Registered Midwife, Ms A

Registered Midwife, Ms B

Registered Midwife Ms C

River Ridge (East) Birth Centre Ltd

A Report by the

Health and Disability Commissioner

(Opinion 11HDC00123)

Table of Contents

Executive summary....1
Complaint and investigation....2
Information gathered during investigation....3
Responses to first provisional opinion....18
Responses to second provisional opinion....19
Opinion: Introduction....20
Opinion: Ms C....23
Opinion: Ms B....24
Opinion: Ms A....25
Opinion: Breach — River Ridge (East) Birth Centre Ltd....29
Opinion: Adverse comment — Ms A, Ms C and Ms B....29
Recommendations....30
Follow-up actions....31
Appendix A — Independent advice to the Commissioner....32

Executive summary

Background

1. In 2010, Mrs F was pregnant with her first child. Registered midwife Ms A provided antenatal care to Mrs F during her pregnancy.

2. Mrs F started having infrequent uterine contractions, which became more frequent by midnight. The following day, at 2am, Mrs F paged Ms A. At that time, Ms A was at River Ridge (East) Birth Centre (River Ridge) with another client, and therefore asked Mrs F to drive to River Ridge.

3. Mrs F asked her friend, Mr E, to drive her to River Ridge, and both recalled arriving at 4am. Mrs F was attended to by River Ridge staff midwives Ms C and Ms B because Ms A was still occupied with another client.

4. During Mrs F's admission, she was intermittently assessed and monitored by Ms C and Ms B. Ms C conducted a vaginal examination, measured Mrs F's pulse at 120 beats per minute (bpm), and commenced CTG trace monitoring. Ms B palpated Mrs F's abdomen, which she recorded was not "tender to touch". Mrs F was also given Entonox[1] for pain relief. Ms C and Ms B recorded that they advised Ms A several times of their concerns about Mrs F's clinical presentation.

5. Mrs F advised HDC that she had constant and severe pain throughout her admission at River Ridge, and that her pain was not sufficiently relieved by inhaling Entonox. The midwives advised HDC that Mrs F was not presenting unusually in terms of her pain.

6. At 5.20am, Ms A's back-up midwife, Ms D, was paged and she arrived at River Ridge at 6am. Ms D stated that Mrs F was distressed and was not in normal labour. At 6.25am, Ms A conducted a vaginal examination and referred Mrs F to the public hospital. Ms A recorded that the reasons for the referral were abdominal pain, the baby was small for gestational age, and the CTG trace recordings were not reassuring.

7. Ms A instructed Mr E to drive Mrs F to the public hospital, without any midwifery support.

8. When Mrs F arrived at the public hospital, the hospital midwife and nurse recorded that Mrs F had constant and severe abdominal pain. Mrs F suffered a placental abruption and required emergency care. Sadly, her baby was stillborn.

Decision summary

Introduction

9. Mrs F's labour at River Ridge did not proceed normally, and the evidence indicates that the midwives were concerned about her. In particular, Ms C and Ms B were aware that Mrs F had a high maternal pulse of 120bpm, documented that Mrs F was in pain and that they were concerned that her pain was disproportionate to the physical findings, and were concerned about the fetal heart rate. Ms C and Ms B

[1] A gas that provides pain relief when inhaled.

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

communicated those concerns to Ms A. Ms C, Ms B and Ms A failed to respond appropriately to those concerns, and breached the Code of Health and Disability Services Consumers' Rights (the Code) as follows.

Ms C — Breach

10. Ms C's assessment and monitoring of Mrs F was fragmented and incomplete. Ms C failed to respond appropriately to Mrs F's presentation with appropriate assessments and monitoring and breached Right 4(1) of the Code.[2]

Ms B — Breach

11. Ms B's assessment and monitoring of Mrs F was fragmented and incomplete. Ms B failed to respond appropriately to her concerns about Mrs F's presentation and breached Right 4(1) of the Code.

Ms A— Breach

12. Ms A failed to take appropriate action to assess Mrs F at River Ridge, in response to the concerns that were relayed to her about Mrs F's presentation. Ms A therefore failed to appreciate the seriousness of Mrs F's presentation. In addition, Ms A's decision to transport Mrs F by private car without any midwifery support was inappropriate in the circumstances.

13. For these failures Ms A breached Right 4(1) of the Code.

River Ridge (East) Birth Centre Ltd — Breach

14. The absence of clear policies contributed to the delay in the actions of staff midwives Ms C and Ms B, particularly in light of their ongoing concerns about Mrs F's presentation. For this reason, River Ridge (East) Birth Centre Ltd breached Right 4(1) of the Code.

Complaint and investigation

15. The Commissioner received a complaint from Mr and Mrs F about the services provided by registered midwife Ms A. The following issues were identified for investigation:

- *Whether registered midwife Ms A provided Mrs F with an appropriate standard of care between 14 Month8[3] and 15 Month9.*

- *Whether registered midwife Ms C provided Mrs F with an appropriate standard of care on 11 Month9.*

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

[3] Relevant dates are referred to as Month8 and Month9, in relation to the relevant stage of gestation, in order to protect privacy.

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

- *Whether registered midwife Ms B provided Mrs F with an appropriate standard of care on 11 Month9.*

- *Whether River Ridge (East) Birth Centre Ltd provided Mrs F with an appropriate standard of care on 11 Month9.*

16. The parties directly involved in the investigation were:

Ms A	Registered midwife/LMC
Ms B	Registered midwife
Ms C	Registered midwife
Ms D	Registered midwife
Mr E	Consumer's friend
Mrs F	Consumer/complainant
Mr F	Complainant
River Ridge (East) Birth Centre	Facility/provider

Also mentioned in this report:

Ms G	Registered midwife
RN H	Registered nurse

17. Independent expert advice was obtained from a registered midwife, Ms Chris Stanbridge (**Appendix A**).

Information gathered during investigation

Mrs F

18. In 2010, Mrs F[4] was pregnant with her first child. Mrs F had an uneventful first and second trimester of her pregnancy. Her birth plan was to deliver at the public hospital and to have her postnatal care at River Ridge (East) Birth Centre (River Ridge). River Ridge is a primary birthing facility for women having a low risk birth and/or postnatal stay.[5]

19. Mrs F's initial Lead Maternity Carer (LMC) was registered midwife Ms G. On 14 Month8, Mrs F had her last antenatal appointment with Ms G as Ms G was going on leave between 27 Month8 and 17 Month9. Ms G recorded in the clinical notes that the baby was active and moving well, and that she had booked an ultrasound growth scan.

[4] Mrs F advised HDC that she is a medically trained doctor but is not a registered health practitioner with the Medical Council of New Zealand.

[5] The District Health Board has an agreement to provide primary maternity services from two facilities, including River Ridge. See www.riverridgeeastbc.co.nz (accessed 18 February 2013).

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

20. From 14 Month8, registered midwife Ms A took over the remainder of Mrs F's antenatal care.[6]

Ultrasound growth scans

29 Month8

21. The growth scan ordered by Ms G was performed on 29 Month8. The radiologist recorded, "Systemically small fetus with normal liquor volume and normal umbilical artery ratios." He recommended another growth scan in two weeks' time.

22. On 30 Month8, Mrs F was assessed by Ms A for the first time. Ms A advised HDC that she had not received the ultrasound scan report at the time of the assessment but arranged to receive a copy of the report later that day. Ms A advised that she discussed with Mrs F the option of a repeat growth scan within a week.

23. Ms A recorded in the clinical notes that there were good fetal movements, the fetal heart rate (FHR) was 130–138 beats per minute (bpm), and the fundal height[7] at 34 weeks' gestation was 31cm. Ms A advised HDC that she discussed with Mrs F the option of having an early induction[8] if the baby's growth slowed significantly. Mrs F advised HDC that she did not consider that an induction was clinically indicated at that stage given the baby's estimated gestational age.

6 Month9

24. Mrs F had another growth scan on 6 Month9. The scan report records the following:

> "Gestational age by scan 35 weeks 4 days +/– 21 days. These measurements lie within the normal range for the given gestational age with the growth parameters between the 5th and 50th centiles. EFW[9] is currently 2562 +/– 374 grams.
>
> Liquor volume is low, moderate oligohydramnios[10] AFI[11] 6.1 cm (below the 5th centile). Umbilical doppler[12] analysis however is normal SD ratio[13] 2.8. The biophysical profile[14] scores 6/8 with a 0 score for fetal tone.
>
> The placenta[15] is anterior clear of the cervix[16] and the os[17] is closed."

---

[6] During the relevant time, Ms A had an access agreement with River Ridge.

[7] Height of the woman's uterus used to assess fetal growth and development during pregnancy.

[8] The starting of labour by artificial means. Medical inductions are carried out using drugs such as prostaglandins or oxytocin, which stimulate uterine contractions. Surgical induction is performed by the artificial rupture of membranes, usually supplemented by oxytocic drugs.

[9] Estimated fetal weight.

[10] A condition in which the amount of amniotic fluid bathing a fetus during pregnancy is abnormally small (0–200ml in the third trimester). It is usually associated with restricted fetal growth.

[11] Amniotic fluid index. The amniotic fluid is the fluid contained within the amniotic cavity. It surrounds the growing fetus, protecting it from external pressure. The amniotic fluid index is an estimate of the amount of amniotic fluid, and is an index for fetal well-being.

[12] A diagnostic technique used for the assessment of many clinical conditions. The Doppler can be used for the assessment of the umbilical artery during pregnancy.

[13] Systolic/diastolic ratio. The term refers to the patient's blood pressure.

[14] A physiological assessment of fetal well-being, including ultrasound scans, cardiotocograms, and fetal movements.

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

25. Mrs F advised HDC that she was concerned about the health of her baby after the scan and consulted Ms A that day. Mrs F stated that Ms A assured her that the amniotic fluid index (AFI) and volume around the baby's limbs were good, and she dismissed Mrs F's concerns as "first mother maternal anxiety" and said that her "medical knowledge as a medical doctor was fuelling [her] anxiety". Mrs F stated that she insisted on a second opinion and a referral to the public hospital. In contrast, in response to the first provisional opinion, Ms A submitted that she did not dismiss the concerns, and made a same-day referral to the public hospital, and re-sent the referral on 10 Month9 (see below).

26. Ms A advised HDC that at the time of Mrs F's appointment, she had not received any telephone calls from the radiology service about the ultrasound scan, and said that the radiologist would usually contact the midwife if there were any concerns indicated by the scan. Ms A stated that no such contact occurred in this case, and that she did not receive a formal scan report from the radiology service.

27. Ms A advised HDC that Mrs F gave her an "informal scan report", which was handwritten. The informal report records that the AF volume had decreased with an AFI of 6.14, that there were "good pockets around limbs", a biophysical profile (BPP) score of 6/8, and estimated fetal weight (EFW) of 2562grams.

28. Ms A stated that she discussed the clinical findings in the informal report with Mrs F and recommended a referral to the Women's Assessment Unit (WAU) at the public hospital.

