate breach in midwifery standards of practice when she did not provide the basic midwifery care and assessment initially without due regard for the antenatal and intrapartum risks associated with this event.

3. <u>Breech Presentation and cord prolapse.</u>

While cervical dilatation was not ascertained, if a woman is so far advanced in her labour, midwives are expected to facilitate the vaginal birth, especially in a primary unit if there is no other safer option, with the knowledge and training for Obstetric emergencies such as breech presentations (Banks, 2004, New Zealand Guidelines Group, 2004, Thorogood & Donaldson, 2010). Standard 6 of the Handbook of practice states that 'the midwife demonstrates competency to act effectively in any maternity emergency situation' (NZCOM, p 20, 2008). According to Thorogood, the incidence of cord presentation resembles 15% of footling breech presentations (Thorogood, 2010). According to Thorogood & Donaldson 'Fewer than 1% of all breech babies are born vaginally in Australia and New Zealand. The New Zealand Guidelines Group stresses that maintaining skills for facilitating vaginal breech birth remains an important goal for all clinicians' (Thorgood & Donaldson, p 828, 2010). While this type of emergency can provoke anxiety and panic for any practitioner, the goal of emergency management is to be calm and resourceful. [Ms B] had quoted she had attended a Technical Skills workshop in May 2012. This is a mandatory workshop that all midwives attend in a three year period to attain and maintain skills in Obstetric emergencies such as breech deliveries and cord prolapse (Midwifery Council, 2005). [Ms B's] inactions have provided me with little evidence that she has reflected on the learnings from this mandatory workshop.

[Mrs A] despite not wanting to push at [the maternity unit], not long after the initial transfer in the ambulance from [the maternity unit], [Mrs A] had an urgent urge to push. The ambulance was then instructed to return to [the maternity unit] for [Ms B] to facilitate a birth there but then disagreement with [the maternity unit] staff about the venue of birth obstructed further timely assessment and management of this event. I believe that if time had been attributed to basic midwifery assessment at 1630 hrs, [Mrs A] would have had a timely admission to [the hospital] well before any crisis occurred. However if there was early assessment and detection of the footling breech and prolapsed cord immediately after the rupture of membranes at 1900hours, even if [Ms B] was not prepared to deliver a breech baby at [the maternity unit], appropriate positioning then would have alleviated cord and head compression for another 26 minutes, avoiding a return to [the maternity unit] a second time but earlier arrival at [the hospital] to

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facilitate an emergency C/S and the birth of the baby earlier than 1957 hrs as noted on the delivery summary. As it has happened there was a delay of 57 minutes which inevitably resulted in some form of cord compression and compression of the after coming head with the breech presentation that compromised the foetal transition to extra uterine life.

I believe that [Ms B] failed to provide reasonable care and skill when she failed to provide basic midwifery assessment in the form of abdominal assessment and vaginal examination after [Mrs A's] waters/membranes ruptured in [the maternity unit] and before attempting an ambulance transfer. I see this as a serious breach of midwifery standards of practice.

4. Neonatal Response to Labour.

The retrospective summary for the transitional response of the Newborn to extra uterine life is reflected in a score out of two for heart rate, respiratory effort, muscle tone, reflex irritability and colour which is called the Apgar score (National Library of Medicine, 2006). [Mrs A's] baby had an apgar score of 1 at one minute, 4 at five minutes and 5 at ten minutes. This result demonstrates difficulty for [Mrs A's] baby to adapt to and maintain respirations which ultimately will be due to an intrapartum insult, in this case probably an episode of hypoxia in the intrapartum period (New Zealand Resuscitation Council Inc., 2010).

While there are no clinical records available for [Mrs A's] baby, there are references in the clinical records of [Mrs A] that state that baby needed resuscitation from the paediatric team in theatre. [Mrs A] discusses in her letter of complaint, conversations with [a doctor], after recovering for her general anaesthetic for her C/S. This doctor informed [Mrs A] of her baby's prognosis: her baby was struggling and had no brain activity and in need of brain cooling techniques. From the clinical records I have, there is no affirmation that this baby has suffered permanently and will be disabled but both parents were prepared for this possibility [by the doctor]; cited in [Mrs A's] letter of complaint. From the clinical records and looking at the evidence, it may be possible that this baby has suffered from Neonatal Encephalopathy (NE).