29. At 6pm that evening, Ms A sent a referral letter to WAU noting that earlier growth scans showed that the baby was small for gestational age. She advised HDC that she attached previous scan reports from 32 and 36 weeks' gestation, a customised growth chart showing EFW under the 10th centile line, and a copy of the graphs from the radiology service showing measurements and growth from the scan of 6 Month9.

30. Ms A advised HDC:

> "I definitely did not minimize [Mrs F's] anxiety about her baby and understood that she was very concerned for her baby's wellbeing and by referring her to the Obstetric Team I was fulfilling my obligations as her LMC."

Follow-up on the referral to WAU

31. Mrs F stated that she called Ms A on 7 and 10 Month9 to follow up on the referral to WAU. Ms A advised HDC that during the telephone conversation of 7 Month9, she

---

[15] An organ within the uterus by means of which the embryo is attached to the wall of the uterus. Its primary function is to provide the embryo with nourishment, eliminate its wastes, and exchange respiratory gases.
[16] The neck of the uterus, which projects into the vagina.
[17] Os refers to the opening of the cervix.

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

assured Mrs F that the referral had been sent the previous day and that WAU would call her directly with an appointment.

32. Mrs F stated that during the conversation on 10 Month9, she requested that Ms A include “red flags” in the referral letter, such as the baby being small for gestational age, intrauterine growth restriction (IUGR),[18] and sudden oligohydramnios. Mrs F advised that Ms A did not like this “intrusion”.

33. Ms A does not recall receiving any telephone call from Mrs F on 10 Month9 but recalls receiving a text message. Ms A advised that she re-sent the referral letter and relevant attachments to WAU at 8.15pm that day. The cover letter records: “Resending with correct ph no on it. Please could you see [Mrs F] in WAU tomorrow [11 Month9].”

34. Ms A advised HDC that she also telephoned WAU on 10 Month9, and the receptionist confirmed to her that the referrals sent on 6 and 10 Month9 had been received. Ms A recorded the following in the notes:

> “Text from [Mrs F] —
> hi its [Mrs F] op d day wasn’t to busy?
> wnt 2kno if [the public hospital] WAU got in touch
> with u abt my baby, wd appreciate a 2nd opinion.
> Do get in touch pls! thnks – 6:38pm.
>
> Phoned her back. No appt from WAU
> yet. Said I would follow up with them.
> Phoned WAU — no appt made yet.
> Too busy to look @ her notes.
> Referral faxed with new ph. no. on it as
> [Mrs F] has shifted over the weekend,
> letter attached to see her on [11 Month9] please.”

35. Ms A clarified to HDC that it was the WAU receptionist who had said that she was “too busy to look at [Mrs F’s] notes” to check whether the referral sent on 6 Month9 had been received.

36. The referral sent on 6 Month9 was actually triaged by WAU on 7 Month9, and Mrs F was to be seen within a week.

Early contractions

37. During the afternoon of 10 Month9, Mrs F started having infrequent uterine contractions, which she thought were Braxton Hicks contractions.[19] Mrs F stated that the contractions became more frequent by midnight and, by then, she was having three contractions every 10 to 20 minutes.

[18] The poor growth of the fetus during pregnancy.
[19] Sporadic uterine contractions.

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person’s actual name.

38. Mrs F paged Ms A at around 2am on 11 Month9. Ms A stated to HDC that she was with another client who was in labour at the time and did not reply to Mrs F until 3.50am. Mrs F said that Ms A asked Mrs F to drive to River Ridge so she could assess her there. In response to the first provisional opinion, Ms A stated that she told Mrs F that she was with another client who was in labour. Ms A said that she did not tell Mrs F to come in, but said to Mrs F that if she thought she was in labour then she could be assessed at River Ridge. Ms A stated, "[Mrs F] sounded like she was in some degree of pain during the phone conversation that indicated she might be in early labour."

39. Mrs F's husband, Mr F, was overseas at the time so she asked her friend, Mr E, to drive her to River Ridge. Mr E advised HDC that Mrs F called him at approximately 3.45am and, when he arrived at Mrs F's home, she was "in serious pain … screaming, bent over, could hardly walk".

Admission to River Ridge

Clinical notes

40. The relevant events that occurred during Mrs F's admission at River Ridge are recorded in both the contemporaneous and retrospective notes. The contemporaneous notes are scant in detail, while the retrospective notes provide a fuller account. However, there are discrepancies in the timing of events between the two records. Ms A and River Ridge staff midwives Ms C and Ms B advised HDC that the correct times are those recorded in the retrospective notes, and that the relevant events occurred 30 minutes to an hour later than is recorded in the contemporaneous notes.[20] For ease of reference, where there is a discrepancy in the timing of events, the time as recorded in the retrospective notes is in brackets next to the time recorded in the contemporaneous notes.

Mrs F's arrival

41. Mrs F and Mr E recall arriving at River Ridge at approximately 4am (4.35am), which is consistent with the contemporaneous notes.[21] Upon her arrival, Mrs F was attended to by Ms B and Ms C. Ms C advised Ms A of Mrs F's arrival, but Ms A was still busy with another client and could not attend to Mrs F. Ms A advised HDC that she anticipated that her other client would soon give birth, and therefore Ms A expected to be able to assess Mrs F within the next half hour.

42. Ms C advised HDC that Mrs F's level of distress when she arrived at River Ridge was "not bad", and her presentation appeared to be that of early labour. Ms C recalled Mrs F saying, "Ooh I'm sore."

43. Ms B stated to HDC that Mrs F "did not appear to be in an unusual amount of pain on arrival".

[20] Ms C's retrospective notes were recorded at 2am on 12 Month9; Ms B's were recorded at 11pm on 11 Month9; and Ms A's were recorded on 12 Month9.

[21] Ms A initially recorded that Mrs F arrived at 4am. On 12 Month9, Ms A changed Mrs F's time of arrival to 4.35am: "NB — error with time above — Arrived at RREBC @ 0435hrs."

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Vaginal examination and commencement of CTG

Contemporaneous notes

44. The contemporaneous notes record that at 4am, Ms C performed a vaginal examination:

> "VE with consent, station 0 cervix not felt completely as very posterior tried to walk forward but too much pain."

45. At 4.10am (5.10am), Ms B tried to commence CTG trace recordings; however, the FHR was not found until 4.20am (5.20am) when Mrs F was in a standing position. The notes record: "Baby's ♥ rate variable some decels [decelerations] noted down to 108, then back up to 120 bpm."

46. The CTG recordings document that monitoring began at 5.06am and continued until 6.46am.

Mrs F's account

47. Mrs F said that the CTG machine was first started at 4.10am and that it showed the FHR was 60bpm. She stated that the midwives assumed that the CTG machine was faulty and brought in a new CTG machine, which measured the FHR at 120bpm with some decelerations. In response to the first provisional opinion, the midwives submitted: "The CTG machine is a reliable indicator of time, being calibrated to the correct time, and recording the first commencement at 0510am."

Midwives' retrospective account

<u>Ms C</u>

48. Ms C's retrospective notes record that Mrs F arrived at River Ridge at 4.35am. Ms C and Ms B escorted Mrs F to a birthing room and asked her whether her membranes had ruptured,[22] to which Mrs F replied, "No," and said that there had been no "bloody show".[23] The retrospective notes also record that Mrs F appeared to be distressed during contractions, which Ms C timed to be approximately 35 to 40 seconds in duration. Ms C recorded that she left the room after showing Mrs F where the call bell was and returned 10 minutes later, at approximately 4.50am, when she noticed that Ms A had not yet checked on Mrs F.

49. Ms C recorded that she then asked for Mrs F's consent to listen to the FHR with a Doppler. The FHR was "very variable ranging in rate from 90 bpm to 125 bpm". In response to the second provisional opinion, Mrs F stated that, in her view, these findings indicate that the baby was in severe distress with a very slow heart rate of 90bpm, which would have resulted in an inadequate blood flow to the baby's brain.

---

[22] The rupture of membranes refers to the amniotic sac breaking, which often occurs at the end of the first stage of labour.

[23] The passage of a small amount of blood or blood-tinged mucus through the vagina near the end of pregnancy. It can occur just before labour or in early labour as the cervix changes shape, freeing mucus and blood that occupied the cervical glands or cervical os. A bloody show is a relatively common feature of pregnancy and it does not signify increased risk to the mother or baby. A larger amount of bleeding, however, may signify a more dangerous, abnormal complication of pregnancy, such as placental abruption or placenta previa.

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Mrs F stated that that was an ominous sign requiring immediate surgical intervention to save the baby's life.

50. Ms C further recorded that she continued to listen for the FHR for about five to ten minutes while Mrs F was in a standing position, but it became more difficult as Mrs F was in "considerable pain with contractions", which Ms C described as "short" and "becoming more frequent".[24] Ms C retrospectively recorded that she then proceeded to check Mrs F's pulse:

> "I checked [Mrs F's] pulse as I had concerns about the low baseline of the fetal heart rate. I could feel [Mrs F's] pulse strong and steady at 120 bpm with a small degree of variability. I was confident that this differed from the fetal heart I auscultated."

51. In response to the second provisional opinion, Mrs F noted her concern that Ms C could not have confidently differentiated a fetal heart rate of 120bpm from a maternal pulse of 120bpm by auscultation alone.

52. Ms C also retrospectively recorded that following her assessment of Mrs F, she "expressed [her] concerns" to Ms B, who was present in the birthing room, before asking Mrs F's consent to conduct a vaginal examination to assess her dilatation. In response to the first provisional opinion, Ms C stated that she "cannot recall advising [Ms B] of any concern regarding the 120bpm and this is consistent with Ms C not considering the 120bpm as a matter of significance at the time as this is within the normal range for a fetal heart rate". Ms C stated that her concerns related to the fetal baseline, and those concerns prompted her to undertake a vaginal examination. The retrospective notes record:

> "VE [Vaginal examination]: station 0[25] cervix just tipped edge of but very posterior tried to walk it forward but [Mrs F] not wanting to be lying on her back as she said it was very sore. I asked her if she meant her stomach but she said no just lying down was uncomfortable. Still could not feel entire cervix so withdrew. Noted that sterile glove was clean. No blood or show or mucous noted either on inco[26] or glove."

53. In response to the second provisional opinion, Mrs F submitted that the response to a fetal heart rate of 90bpm should not just have been a vaginal examination. Mrs F stated that the baby needed an urgent blood gas assessment to check the level of oxygenation, which was a procedure the midwives could not perform, and which River Ridge was not equipped to deal with.

---

[24] In response to the first provisional opinion, Ms C submitted that the pain she referred to in this retrospective note should not be interpreted to mean the pain was anything other than normal expected pain during contractions.

[25] "Station" refers to a baby's position in the womb in relation to two bony spurs in the mother's pelvis. "0 station" means that the baby is level with the bone spurs and has dropped into the pelvis.

[26] Incontinence sheet.

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

54. Ms C retrospectively recorded that she then left the birthing room to inform Ms A about her concerns and the vaginal examination findings: "I recall telling [Ms A] that [Mrs F] was in a lot of pain and not coping with the contractions despite physical findings." In response to the first provisional opinion, Ms C said that she had no concerns about Mrs F's pain and did not discuss the pain with any other practitioner. In response to the second provisional opinion, she submitted that her comment should be interpreted to mean only that Mrs F did not find pain easy to cope with in the early stage of labour, not that the pain was beyond normal.

55. In response to the second provisional opinion, Mrs F stated that, in clinical practice, pain is assessed based on what the client says it is, and that Ms C and her colleagues discounted Mrs F's continuous painful distress, pleas for help, and requests for referral to hospital, because of their interpretation that she was over-reacting.

56. Ms C advised HDC that although she thought the findings of the vaginal examination did not necessarily provide reassurance for the CTG findings, she was not overly concerned at that stage because the situation did not appear to be critical. However, Ms C subsequently advised HDC that she said to Ms A "something along the lines of 'something doesn't add up', and that [Ms C] was not happy with the CTG". In response to the first provisional opinion, Ms C stated that these concerns related to the low baseline FHR.

Ms B

57. Ms B also retrospectively recorded that Mrs F arrived at 4.35am and that Ms C had made Ms A aware of Mrs F's arrival. Ms B recorded that 10 minutes after Mrs F's arrival, at approximately 4.45am, Ms C listened to the FHR, as Ms A was still preoccupied with her other client. Ms B recorded that 10 minutes later, at 4.55am, Ms C told her in the staff room that she had checked Mrs F's maternal pulse, that Mrs F's contractions were "frequent, intense and short in duration", and that the FHR was variable ranging from 90–125bpm.

58. Ms B retrospectively recorded that she entered the birthing room at 5am while Ms C was conducting a vaginal examination of Mrs F. Ms B recorded that Ms C said that the cervix was very posterior and that there was "no bloody show". Ms C left the birthing room after the vaginal examination, and Ms B stayed to assess Mrs F further. The retrospective notes record that Ms B proceeded to palpate Mrs F's abdomen, which was "not tender to touch", and Mrs F described her abdominal pain as "low and towards the groin".

59. Ms B retrospectively recorded that she then monitored Mrs F by CTG but was unable to find the FHR and called for assistance. The retrospective notes record that during this time, Mrs F "seemed relatively comfortable" and was on her cellphone talking to her husband.

60. Ms B retrospectively recorded that when Ms C returned to the birthing room, Ms B asked Ms C to swap the existing CTG machine with another, and recording began on the new CTG machine. In response to the second provisional opinion, Mrs F stated that there was an initial recording of the FHR at 60bpm on the first CTG before it was

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

swapped for the new CTG. Mrs F queried why there is no record of the initial CTG in the contemporaneous notes.

61. Ms B also recorded that at the time the CTG was commenced, she expressed to Ms C her concerns about Mrs F's clinical presentation:

> "Baby's heart rate was variable with baseline of 110bpm. I discussed with [Ms C] my discomfort with the situation & [Ms C] agreed."

62. In response to the first provisional opinion, Ms C and Ms B stated that Mrs F was "not presenting unusually in terms of pain". Ms B submitted that her "discomfort" was in relation to the situation concerning staff levels, and that there was no LMC with Mrs F. In addition, the baseline FHR of 110bpm was at the lower end of normal. Ms B stated that staff were busy, and the low baseline reading required more constant observation than staff could give. In response to the first provisional opinion, Ms B also submitted that her unease was not because the clinical picture did not fit with early labour, and that there is nothing unusual in a woman being distressed at any stage of labour.

<u>Ms A</u>

63. Ms A advised HDC that Ms C spoke to her twice about Mrs F. Ms A stated that the first time was at approximately 5am, when Ms C advised that Mrs F had been given Entonox to use in the interim, that the FHR ranged between 90–125bpm, and that a CTG had been commenced. Ms A stated that she asked Ms C to conduct a vaginal examination to determine whether Mrs F was in labour.

64. Ms A stated that at 5.15am, Ms C informed her that Mrs F's vaginal examination had been difficult to conduct but Ms C felt that Mrs F's cervix was posterior and closed. Ms A stated that she then asked Ms C to call her back-up midwife, Ms D. There is no contemporaneous record of the discussions.

Entonox and Mrs F's use of her cellphone

Contemporaneous notes

65. The contemporaneous notes record that Mrs F commenced using Entonox at 4.25am (5.25am). There is no reference in the contemporaneous notes as to whether it provided Mrs F with sufficient pain relief.

66. Ms C recorded the following in the contemporaneous notes at 4.50am (5.50am):

> "[Mrs F] vomited ++ Contractions Are becoming […] more intense now. [Mrs F] says she feels like a poo when the contractions is at its worst. FHR remains reactive and variable, baseline 110bpm. Contractions 1:4 40 sec now. [Mrs F] using the gas."

Midwives' retrospective account

<u>Ms C</u>

Ms C's retrospective notes record that she advised Mrs F on how to use Entonox effectively. Ms C recorded that Mrs F "seemed to be getting some relief from the

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Entonox and was talking on her cellphone between contractions". Ms C advised HDC that although Mrs F was saying, "Oooh I'm so sore," and, "Oooh my goodness," she was not alarmed by Mrs F's pain because Mrs F was not screaming, had stated, "I'm probably just making a fuss," and was able to talk and text on her cellphone frequently. Ms C further stated that Mrs F never said that her pain was "constant" or that she felt a "tearing pain". In response to the second provisional opinion, Mrs F submitted that it is not true that she said, "I'm probably just making a fuss."

Ms B

67. Ms B advised HDC that as Mrs F was able to converse easily, it gave her the impression that Mrs F was in early labour. Ms B further advised that Mrs F never said that the pain was constant, and did not offer any description other than that the pain was low and in the groin area. Ms B's retrospective notes record the following:

> "[Mrs F] continued to be using the Entonox well and was in relatively no discomfort in between contractions. [Mrs F] also remained on the phone to her husband. I spoke to [Ms A] who was busy in a birth room regarding the monitoring and express[ed] my lack of ease with the situation."

Ms A

68. Ms A's retrospective account was that she entered the birthing room at 5.45am to check on Mrs F and then left at 5.55am to attend to her other client. Ms A recorded:

> "I popped in to see [Mrs F] who had a large vomit on the floor on my arrival to the room. I commenced the CTG which was going & FH was between 100–130 bpm. Due to her distress I attempted to encourage her to use Entonox. This was to enable me to do a VE & assess her labour as her contractions appeared to be much closer together. She was only having one suck of entonox & not using it effectively so I continued to talk to her about assessing her."

69. Ms C, Ms B, and Ms A all acknowledge that they did not measure Mrs F's blood pressure, and that her pulse was measured only once, and that was carried out by Ms C.

Accounts of Mrs and Mr F and Mr E

Mrs F

70. Mrs F has provided a different account of events to that of the midwives. Mrs F advised HDC that she spoke to her husband on her cellphone for about five to ten minutes when she first arrived at River Ridge to tell him that she was being attended to. She stated that she told her husband that she could not talk as she was in too much pain and ended the call. Mrs F advised that she did not speak, or send text messages, to her husband after that call because she was in too much pain.[27]

[27] HDC was unable to obtain Mrs F's cellphone records because Mrs F was on prepay at the time and the telephone company can view usage details for prepay customers going back only to the previous six months.

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

71. In response to the second provisional opinion, Mrs F stated that the midwives' account that she was comfortable and talking to her husband on the phone "is a pure fabrication".

72. Mrs F advised HDC that her abdominal pain was "constant", "severe", and not sufficiently relieved by inhaling Entonox. She stated:

> "Shortly after arriving at the birth centre, I became very distressed and agonising in pain, I wasn't getting any relief from the Entonox and I had no respite from the pain, it was the worst pain of my life (it felt as if my uterus was being ripped apart with a knife), I repeatedly told the birth centre staff that this pain is constant and not going away, I pleaded to go to hospital as I need a better pain control, it was a real agony. Unfortunately they said only [Ms A] could make that decision …"

73. In response to the second provisional opinion, Mrs F stated: "I kept on insisting the entonox wasn't working and my pain [was] not going away, I pleaded to be sent to the hospital for a better pain relief but they turned a blind eye, trivialised my level of discomfort and ignored my constant pleas for help."

Mr E

74. Mr E advised HDC that he was present in the birthing room for most of the time. He stated that Mrs F was in "serious pain" throughout her admission at River Ridge. He said that she was screaming, "I'm dying," and moaning in pain. He further stated that the midwives would hold up the Entonox to Mrs F's face to show her how to inhale it, but she told the midwives more than three or four times that she was in constant pain and that the Entonox was not providing her with pain relief.

75. Mr E said that Mrs F did not speak to her husband on a cellphone while she was at River Ridge and that it was he who spoke directly to Mr F. Mr E advised that he is "disgusted" that the midwives claim Mrs F was able to converse with her husband when he believes that she was not able to talk and was screaming in excruciating pain.

Mr F

76. Mr F advised HDC that at 4am he called Mr E and then attempted to call his wife at around 4.30am. Mr F stated that his wife did not answer so he again called Mr E asking to speak to his wife. Mr E's cellphone records show that Mr F made three calls to Mr E at 4.09am,[28] 4.10am[29] and 5.01am.[30]

77. Mr F stated that his wife was in too much pain to talk, and he could hear her saying, "Oh my god," and groaning in pain. Mr F also advised that he did not engage in any other cellphone or text message correspondence with his wife.[31]

---

[28] The cellphone call was seven seconds.
[29] The cellphone call was 28 seconds.
[30] The cellphone call was 5.3 minutes.
[31] HDC was unable to obtain Mr F's cellphone records because Mr F was on prepay at the time, and the telephone company can view usage details for prepay customers going back only to the last six months.

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

78. In response to the second provisional opinion, Mr F submitted that he was unable to talk to his wife (after the initial confirmation of her arrival at the birth centre) until he arrived at the public hospital, and that Mr E gave him updates on Mrs F's progress. With regard to the account from the midwives that Mrs F was talking on the phone with him, Mr F stated: "[T]his fabrication by the midwives is rather disturbing."

Arrival of Ms D

79. The contemporaneous notes record that Ms A's back-up midwife, Ms D, was paged at 4.25am (5.25am). Ms D recalled being paged at 5.20am and arriving at River Ridge at 6am.

80. Ms D advised HDC that when she was at the front door of River Ridge she could hear that Mrs F was highly distressed, calling out, "Help me please god." Ms D stated that she advised Mr E that Mrs F was not in normal labour and that she needed to be assessed. However, Mrs F would not let Ms D take her pulse.

81. In response to the second provisional opinion, Mr and Mrs F stated:

> "We cry every time we read [Ms D's] recount of events and her timely intervention. She stated [she] knew things were not right after the examination. We still struggle to understand how these three personnel would have the heart to turn a deaf ear and ignore the plight of a fellow human in such a high level of distress!"