The Perinatal and Maternal Mortality Review Committee (PMMRC) have just released the 2011 report which discusses NE in terms of perinatal morbidities. The case definition: 'Neonatal encephalopathy (NE) is a clinically defined syndrome defined by difficulty in initiating and maintaining respiration, depression of tone and reflexes, subnormal level of consciousness and often seizures' and goes on to say 'hypoxic-ischaemia is the predominant pathology' (PMMRC, p113, 2013). While there is no record of the blood gas value that was taken in theatre for this baby, but the Apgar score, the admission to SCBU and the conversation with the Paediatrician about baby's probable long term prognosis, along with the brain cooling treatment would indicate that this baby may well have suffered from NE. The PMMRC report gives key findings; '24% of mothers of babies with NE had an acute severe peripartum event and 83% of babies with neonatal encephalopathy had either an abnormal cord blood gas at birth or an Apgar score <7 at one

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minute' (PMMRC, p5, 2013). In 2010–2011, of the 149 babies with NE and born from peripartum complications, of those babies; 3.4 % were babies born after a cord prolapse and 0.7% from head entrapment with breech presentation (PMMRC, 2013). Battin discusses aetiology in terms of Apgar scores with this condition 'Apgar scores: a low Apgar score indicates an abnormal condition at birth but it is not exclusive to asphyxia and drug exposure, trauma, hypervolemia, infection, or congenital anomalies should be excluded' (Battin, 2004).

There is an overwhelming cost not only to the parents during the experience psychologically, but emotionally and physically for the rest of their parenting years, not to mention the social cost on the health system for the life of this infant. I believe that the implication of perinatal morbidity of this nature in this experience would need further investigation due to the absence of the baby's clinical records before passing a view on any deviations from midwifery standards of practice; however the implications of this type of morbidity may well have been avoided if early assessment at the very first phone call had been facilitated.

In summary, [Ms B] has failed to provide basic midwifery care and assessment for [Mrs A] in the early stages of labour. [Ms B] failed to assess labour progress on two different occasions allowing a cascade of serious complicated events that in all probability could have been avoided.

1. The phone conversations in early labour care; by failing to provide the initial physical midwifery assessment of abdominal palpation and vaginal examination for early labour assessment [Ms B] did not recognise [Mrs A's] labour status: moderate departure of standards of midwifery practice

2. The initial acute assessment at [the maternity unit]; by failing to provide the initial midwifery assessment for any intrapartum risks for [Mrs A] by way of a vaginal examination after [Mrs A's] waters/membranes ruptured in [the maternity unit] and before attempting an ambulance transfer: serious departure

3. I also believe that [Ms B] has breached the provision of Right 4 of the Health and Disability Services Consumers' Rights; 'Right to Services of an appropriate Standard (1). Every consumer has the right to have services provided with reasonable care and skill'.

I am comforted by the fact that [Ms B] has reflected in her report about those aspects of midwifery care related to abdominal palpation and vaginal examinations however, I believe phone assessments do not allow for acceptable recognition of all factors with urgent calls especially in light of pregnancy risk factors; premature labour and previous pregnancy history of C/S. There was no indication that [Ms B] was occupied by other midwifery matters that evening and therefore an initial thorough physical assessment at 16.30 hours may have changed the course of this outcome.

…

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Further advice

"[deleted as repeat of earlier advice]

Information Received:

[Mrs A's] complaint to HDC [date].

Summary of telephone conversation between HDC Investigator and [Mrs A] dated 29 November 2011.

Statement from [Ms B], dated 19 September 2012.

Letter from [the], NZCOM lawyer dated 23 September 2013 enclosing statement from [Ms B].

Transcript of interview with [Ms B] dated 5 November 2013.

Statement from [Ms C] dated [16 September 2013].

Transcript interview with [Ms C] dated 5 November 2013.

[Ambulance service] 'incident details' and 'clinical audit report'

Copy of clinical records supplied by [the] DHB.

Copy of additional records supplied by [Ms B].

[Deleted as repeat of earlier advice.]

Expert Advice Required:

I have been asked to review this new information and provide any amendments to my original report if necessary. My advice is as follows:

Please comment generally on the standard of care provided by [Ms B]:

[Ms B] as the backup midwife: The adequacy of the information [Ms B] had as the backup midwife.
The information that [Ms B] had to be able to provide midwifery care for [Mrs A] was adequate. [Ms B] had seen [Mrs A] previously for an antenatal check and [Mrs A] had her own set of notes available at [the maternity unit] when she was in labour. [Ms B] has commented on a previous relationship with [Mrs A] in the first pregnancy as well as having regular Thursday meetings with her practice partner; [Ms D], to discuss their clients. This is reasonable midwifery practice as stated in Standard Seven of the Midwives' Handbook for Practice, 'identifies processes for ensuring midwife back-up, access and support to other colleagues as necessary' (NZCOM, p 21, 2008).

Phone conversations:
The outcome of the two initial phone calls to [Ms B] on the birthday of [Mrs A's] baby has led to a series of events that amounted to an obstetric emergency that may have been avoided.

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While there continue to be contradictions with both accounts of the events in regards to the written responses from [Ms B] and [Mrs A], I believe that neither one really understood the acuity of the situation.

[Mrs A] states she did tell [Ms B] she was having contractions but did not appear to convey this message clearly enough for [Ms B] to be convinced over the phone about her labour status.