82. The contemporaneous notes record the following at 6.05am:

> "[Ms D] present for [Ms A]
>
> S — LMC on leave, [Ms A] as above. Appears established
>
> B — Onset of labour 1400hrs 10:1:11. Primup? SGA[32] labour
>
> A — Assess and plan for from here
>
> R — Plan for analgesia — possible transfer
>
> CTG on continuous, baseline 120 bpm, reactive to contractions, variability 75 bpm. [Mrs F] distressed. Contracting 1:3. Explained that VE [vaginal examination] will be required for assessment of pain relief."

Ms A's assessment

83. Ms A returned to the birthing room at 6.25am and conducted a vaginal examination. She retrospectively recorded the following:

> "Cx. Midline, closed, 80% effaced, station –2. For discussion with oncall Reg [Registrar] CTG insitu — FH — 100–120 bpm, no decelerations noted, good variability SGA baby. Reluctant to give pethidine as not in labour, SGA baby & CTG not totally reassuring. To ring [the public hospital]."

[32] Small for gestational age.

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

84. Ms D, who was present in the birthing room when Ms A conducted the vaginal examination, advised HDC that "she knew things were not right" with Mrs F's presentation following the examination and therefore put pressure on Ms A to transfer Mrs F to hospital.

85. Ms C retrospectively recorded:

> "… [Ms B] and I further questioned the non-reassuring trace and apparent pain that was disproportionate of VE findings. [Ms A] then arrived in staff room having birthed her other woman and we proceeded to discuss [Mrs F's] situation. Conversation went back and forth between all three parties about a plan of action and I suggested to consult with the obstetric registrar and seek advice."

86. In response to the first provisional opinion, Ms C submitted that the use of the word "disproportionate" was her way of describing a woman who experiences pain earlier in labour than the average, but where the pain is "still within the bell-curve of 'normal' and not necessarily indicative of anything other than an expression by that woman of normal pain". In response to the second provisional opinion, Mrs F stated that this is a disturbing comment as it suggests to her that Ms C considers she can assess a patient's pain, rather than accepting that the pain is what the patient tells her it is. Mrs F questioned the basis of saying there is a normal bell curve of pain in labour.

87. Mrs F stated that Ms C and Ms B knew the CTG tracing was non-reassuring throughout and that Mrs F was distressed and in pain that was not in keeping with their VE findings. Mrs F stated that this is in contrast to their retrospective notes, which state that the level of her pain was normal and she was relatively comfortable.

88. In response to the first provisional opinion, Ms A stated that the decision to call the public hospital was her own, as she "considered a transfer could enable Mrs F to have pain relief other than Entonox or Pethidine". In response to the second provisional opinion, Mrs F stated that she "had pleaded all night to be transferred to [the public hospital] for better pain relief".

Transfer to the public hospital

89. At 6.48am, Ms A called the registrar at the public hospital. Ms A advised HDC that the registrar seemed reluctant to accept Mrs F despite Ms A advising of the vaginal examination findings, non-reassuring CTG trace, and Mrs F's distress, and that Mrs F's baby was small for gestational age. Ms A stated that she had to "persuade" the registrar otherwise.

90. The District Health Board's (the DHB's) Obstetrics Telephone Information Record notes the following:

> "CURRENT PREGNANCY
>
> LMC Name: [Ms A] Direct Contact Number: ________
>
> G: I P: O Gestation: 38

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

RELEVANT MEDICAL/OBSTETRIC HISTORY

SGA babs

Abdo pain

? Non-reassuring CTG"

91. Ms A advised HDC that she instructed Mr E to drive Mrs F to the public hospital, and said she would go as soon as she could, but her other client had given birth at 6am. Ms A explained to HDC that although she considered an ambulance, she believed that it would be quicker by private car. In response to the first provisional opinion, Ms A submitted that the ambulance service "had known delays".

92. Ms D advised HDC that she was unhappy with Ms A's decision, and she told Ms A twice that she should go with Mrs F to hospital, which Ms A declined to do. In response to the first provisional opinion, Ms A said that this conversation did not occur and, in any event, Ms D could have called an ambulance or accompanied Mrs F in the car herself if she considered there was a need to do so. Ms A submitted that the journey was 10 minutes by car, but an ambulance transfer may have taken up to 60 minutes and, "[a]s [Mrs F] was in early labour/establishing, there was no need to monitor her in the car for the short time it would take to transfer to [the public hospital]".

93. An undated DHB "Antenatal Assessment Sheet" records:

> "Referring LMC: [Ms A]
>
> Reason for referral: abd pain — constant 38/40
>
> **Initial examination**
>
> …
>
> Baseline observations: Temp 36.8 Pulse 116 Blood Pressure 140/85."

94. The DHB confirmed to HDC that the Antenatal Assessment Sheet was completed by the staff midwife.[33] The DHB stated that its staff midwives realised the acuteness of Mrs F's presentation and retrospectively documented that in the clinical notes.

Admission to the public hospital

95. Mrs F arrived at the public hospital sometime between 7–7.30am.[34] Registered nurse RN H recorded that at 7.30am she found Mrs F "writhing on the bed, [saying] 'I'm in pain, so much pain'". RN H conducted an examination and recorded the following:

> "I helped her change into a nightie then listened for the fetal heart — did not palpate [Mrs F] as she was too sore + pushed my hands away. Reported no SRM[35]

[33] The staff midwife now resides overseas.

[34] The DHB's Maternity Patient Admission Form is undated and the time of admission and admitting clinician are not recorded. However, it can be surmised from the clinical records that Mrs F arrived between 7–7.30am.

[35] Spontaneous rupture of membranes.

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

or bleeding. As she reported the pain to be constant + I could not ascertain if contracting or not, I called for help. I had picked up a heart rate around 112–117 BPM in lower abdomen.

[The staff midwife] came to help — took mat [maternal] pulse — 120 BPM, BP [blood pressure] 140/85.

Decision made to take [Mrs F] to del [delivery] suite for closer monitoring."

96. The clinical notes record that as Mrs F was being transferred, she suddenly started bleeding and required emergency care. Mrs F suffered a placental abruption and, sadly, her baby was stillborn.

Subsequent events

Competency review

97. In 2011, following receipt of Mrs F's complaint,[36] the Midwifery Council of New Zealand required Ms A, Ms C and Ms B to undergo competency reviews.

98. Ms A is required by the Midwifery Council of New Zealand to practise under supervision, and currently Ms C does not hold a practising certificate.[37]

Amendment of River Ridge's policy

99. During the relevant time, River Ridge had a policy outlining the LMC's responsibility when a client is admitted to River Ridge. The *Admission to Birth Room* policy provides that it is preferable that the LMC is present upon the client's arrival at River Ridge, and the LMC is to be present within 20 minutes of a client's arrival. The policy makes clear that it is the LMC's responsibility to arrange for a back-up midwife, and staff midwives are to provide "assistance **only**" (River Ridge's emphasis).[38]

100. The policy was amended in December 2012 to include a provision setting out the LMC's responsibility where the LMC has two clients in labour present at River Ridge at the same time. The provision provides:

> "If the LMC has got two clients who are in labour at RREBC she will arrange for her back up LMC (who has an access agreement) to attend immediately to care for a client long term. If the LMC fails to call her back up, the staff midwife will arrange for the back up LMC to attend immediately or arrange transfer to [the] DHB to care for one of the clients."

101. River Ridge's *Transfers Out* policy recommends that all women are transported to hospital by ambulance and escorted by either the LMC or a staff midwife.[39]

[36] Mrs F's complaint was referred to HDC under section 64 of the Health Practitioners Competence Assurance Act 2003.
[37] Information accessed from the Midwifery Council of New Zealand's website on 15 April 2014.
[38] Policy issued in August 2008. Updated in October, September and December 2010.
[39] Policy issued in August 2006. Updated in September 2010.

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Responses to first provisional opinion

102. In addition to the comments included elsewhere in the opinion, Ms B, Ms A and Ms C submitted as follows:

- They are “devastated and shocked at the Commissioner’s provisional findings”. They maintain their evidence is true, and Ms B and Ms C submitted that their comments to HDC staff have been taken out of context.

- It is erroneous to find that Mrs F was not in early labour. It was also submitted that “[t]he clinical observations on record show that by 5.15am as per the CTG, [Mrs F] was not assessed as in established labour; her cervix was closed and the contractions were short in duration”.

- Mrs F was not in severe and constant pain. She was not presenting unusually in terms of her pain, in that her pain was associated with her contractions and therefore was “short” and “becoming more frequent”, not continuous. The fact that a CTG was strapped on when Mrs F was standing, and that Mrs F tolerated a vaginal examination and abdominal palpation is inconsistent with a finding that she was in constant and severe pain. In addition, if Mrs F had been in severe and constant pain, it would have been apparent to all practitioners and four individual practitioners would not have let a woman suffer constantly and severely for a lengthy period. Ms C submitted that “[n]owhere is severe and constant pain indicated which one would expect if it was observed”.

- The first provisional opinion fails to give appropriate and consistent weight to the retrospective records, which were made within 20 hours of the event “without knowledge of the particulars of the subsequent complaint”.

Mrs F

103. Mrs F pointed to the inconsistencies in the accounts of the midwives.

River Ridge

104. River Ridge submitted that a situation where the LMC was present but unable to fulfil her responsibilities had not occurred previously.

105. River Ridge further submitted that “the midwives were overly cautious about preserving the role of the LMC and did not sufficiently identify that this was a situation requiring action”, and that this was a failure of the midwives rather than a systems or cultural issue for River Ridge.

106. River Ridge also submitted that a developing placental abruption can be easily missed, as happened in this case.

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person’s actual name.

Responses to second provisional opinion

107. The midwives made no further responses to the second provisional opinion. They stated that they were willing to supply apologies and reflections as recommended.

River Ridge

108. In addition to the comments included elsewhere in the opinion, River Ridge submitted as follows:

- The midwives were overly cautious about preserving the role of the LMC and did not sufficiently identify that this was a situation requiring action on their part. However, policies were in place that required them to take action.

- The admission protocol has been amended to define more clearly the staff midwives' responsibilities should a woman in labour arrive when the LMC is not present.

- It has audited its compliance with the Admission to Birth Room policy and Transfers Out policy and reported 100% compliance.

Mr and Mrs F

109. In addition to the comments included elsewhere in the opinion, Mr and Mrs F submitted as follows:

- They are still struggling to deal with these events.
- They always had concerns about delivery in birthing centres, and it was never an option they would have considered for delivery. When Mrs F became pregnant, they expressly made it clear to the LMC that delivery must be at the hospital and postnatal care at River Ridge.
- The reason Mrs F went to River Ridge was for an initial assessment by Ms A, at Ms A's request. Mrs F was to be transferred to the hospital for subsequent care.
- Ms A was aware that Mr F was away at that time, as that had been discussed with Mrs F's previous LMC, Ms G, who handed over the information to Ms A.
- The midwives' accounts demonstrate a basic lack of understanding of the difference between uterine-associated pain and peritoneal (abdominal) pain. Although sometimes the distinction can be blurred, constant and severe pain from a uterine origin does not necessarily involve the peritoneum (thin lining of the abdominal cavity), except that if there has been a rupture of the uterus with the contents causing an irritation of the peritoneum, the pain would present as a generalised peritonitis pain, which could be felt across the whole abdomen. That type of pain would be similar to the pain experienced by someone with a perforated gut.
- The midwives' assertion about the CTG strap is not plausible. Mrs F did not have a peritonitis pain, and CTG straps are not compressive.

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

- Tolerating an abdominal examination is not a clinical yardstick to determine the severity and constancy of pain.
- The midwives said that they would not have let a woman suffer constantly and severely, but Mrs F's pain was obvious to every other person involved. It is hypocritical for the midwives to state that they would not have let a woman suffer, because they recorded their ongoing concerns about Mrs F's level of distress, but ignored the distress.
- Following this tragedy, Mrs F and her husband have been shattered emotionally and "scarred by the level of inhumanity meted out to [them] by the midwives in [Mrs F's] time of need."

Opinion: Introduction

110. There are significant factual discrepancies between the accounts of Mrs F and the midwives, particularly in relation to Mrs F's overall clinical presentation during her admission at River Ridge. Furthermore, the midwives' accounts in the contemporaneous notes, retrospective notes, and responses to the provisional opinion have differed to the extent that determination of events has been difficult and time-consuming. Accordingly, I will first deal with the relevant factual issues before determining whether the individual midwives or River Ridge itself provided Mrs F with an appropriate standard of care.

111. Mrs F advised HDC that her abdominal pain was constant and severe throughout her admission at River Ridge, and that she told the midwives about this several times.

112. In contrast, Ms A, Ms C and Ms B stated that at no time did Mrs F say her abdominal pain was constant and severe. The three midwives submitted that Mrs F's constant and severe pain began on admission to hospital.

113. It is recorded in the DHB's "Antenatal Assessment Sheet" and RN H's clinical notes that Mrs F was in constant pain at the public hospital. The description of Mrs F's abdominal pain recorded there is consistent with Mrs F's description to HDC of her pain while at River Ridge. However, the fact that Mrs F was in constant pain while she was at the public hospital is not, in itself and for the purposes of my investigation, determinative of her condition at River Ridge.

114. It is clear that Mrs F was in significant pain while at River Ridge. However, in light of the conflicting evidence and, for the purposes of my investigation, I am unable to make a factual finding as to the constancy and severity of Mrs F's pain at River Ridge, or the extent to which she told the midwives about that pain.

115. Nevertheless, I consider that the evidence indicates that Mrs F's presentation while she was at River Ridge was unusual, in that her labour was not proceeding normally.

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

In particular, Mrs F had a high maternal pulse of 120bpm, and the midwives were concerned that the CTG trace was non-reassuring.

116. I consider that the midwives should have been aware of the evidence that Mrs F's labour was not proceeding normally, and the evidence before me indicates that they did have some such concerns. In particular:

- The midwives were aware of Mrs F's high maternal pulse. Ms C retrospectively recorded, "I checked [Mrs F's] pulse as I had concerns about the low baseline of the fetal heart rate. I could feel [Mrs F's] pulse strong and steady at 120 bpm with a small degree of variability." Ms C recorded that, following her assessment of Mrs F, she expressed her concerns to Ms B, who was present in the birthing room, and to Ms A. Ms B recorded that Ms C told her that she had checked Mrs F's maternal pulse. I find it more likely than not that, when reporting her concerns, Ms C advised Ms B and Ms A of Mrs F's high maternal pulse.

- The midwives documented that Mrs F was in pain, and that they were concerned that Mrs F's pain was disproportionate to the physical findings as follows:

  - On Mrs F's arrival at River Ridge, Ms C performed a vaginal examination. She documented her findings as: "VE with consent, station 0 cervix not felt completely as very posterior tried to walk forward but too much pain."
  - Ms C retrospectively recorded that, shortly after the first vaginal examination, she told Ms A that Mrs F was in a lot of pain and not coping with the contractions despite physical findings.
  - Ms B recorded that Mrs F was experiencing abdominal pain that was "low and towards the groin".
  - Ms A recalls that, at 5.15am, Ms C informed her that Mrs F's cervix was posterior and closed, but when Ms A assessed Mrs F at 5.45am, she noted that Mrs F's contractions appeared to be much closer together, and Mrs F was distressed.
  - When Ms D arrived, she said she could hear from the door of River Ridge that Mrs F was highly distressed.
  - Ms A conducted a vaginal examination at 6.25am and noted: "[Cervix] Midline, closed, 80% effaced, station –2 … Reluctant to give pethidine as not in labour."
  - Ms C retrospectively recorded: "… [Ms B] and I further questioned the non-reassuring trace and apparent pain that was disproportionate of [vaginal examination] findings."
  - The DHB's Obstetrics Telephone Information Record notes indicate that when Ms A called the hospital to transfer Mrs F, she informed the hospital that Mrs F was experiencing abdominal pain.

- The midwives documented that they were concerned about the fetal heart rate as follows:

  - Shortly after Mrs F's admission, Ms C also recorded that the fetal heart rate was "very variable ranging in rate from 90 bpm to 125 bpm". Ms C stated

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

that she "checked [Mrs F's] pulse as [she] had concerns about the low baseline of the fetal heart rate". Ms C said that she expressed her concerns about the fetal baseline to Ms B, and that those concerns prompted her to undertake a vaginal examination.

- Ms C advised HDC that she thought the findings of the vaginal examination did not necessarily provide reassurance for the CTG findings.
- Ms C advised HDC that she informed Ms A that "something doesn't add up", she was "not happy with the CTG" and that by that she meant that she was concerned about the low baseline fetal heart rate.
- Ms B recorded that initially she was unable to find the fetal heart rate. She then recorded that, at the time the CTG was commenced, she expressed to Ms C her concerns about Mrs F's presentation, in particular: "Baby's heart rate was variable with baseline of 110bpm. I discussed with [Ms C] my discomfort with the situation & [Ms C] agreed." Ms B advised HDC that the fetal heart rate baseline of 110bpm was at the lower end of normal, and she was concerned that it required more constant observation than staff could give (in the absence of the LMC).
- Ms C retrospectively recorded: "… [Ms B] and I further questioned the non-reassuring trace and apparent pain that was disproportionate of [vaginal examination] findings."
- On examining Mrs F at 6.25am, Ms A retrospectively recorded her findings as including "CTG not totally reassuring", although she did not note in what regard she considered that the CTG was not reassuring.
- The DHB's Obstetrics Telephone Information Record notes indicate that when Ms A called the hospital to transfer Mrs F, she informed the hospital that the CTG was not reassuring.

117. Furthermore, Ms D advised HDC that, following the vaginal examination at 6.25am, conducted by Ms A, "she knew things were not right" with Mrs F's presentation.

118. Given the above, I consider that the evidence indicates that Ms B and Ms C were aware that Mrs F's maternal pulse was 120bpm, that Mrs F was experiencing pain, and that they considered that her pain was disproportionate to the physical findings. I also consider that the evidence indicates that, at the time, Ms B and Ms C were concerned about the CTG. In these circumstances, I do not accept their submissions in response to the first provisional opinion that they had no concerns at the time about Mrs F's presentation, including her pain and/or the CTG.

119. I also find that, at the time of the events, both Ms C and Ms B communicated their findings and concerns to Ms A. This may have occurred as early as when Ms C says she told Ms A of those concerns and the vaginal examination findings, that is, shortly after 4.50am or, at the very latest, at around 6.25am when Ms A conducted the second vaginal examination.

120. I reject subsequent submissions made by the midwives that suggest they were not concerned about Mrs F's pain, the physical findings, or the fetal heart rate/CTG, or that those concerns were not communicated to Ms A.

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

121. With the above in mind, I will now turn to the standard of care provided to Mrs F by each midwife and by River Ridge itself.

Opinion: Ms C

Care of Mrs F at River Ridge — Breach

122. Along with Ms B, Ms C was responsible for the monitoring and assessment of Mrs F while Ms A was engaged with another patient.

123. As noted above, I find that, on the basis of her intermittent monitoring of Mrs F, Ms C was concerned about Mrs F's presentation, in particular that Mrs F's pain was disproportionate to the physical findings, and that the fetal heart rate baseline was of concern. Ms C was also aware that Mrs F's maternal pulse was high at 120bpm.

124. In my view, Mrs F's presentation should have triggered Ms C to conduct a full assessment of Mrs F. I find that Ms C failed to assess Mrs F adequately, and did not act sufficiently proactively in response to the situation.

125. In particular, when Ms C measured Mrs F's maternal pulse, she noted that it was 120bpm. I accept the advice of my independent expert midwifery advisor, Ms Chris Stanbridge, that Mrs F's maternal pulse of 120bpm was rapid and a significant clinical finding that required further investigation and monitoring. Ms Stanbridge stated that Mrs F's pulse rate should have prompted Ms C to take Mrs F's blood pressure and further monitor the maternal pulse. Ms C did not do this. There is also no record that Ms C palpated Mrs F's abdomen or assessed fetal activity.

126. I am also concerned that Mrs F's pulse of 120bpm did not appear to trigger an assessment of the CTG by Ms C. For periods, it appears that the fetal heart rate as recorded by the CTG was similar to the only recorded maternal pulse of 120bpm.

127. Ms Stanbridge stated that although the CTG could reasonably have been read as a reassuring CTG, "In retrospect, the possibility could be raised that some, or all, of it could have been maternal pulse". Ms Stanbridge further stated:

> "[I]n retrospect it is unclear if the CTG was showing fetal or maternal heart rate … maternal pulse should be checked at any time a CTG is applied, to ensure a differentiation between maternal pulse and fetal heart."

128. The New Zealand College of Midwives "Consensus Statement Foetal Monitoring in Labour" (2005) recommends: "Prior to any form of foetal monitoring, the maternal pulse should be palpated simultaneously with [fetal heart rate] auscultation in order to differentiate between maternal and foetal heart rates."

129. In my view, Ms C's assessment and monitoring of Mrs F was fragmented and incomplete. I agree with Ms Stanbridge that Ms C's failure to conduct further

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

investigations in response to Mrs F's maternal pulse of 120bpm resulted in Ms C missing a potential warning sign, and that this failure would be viewed by Ms C's peers with moderate disapproval.

130. While I note that Ms A was the LMC, Ms C also had a responsibility to provide Mrs F with services with reasonable care and skill. Ms C was concerned about Mrs F's presentation, including the low fetal heart rate baseline, and was aware that Mrs F's pulse was rapid. For the reasons set out above, I consider that Ms C failed to respond to Mrs F's presentation adequately with appropriate assessments and monitoring and, accordingly, I find that Ms C breached Right 4(1) of the Code.

Opinion: Ms B

Care of Mrs F at River Ridge — Breach

131. Along with Ms C, Ms B was responsible for the assessment and monitoring of Mrs F while Ms A was engaged with another patient.