[Ms B] did not interpret [Mrs A's] conversation in terms of active labour symptoms.

The appropriateness of the assessment at [the maternity unit]:
[Ms B] thought the interim diagnosis for [Mrs A's] back pain may have been a urinary tract infection (UTI) or *something else* as indicated on page 2 of [Ms B's] transcript interview. The ability to perform a full medical assessment at this primary unit is limited and considering [Mrs A's] previous history of caesarean section, the assessment would have been more appropriately performed at [the hospital] based on the unclear diagnosis of the back pain.

As previously discussed in my original report, the appropriate assessment for early labour based on [Mrs A's] pregnancy risk of previous caesarean section should have included a minimum of abdominal palpation and or vaginal examination to exclude whether labour had begun (Thorpe & Anderson, 2010). This was not performed on two occasions: after the first contact via phone and at the first contact at [the maternity unit].

Further contradictions arise between [Ms B] and [Mrs A] related to [Ms B's] suspicion about being able to perform the abdominal and vaginal assessment at [the maternity unit] due to [Ms B's] anxieties. [Mrs A] states that she was calm and would have consented to an assessment: abdominal palpation or vaginal examination where as [Ms B] states that [Mrs A] was too restless and uncomfortable to perform this assessment. There is no documented record where [Ms B] asked [Mrs A] or attempted to assess by palpation or vaginal examination prior to leaving for [the hospital]. By assessing vaginally after the membranes had ruptured a breech or cord presentation could have been established. At 1855hrs noted by [Ms B], when the membranes ruptured, and prior to leaving at 1926hrs by [ambulance service] records; [39 minutes] manoeuvres; maternal hands and knees position as well as digital pressure vaginally on the presenting part, could have been used to prevent further descent of the baby or compression on the cord; reducing fetal compromise even further. [Ms B] would not have set out initially on her own in the ambulance had this been established by vaginal examination and the management of the emergency may have been less stressful. However the management of the footling breech and cord prolapse during the [ambulance] transfer was acceptable practice.

Documentation:
The documentation of the telephone calls can be unreliably recalled especially if recorded well after an event like this. Documentation is incredibly important as if the event is not written it would seem not to be done.

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<u>*What standards apply in this case?*</u>
The standards of Practice are:

The Competencies for Entry to the Register of Midwives set down by the New Zealand Midwifery Council:

Competency One 'The midwife works in partnership with the woman/wahine throughout the maternity experience': 1.9, 'communicates effectively with the woman/wahine and her family/whanau as defined by the woman/wahine' (NZCOM, p 5, 2008).

Competency Two 'The midwife applies comprehensive theoretical and scientific knowledge with the affective and technical skills needed to provide effective and safe midwifery care' 2.5, 'attends, supports and regularly assess the woman/wahine and her baby/tamariki and makes appropriate, timely midwifery interventions throughout labour and birth' (NZCOM, p 7, 2008).

The Standards of Midwifery Practice:

Standard Three 'documents her assessments and uses them as the basis for on-going midwifery practice' (NZCOM, p17, 2008).

Standard Five 'considers the safety of the woman and baby in all planning and prescribing of care' (NZCOM, p19, 2008).

Standard Six 'identifies deviations from the normal, and after discussion with the woman, consults and refers as appropriate' (NZCOM, p20, 2008).

<u>*Were those standards complied with?*</u>
As with my previous report, unfortunately, I believe there has been a moderate deviation from the above midwifery standards when [Ms B] provided care for [Mrs A] [in] 2012.

…

<u>References</u>

New Zealand College of Midwives. (2008). *Midwives handbook for practice* (3rd ed.). Christchurch.

Thorpe. J, & Anderson. J. (2010). Supporting women in labour and birth. In S. Pairman., Pincombe., J., Thorogood., C., & Tracy., S. (Ed.), *Midwifery: preparation for practice 2e* (2nd ed., Vol. chapter 24, pp. 487–510). New South Wales: Elsevier."

Additional expert advice

Ms McDougal was asked to provide further comment on [Ms B's] decision to return to [the maternity unit]. Ms McDougal advised:

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"I have stated in my report, that the management of the footling breech and prolapsed cord in the ambulance to [the hospital] when [Ms C] was accompanying [Ms B] & [Mrs A] was adequate.

… [Ms B] states she did not assess visually in the ambulance, and at this point it may have been more prudent to spend another 10–15 minutes continuing to [the hospital] (my understanding of information re distances between facilities was 20 minutes +\–) and encouraging [Mrs A] not to push.

I am of the opinion that [Ms B] would have been better continuing even with both scenarios you have asked me to comment on; the baby was born 30 minutes+\– after they had left [the maternity unit] the second time. So even with some encouragement for [Mrs A] not to push, they would have arrived at [the hospital] quicker than they had to have theatre help at hand sooner."

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