132. As noted above, I find that, on the basis of her intermittent monitoring of Mrs F, Ms B was concerned about Mrs F's presentation, in particular that Mrs F's pain was disproportionate to the physical findings, and that the fetal heart rate baseline was of concern. Ms B was also aware of Mrs F's high maternal pulse.

133. In my view, Mrs F's presentation should have triggered Ms B to conduct a full assessment of Mrs F. I find that Ms B failed to assess Mrs F adequately, and did not act sufficiently proactively in response to the situation.

134. In particular, Ms B recorded that she palpated Mrs F's abdomen, which was "not tender to touch". However, Ms B did not measure or monitor Mrs F's pulse or blood pressure. This is despite Ms C recording a high maternal pulse of 120bpm which, as advised by my independent expert midwifery advisor Ms Chris Stanbridge, was a significant clinical finding that required further investigation and monitoring. Such assessment and monitoring would have reasonably included the taking of Mrs F's blood pressure and further monitoring of the maternal pulse. Ms B did not do this, nor is there any record that she assessed fetal activity.

135. I accept Ms Stanbridge's advice that the failure to monitor the maternal pulse and blood pressure in this case represented a departure from accepted standards.

136. I am also concerned that Mrs F's pulse of 120bpm did not appear to trigger an assessment of the CTG by Ms B. For periods, it appears that the fetal heart rate as recorded by the CTG was similar to the only recorded maternal pulse of 120bpm.

137. Ms Stanbridge stated that, although the CTG could reasonably have been read as a reassuring CTG, "[i]n retrospect, the possibility could be raised that some, or all, of it could have been maternal pulse". Ms Stanbridge further stated:

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

"[I]n retrospect it is unclear if the CTG was showing fetal or maternal heart rate … maternal pulse should be checked at any time a CTG is applied, to ensure a differentiation between maternal pulse and fetal heart."

138. The New Zealand College of Midwives "Consensus Statement Foetal Monitoring in Labour" (2005) recommends: "Prior to any form of foetal monitoring, the maternal pulse should be palpated simultaneously with [fetal heart rate] auscultation in order to differentiate between maternal and foetal heart rates."

139. In my view, Ms B's assessment and monitoring of Mrs F was fragmented and incomplete. While I note that Ms A was the LMC, Ms B also had a responsibility to provide Mrs F with services with reasonable care and skill. Ms B was concerned about Mrs F's presentation; however, for the reasons set out above, I consider that Ms B failed to respond appropriately to those concerns. Accordingly, I find that Ms B breached Right 4(1) of the Code.

Opinion: Ms A

140. Ms A was Mrs F's LMC and therefore had primary responsibility for Mrs F's pregnancy, including management of her labour and birth. Ms A was also responsible for conducting relevant assessments to identify whether Mrs F and/or her baby were at risk and, if so, whether specialist referral was indicated.[40]

Care provided between 14 Month8 and 10 Month9 — No breach

141. From 14 Month8, Ms A took over Mrs F's antenatal care. Ms A assessed Mrs F on 30 Month8 following the ultrasound scan performed on 29 Month8, and discussed the option of a repeat scan within a week. Ms A measured the fundal height and FHR, and noted good fetal movements.

142. On 6 Month9, Ms A assessed Mrs F for a second time and discussed the results of the ultrasound scan performed that day. Following that consultation, Ms A referred Mrs F to WAU. Ms A recorded that the baby was small for gestational age and attached relevant information from previous scans to support the referral.

143. My expert midwife, Chris Stanbridge, advised that Ms A's standard of care during that period was appropriate. Ms Stanbridge stated that Ms A provided ongoing monitoring of Mrs F's fundal height, fetal growth and movements, and appropriately followed the radiologist's recommendation for a repeat scan.

144. Ms Stanbridge also advised that Ms A appropriately responded to Mrs F's concerns of 6 Month9 by referring her to WAU and later following up the referral on 10 Month9.

---

[40] Primary Maternity Services Notice, Section 88, Health and Disability Services Safety Act 2000, Maternity Services 2007.

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Accordingly, I consider that Ms A provided maternity services of an adequate standard to Mrs F during that period.

Care of Mrs F at River Ridge — Breach

145. When Mrs F arrived at River Ridge on 11 Month9, Ms A was occupied with another patient and was unable to assess Mrs F fully until 6.25am. Therefore, for the majority of the time, Mrs F was attended to only by Ms C and Ms B. However, Ms A remained primarily responsible for Mrs F's care because that responsibility had not been formally referred to anyone else.[41]

146. As noted above, I find that Ms C and Ms B informed Ms A of their findings and shared their concerns about Mrs F's presentation with her, in particular that Mrs F's pain was disproportionate to the physical findings and that the fetal heart rate baseline was not reassuring. Ms C and Ms B were also aware that Mrs F's pulse had been recorded as 120bpm, which was a significant finding. I find that Ms C communicated that information to Ms A.

147. My independent expert midwifery advisor, Ms Chris Stanbridge, did not raise concerns about the care Ms A provided to Mrs F at River Ridge. Ms Stanbridge advised that the CTG was interpreted as adequate, although Ms Stanbridge also noted that "in retrospect it is unclear if the CTG was showing fetal or maternal heart rate … [M]aternal pulse should be checked at any time a CTG is applied, to ensure a differentiation between maternal pulse and fetal heart." Ms Stanbridge further noted that although Mrs F was distressed with contractions and finding it difficult to cope, that "could have well been within the normal range of responses to labour".

148. The adequacy of a midwife's clinical judgement is assessed substantially by reference to usual practice of comparable practitioners. In this case, Ms Stanbridge is a comparable practitioner to Ms A.

149. I have carefully considered all the information gathered in the course of my investigation, including Ms Stanbridge's advice. Having done so, I disagree with my advisor that Ms A provided adequate care to Mrs F at River Ridge. I do not make the decision to disagree with my advisor lightly. However, as this Office has previously stated:[42]

> "[E]ven in relation to diagnosis and treatment, medical opinion is not necessarily determinative.[43] I am not bound to accept expert opinions uncritically.[44] It is open to HDC to hold that the standard acceptable to the profession was nonetheless not reasonable. Ultimately the reasonableness of any standards adopted by the medical practitioner is for the Commissioner to determine, taking into account usual practice, as well as patient interests and community expectations.[45] In the

[41] See Opinion 09HDC01311 at paras 91–95 (available at www.hdc.org.nz).
[42] See Opinion 09HDC01592 and Opinion 08HDC07350 (both available at www.hdc.org.nz).
[43] *B v Medical Council of New Zealand* 8/7/96, Elias J, HC Auckland HC11/96.
[44] Skegg and Paterson, *Medical Law in New Zealand* (Brookers, Wellington, 2006), ch 4, p114.
[45] *Lake v Medical Council of New Zealand* 23/1/98, Smellie J, HC Auckland, HC123/96.

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

leading decision of *Bolitho v City and Hackney HA*, the House of Lords stated:[46] 'If, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold the body of opinion is not reasonable or responsible.'"

150. In my view, the standard for a midwife in Ms A's particular circumstances, as expressed by Mrs Stanbridge, is not reasonable. Having regard to usual practice, patient interests and community expectations, I do not consider that Ms A responded appropriately to the concerns that were relayed to her about Mrs F's presentation, and did not act sufficiently proactively in response to the situation. The reasons for my view in this regard are set out below.

151. The *Midwives Handbook for Practice* states that LMCs are responsible for ensuring that their actions are prioritised and implemented appropriately, with no midwifery action or omission placing the woman and/or her baby at risk. The LMC is required to identify deviations from the normal, ensure that potentially life-threatening situations take priority, and take the maternal blood pressure and pulse when assessing a woman in labour.[47]

152. Despite the concerns relayed to her, in particular that Mrs F's maternal pulse was 120bpm, that the midwives were concerned about the CTG, and that Mrs F was experiencing pain that was disproportionate to the clinical findings, Ms A did not assess Mrs F until 6.25am, including by way of vaginal examination or taking maternal observations. This is despite Ms A entering the birthing room at 5.45am to check on Mrs F.

153. I appreciate that Ms A anticipated that she would be free to assess Mrs F within half an hour of Mrs F's arrival at River Ridge, and that her back-up midwife was called some time later when it became clear that Ms A would not be able to attend Mrs F promptly. However, the result was that Mrs F was assessed and monitored by Ms C and Ms B only intermittently, and that their concerns about Mrs F's presentation, which they relayed to Ms A, were not addressed with sufficient priority. In the circumstances of Mrs F's presentation, as Ms A knew them to be at the time of the events, this was unacceptable.[48]

154. I note that following Ms A's assessment of Mrs F at 6.25am, Ms A appears to have been sufficiently concerned about Mrs F's condition to refer her to secondary care. This is evidenced by her retrospective notes documenting her 6.25am assessment of Mrs F, where she recorded, "CTG not totally reassuring", and the advice she provided the District Health Board when arranging the transfer, in particular, "Abdo pain" and "non-reassuring CTG". On the basis of this documentation, I reject Ms A's response to the provisional opinion that the decision to call the public hospital was made only on the basis that a transfer "could enable [Mrs F] to have pain relief other than Entonox or Pethidine".

[46] [1977] 4 All ER 771, 779 (HL).
[47] New Zealand College of Midwives, *Midwives Handbook for Practice* (2008), at p20.
[48] River Ridge's policy states that it is the LMC's responsibility to arrange a second midwife, and that staff midwives are available for assistance only.

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

155. In my view, Ms A failed to meet her responsibilities as set out in the *Midwives Handbook for Practice.* Ms A was aware that: Ms C and Ms B were concerned that Mrs F's pain was disproportionate to the clinical findings; Mrs F's maternal pulse was 120bpm; the fetal heart rate as recorded by the CTG was similar to the only recorded maternal pulse of 120bpm; and there were concerns about the CTG trace. Mrs F's presentation in this regard should have triggered an earlier assessment by Ms A. That did not happen. Ms A did not assess Mrs F clinically until 6.25am. Ms A did not take any maternal observations (including Mrs F's pulse and blood pressure) despite the concerns that were relayed to her, nor were there any documented abdominal palpations by Ms A or assessments of fetal activity.

156. Ms Stanbridge stated that, without the maternal pulse having been monitored consistently, it is unclear whether the CTG was showing the fetal or the maternal heart rate. Ms Stanbridge further stated that, although the CTG could reasonably have been read as a reassuring CTG, "In retrospect, the possibility could be raised that some, or all, of it could have been maternal pulse." Ms Stanbridge further stated that "maternal pulse should be checked at any time a CTG is applied, to ensure a differentiation between maternal pulse and fetal heart".

157. The New Zealand College of Midwives "Consensus Statement Foetal Monitoring in Labour" (2005) recommends: "Prior to any form of foetal monitoring, the maternal pulse should be palpated simultaneously with [fetal heart rate] auscultation in order to differentiate between maternal and foetal heart rates."

158. Ms A's failure to take appropriate action to assess Mrs F meant that she did not position herself adequately to identify deviations from the normal in Mrs F's labour, as required by the *Midwives Handbook for Practice*. In my view, this was inadequate.

159. I also do not consider that Ms A's decision for Mr E to transport Mrs F to the public hospital by private car without midwifery support was appropriate, given:

- Mrs F's presentation;
- Ms A was concerned enough about Mrs F's presentation to transfer Mrs F to secondary care;
- Ms D twice expressed her concern to Ms A that Ms A should travel with Mrs F to hospital; and
- River Ridge's Transfers Out policy, which recommends that clients are transported by ambulance service only, and that they are to be escorted by the LMC or a staff midwife.

160. In these circumstances, I find that Ms A failed to provide services of an appropriate standard to Mrs F. I consider that Ms A failed to assess Mrs F appropriately in light of her presentation, and therefore failed to appreciate the seriousness of Mrs F's presentation. In addition, Ms A's decision to transport Mrs F by private car without any midwifery support was inappropriate in the circumstances. For these failures, I find that Ms A breached Right 4(1) of the Code.

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Opinion: Breach — River Ridge (East) Birth Centre Ltd

161. River Ridge had a responsibility to ensure that it had appropriate policies and systems in place for the provision of safe and seamless care.

162. During the relevant time, River Ridge had a policy stating that it was the LMC's responsibility to arrange for a back-up midwife when required, and that staff midwives were to be available for assistance only. In response to the second provisional opinion, River Ridge stated that its duty of care policy at the time required midwives to support LMCs and their clients according to midwifery standards and, in the absence of the LMC, to act on their observations. However, the policy did not stipulate a process for when the LMC had two clients in labour at River Ridge at the same time. I note that River Ridge has since amended its policy to include a provision that, in such circumstances, the LMC is to arrange for the back-up midwife to attend "immediately" and, if the LMC fails to do so, the staff midwife is to call the back-up midwife or arrange transfer of the woman to the DHB.

163. In my view, such procedures ought to have been in place already at the relevant time to provide guidance to the LMC and staff midwives, specifying at what point the LMC and/or the staff midwife should call the back-up LMC. River Ridge should also have had policies clearly specifying the responsibility of its staff midwives if an LMC was not readily available to assess a patient. In my view, in the event that an LMC is unable to provide immediate maternity services to a patient, the staff midwife should take appropriate clinical action to ensure that the patient receives an appropriate standard of care until the LMC becomes available.

164. I consider that the absence of clear policies contributed to the delay in the actions of staff midwives Ms C and Ms B. Therefore, I find that River Ridge (East) Birth Centre Ltd breached Right 4(1) of the Code.

Opinion: Adverse comment — Ms A, Ms C and Ms B

165. The importance of good record-keeping cannot be overstated. It is the primary tool for continuity of care, and an important tool for managing patients. A patient's clinical record must be dated, legible and accurate, and comprehensively document all relevant aspects of a patient's symptoms, signs, diagnosis and treatment. There are clear discrepancies in the detail and timing of the events as recorded in Mrs F's contemporaneous and retrospective notes. The retrospective notes are also inconsistent with Mrs F's and Mr E's accounts of what occurred, which causes me some concern.

166. I suggest that the midwives reflect on their record-keeping practices in light of my comments.

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Recommendations

167. As previously stated, in 2011, following receipt of Mrs F's complaint,[49] the Midwifery Council of New Zealand required Ms A, Ms C and Ms B to undergo competency reviews.

168. In my second provisional opinion, I recommended that Ms A, Ms C and Ms B each undertake the following:

- Provide a written apology to Mrs F. The apology is to be sent to HDC within one month of the date of this report, for forwarding to Mrs F.

- Provide a written report to HDC on the changes made to their practice as a result of the case, within one month of the date of this report.

169. I note that Ms C has subsequently complied with the above recommendations.

170. I look forward to confirmation from both Ms A and Ms B, of their compliance with the above recommendations.

171. I recommend that River Ridge:

- Carry out a further audit of compliance with the *Admission to Birth Room* policy and *Transfers Out* policy and report to HDC on the outcome of that audit within three months from the date of this report.

- Review its *Admission to Birth Room* policy and any other relevant policies, insofar as they state that the role of the River Ridge staff midwife is to provide "assistance only". Any such policy or policies must emphasise that River Ridge staff midwives, even though not the woman's chosen LMC, still have a role as an advocate for the woman and baby and must take appropriate action in response to any concerns they have. River Ridge must ensure that there is an appropriate escalation path for their midwives to follow where any such concerns are not resolved between the staff midwife and LMC.

- Implement the above reviewed policy or policies within three months from the date of the final report.

- Audit compliance with the reviewed policy or policies 12 months after implementation of the policy or policies.

- Report to HDC on the outcome of the audit of the reviewed policy or policies within 15 months of implementation of the policy or policies.

[49] Mrs F's complaint was referred to HDC under section 64 of the Health Practitioners Competence Assurance Act 2003.

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Follow-up actions

172. - A copy of this report with details identifying the parties removed, except the expert who advised on this case and River Ridge (East) Birth Centre Ltd, will be sent to the Midwifery Council of New Zealand, the New Zealand College of Midwives, and the District Health Board, and they will be advised of Ms A's, Ms C's and Ms B's names.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case and River Ridge (East) Birth Centre Ltd, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix A — Independent advice to the Commissioner

Advice received on 24 July 2011

The following advice was obtained from independent expert midwife Ms Chris Stanbridge:

"Documentation received

- Letter requesting advice
- [Mrs F's] complaint forwarded to HDC by Midwifery Council on [date]
- [The public hospital's] (partial) clinical records for [Mrs F]
- River Ridge's clinical records for [Mrs F]
- Response and accompanying clinical records for [Mrs F] from [Ms A].

Comment

The case notes refer to [Mrs F's maiden name].

In [Ms A's] report and attached clinical notes there are possibly two pages missing — there are pages noted as 2, 4 and 5 but none labelled 1 or 3.

There are two separate issues raised, either of which could have happened independently and not necessarily related to one another. That is, the slower rate of growth of baby isn't an indication of the likelihood of an abruption, and baby's lower growth rate didn't necessarily impact on her demise — an abruption of significance is likely to result in the baby's death regardless of rate of growth.

Antenatal care:

The case notes received show [Mrs F] basically had a straight forward antenatal course with visits from her LMC or back up at appropriate intervals with appropriate assessments. Her assessments were generally normal including a normal blood pressure throughout.

[At 32 weeks] [Ms G] (LMC) ordered a growth scan when fundal height was less than expected for that gestation.

The report was reassuring with satisfactory size and fluid volume. The radiologist's recommendation for a customised growth chart was heeded, calculated and measurements entered.

[At 34 weeks], her antenatal notes state [Ms G] ordered another scan even though there was the reassurance of an almost compatible fundal height assessment, an active and 'moving well' baby, and the previous scan had been normal.

This scan appears to have been performed [at 36 weeks]. It reports a symmetrically small baby with normal fluid levels and cord blood flow. The estimated baby weight was within the normal range. The radiologist recommended a subsequent scan in two weeks.

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

[At the 36 week visit], the fundal height (by a different observer, back up LMC [Ms A]), showed a small fundal height for dates.

Review of the scan of the previous day showed EFW (estimated fetal weight), when charted on the customised growth chart, was acceptable (it was following the curve, even though at the lower (10th) centile line). Good movements were noted. At this stage another scan was organised for the following week, and discussion presumably took place about the possibility of needing to intervene as there is a note '[Mrs F] not keen on induction of labour'.

[At 37 weeks], recordings were within the normal range, and baby was reported to be 'moving well'. Scan that day showed 'growth parameters lay within the normal range between 5th and 50th centiles'. A further scan was recommended for two weeks. The radiologist also noted 'possibly the abdominal circumference may have flattened compared to the previous scan but this could be interobserver variation, the measurements still lie within the normal range'. Of note is that the EFW continues to follow the curve.

It appears a written report for this was not received until some time later but [Ms A] has noted the EFW and fluid levels on her notes. At this same visit a plan is made for referral to WAU (Women's Assessment Unit at [the public hospital]); notes indicate the referral has been received, and seen the following day by [an obstetrician] who has indicated [Mrs F] should be seen at the unit within a week.

In their email of 30.5.11 [Mr and Mrs F] were concerned [Ms A], in her referral to WAU, had not mentioned oligohydramnios (abnormally low fluid levels around baby) nor decreased biophysical profile, nor baby's small size.

[Ms A's] referral is quite explicit about baby's small size (SGA — small for gestational age).

It is unclear exactly what information [Ms A] had about the scan given she appears not to have received the faxed copy of the report. Her letter to the Midwifery Council indicates she had a handwritten report and she indicates on the clinical notes there were 'good pockets [of fluid] around limbs'; and mentions AFI (but not the score [16.1 which is below the 5th centile]). The report indicates 'decreased' liquor but not oligohydramnios. The implication of biophysical profile of 6/8 is unclear — no entry for fetal tone is unclear whether this is zero, or just not entered. It would not normally be expected of an LMC to interpret this. This is why the LMC refers to the specialist radiologist for advice.

The report shows normal dopplers (cord blood flow) which is reassuring.

It is unclear if [Ms A] has received the reassurance of the radiologist that the overall scan was acceptable with the only recommendation being a repeat scan in two weeks. The handwritten scan report in the notes I have received appears to be undated. Overall this report appears to indicate an acceptable situation.

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

The formal report, which [Ms A] does not appear to have received until [12 Month9], shows the radiologist reporting growth within the normal parameters. S/he did not interpret the results showing anything untoward that needed management other than what was being provided ie, ongoing monitoring. [Ms A], in conjunction with [Mrs F], had already instigated further care, requesting an obstetric consultation.

At the visit of [6 Month9], in her concurrent notes, [Ms A] does not record any specific issues from [Mrs F] but does note she is now ‘keen to have baby out if safer for her’. She notes baby is ‘moving well’; again this is reassuring.

[Ms A] has followed up with the hospital, ensuring they have current contact details, when [Mrs F] was concerned she had not received an appointment.

Advice

[Ms A's] care antenatally appears to be appropriate. She has provided on-going monitoring of [Mrs F's] fundal height, and baby's growth and movements, and followed the advice from the radiology specialist (who was happy with the scans throughout, including the last one).

Recent research shows individualised fetal growth charts are helpful in limiting unnecessary scans and interventions while alerting health professionals and women to situations that do need intervention. They are calculated from an established formula that takes heed of a number of factors eg, the mother's dates, maternal and family history, parity, age, height, weight, ethnicity. While the specific estimated fundal height or fetal weight itself is not so important, its relationship to earlier recordings is. If the growth follows the curve of the centile lines, this is more important than the actual weight *per se*.

[Ms A] has responded to concerns expressed by [Mrs F] in the latter weeks of pregnancy. This included re-sending the referral with a request for an appointment the next day and phoning to ensure the referrals had been received.

She has organised repeat scans and referred [Mrs F] to the WAU obstetrician.

Possible area of concern

It is reasonable for LMCs to expect specialists (eg, radiologist) to interpret findings in their area of expertise, and for the LMC to be guided by that. Where there is a significant concern, it is reasonable to expect that result will be communicated with the LMC promptly and personally. While this addresses immediate concerns, it appears [Ms A] and [Ms G] had not established a system to ensure non-urgent results that were mailed or faxed through to [Ms G] were accessible, or passed on, to [Ms A]. In this situation it would have had no influence on the care as the scan result was acceptable and the radiologist did not recommend any immediate change of care.

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Labour care:
Going from [Ms A's] notes, written at 6.35am on [11 Month9], [Mrs F] had paged [Ms A] who phoned back (some 1 hour 50 minutes later). As [Ms A] was with another labouring woman she asked [Mrs F] to attend River Ridge, (she was booked to birth at the public hospital), where [Ms A] was for assessment. Her notes indicate [Mrs F] was contracting about every 15 minutes but she sounded distressed. [Ms A] records her arriving at River Ridge at 4am or 4.50 (unclear), later corrected to 4.35am. Core midwifery notes indicate arrival at 4.00am, although times have been corrected to an hour later than initially recorded. The times on the CTG would indicate the latter/corrected times are probably the correct times (appears to have been commenced about 0510 hours; handwritten notes say CTG commenced at 0410 hours).

As [Ms A] was not free to see [Mrs F] at this time, she was seen and assessed by core midwife [Ms C] who has written up an internal examination showing the presenting part at station 0, and the cervix not able to be reached as it was very posterior. She noted [Mrs F] found the examination painful.

Another (presumably) core midwife records a quick palpation of [Mrs F's] abdomen which indicated the baby was head first with her back on the left. She records [Mrs F] being uncomfortable lying on her back, preferring her side. Shortly afterwards she was up standing. The midwife commenced a CTG (cardio tocograph — a tracing of the baby's heart rate and changes in pressure in the maternal abdomen). She notes the heart rate as variable with some decelerations down to 108, then back up to 120 (normal rate as 110 to 160).

At 4.25am/5.25 she notes [Mrs F] using Entonox (pain-reducing gas) during contractions and [Ms A's] back up LMC [Ms D] having been paged as [Ms A] not free to attend [Mrs F].

The first core midwife then records [Mrs F] vomiting, and the contractions increasing in intensity. She records [Mrs F] reporting bowel pressure at the peak of her contractions. She notes the baby's heart rate remaining reactive with a baseline of 110. She records [Mrs F's] contractions every four minutes lasting 40 seconds, and that she is using the gas.

[Ms D] (back up LMC to [Ms A]) records next, at 6.05am, as she provides care for [Ms A]. She notes [Mrs F] starting contractions at 2pm, that it's her first baby, and that there is a question of 'small for gestational age'. She notes the CTG is continuous, baseline is 120 with normal variability and heart rate reactive to contractions. She has recorded that [Mrs F] is contracting three in ten at this stage, and that she is distressed. The plan is for an internal examination and to plan for pain relief, with possible transfer to (the public hospital).

At this stage [Ms A] is present and the following notes are retrospective, written up shortly afterwards. [Ms A] examined [Mrs F] vaginally. The cervix was midline and closed, 80% effaced. The presenting part was –2. The CTG was

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

noted as baseline 100–120 with no decelerations and good variability. Pain relief was needed, but [Ms A] was reluctant to use pethidine as [Mrs F] was not in established labour (no dilation of the cervix) and [Ms A] was cognisant of baby being smaller and that the CTG was not 'totally reassuring'. She phoned the registrar at the public hospital at 6.48am and arranged for them to see and assess [Mrs F]. She travelled by car.

She arrived at [the public hospital's] WAU at about 7.30am (core midwife's retrospective notes). The core midwife found [Mrs F] distressed and writhing with pain. She assisted her to change into a gown, but could not palpate her abdomen as [Mrs F] was too sore. There was no vaginal bleeding or loss. The pain was now constant. Fetal heart was thought to be 112–117. Maternal pulse 120. Blood pressure 140/85. She was being moved to delivery suite for closer monitoring when she began bleeding.

Emergency care was initiated. [Mrs F] had an emergency Caesarean delivery under general anaesthetic. Her baby was stillborn. She experienced some of the recognised complications caused by abruptions.

[Ms A] continued to provide postnatal care.

[Mrs F] recalls Braxton Hicks, (practice contractions) or tightening, beginning at 3pm. By midnight she believes they were 3 contractions in ten to twenty minutes. She recalls being in constant pain at the birthing centre. She believes she told the birthing centre staff that the pain was constant, and pleaded to go to the hospital for pain relief.

<u>Advice:</u>
[Ms A] was involved with another woman in labour when [Mrs F] initiated contact.

[Ms A] responded, and although [Mrs F] reported contracting every 15 minutes, [Ms A] was proactive in recommending she come to her for assessment. Normally someone contracting at these intervals would be advised of comfort cares and to wait for the contractions to be coming regularly and consistently at least five minutely.

On arrival at the birthing centre, [Mrs F] was seen by the core midwives. It was reasonable for [Ms A] to use this service given she was closely involved with another woman close to birthing.

[Ms A] remained involved with the first woman longer than she expected, and after the core staff had advised her of their assessment (distressed with minimal cervical changes at this stage) she recalls asking the core staff to call in her back up LMC.

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

[Ms A] was able to see [Mrs F] briefly and advised her on how to use the Entonox correctly. She recalls [Mrs F] was contracting about 3 minutes, and she vomited while she was with her. The core midwife remained with [Mrs F] when [Ms A] was recalled to her first woman.

The back up LMC duly arrived and assessed [Mrs F's] situation. [Ms A] was able to attend her and did a vaginal assessment. She recalls discussing with [Mrs F] the need for pain relief and moving to the public hospital. She rang the registrar whom she recalls was initially reluctant to accept her as they were having staff difficulties.

[Mrs F] did move to the public hospital, going by car which [Ms A] felt was appropriate and faster than ambulance transfer.

Core staff are available to do assessments and provide care for women in labour until their LMC is available. Initially it looked as if [Ms A] would be available a short time after [Mrs F's] admission. In the event, this was not so and her back up was called in and attended.

When [Ms A] was free, she worked with the back up midwife to complete [Mrs F's] assessment and made arrangements for her to be seen at the public hospital.

This care appears to be appropriate. Certainly both [Ms A] and [Mrs F] could expect core staff to provide appropriate care, and the same of her LMC colleague, until such time as [Ms A] was available. [Ms A] decided against the option of pethidine for pain relief. She advised and arranged for assessment at the public hospital. (There is no financial benefit or loss for referring women for obstetric opinion or care.)

Her decision for care transport appears appropriate given the staff were happy with [Mrs F], her baby's immediate condition appeared stable, and car transport was faster than ambulance.

There were a total of four midwives who were involved in [Mrs F's] care while she was at the birthing centre. None recorded [Mrs F] having constant pain, but referred to her having contractions (which by their nature come and go), also noting that at the peak of contractions she was feeling bowel pressure, and that the fetal heart was reactive to contractions. It appears none of them observed or were aware of the constant pain [Mrs F] recalls experiencing at that time.

Similarly, on admission to WAU, while [Mrs F] was clearly distressed, the midwife there assisted her to change into a nightie before doing her assessment. Presumably she did not perceive [Mrs F] to be distressed other than she would see with someone in labour. It was not until she began to assess her and realised [Mrs F] was not happy for her to palpate her abdomen, and reported continuous pain, that she appreciated all was not well and called for help.

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Although it is obvious in retrospect that [Mrs F] experienced a devastating placental abruption, it is not clear when this began. Although abruptions (bleeding as a result of premature separation of the placenta) can occur with precursor, there were none of the known recognised factors that might be associated with abruption, the strongest associations being raised blood pressure and trauma. There was no vaginal blood loss until just prior to delivery.

Without the maternal pulse being taken by any of the staff, in retrospect it is unclear if the CTG was showing fetal or maternal heart rate. This is one area all involved could learn from this distressing event — maternal pulse should be checked at any time a CTG is applied, to ensure a differentiation between maternal pulse and fetal heart.

Overall [Ms A] appears to have provided care of a reasonable standard."

Advice received on 1 September 2011

"Radiology report:

As would be expected, it appears [Ms A] has received a prompt report from the radiology centre, with acknowledgement of receipt being on [7 Month9], the following day. [Ms A's] note, that the report was not received until [12 Month9], appears to be incorrect, and it would be interesting to see [Ms A's] response to the radiology service's letter.

Apart from this, assuming [Ms A] read the report this would suggest she had the reassurance of the radiologist that there was no immediate threat to [Mrs F's] baby with the advice being that of review in two weeks. [Ms A] and [Mrs F] had already agreed to refer to WAU, and this had occurred.

See also the comment below (under referral) about the handwritten report if this is what [Ms A] was working from.

It is appropriate to accept the conclusion and advice sought from the specialist radiologist with interpretation of the scan.

Care from other midwives; attendance of back up midwife:

While fragmented (which isn't unusual in the secondary/tertiary sector), the care provided by each of the midwives appears to be adequate.

[Mrs F] was seen on arrival at the birthing unit and had a basic assessment — palpation, internal assessment, fetal heart rate assessed and then CTG. It was anticipated [Ms A] would be free to provide care in a short period of time and the internal examination suggested [Mrs F] probably had some hours of labour ahead of her.

When [Mrs F] was admitted to the birthing unit [Ms A's] other client appears to have been fully dilated and pushing. Given she had had two previous babies, it

HDC

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

was reasonable to expect she would birth soon after, thus freeing [Ms A] to attend [Mrs F].

When it became apparent [Ms A] was not going to be available in the immediate future, the core midwives continued to work with [Mrs F], and [Ms A's] back up midwife was called in. Forty minutes to come into the unit to attend a woman in early labour who had midwifery care available from core staff is a reasonable time — this would allow the back-up time to maybe shower, dress, perhaps eat, and to get to the unit.

There are frequent notes of what was happening for [Mrs F], and care given (5am, 5.10, 5.15, 5.25, 5.50, 6.05, 6.25am, and then later, retrospective notes until transfer occurred at 7.10am). There was a review of the situation by the in-coming back up LMC. There was continuous monitoring of baby's heart rate.

The care of the core midwife at WAU appears adequate. In retrospect she might have left changing [Mrs F] into a nightie before assessing her, but she did not appreciate at that stage the significance of [Mrs F's] pain. Once aware of the nature of [Mrs F's] pain she sought assistance, baseline recordings were taken, and they planned to move [Mrs F] to the delivery suite in a wheelchair. While doing this, events declared themselves and the 'team' took over care.

Referral:
[Ms A's] referral addressed the prime issue for referral — that of slow growth. The scan reports were reassuring in that the growth was between the 5th and 50th centiles, was growing in line with the centile lines, and although there was reduced liquor, dopplers were normal and the radiologist's recommendation was for a further two weeks before reassessment was needed.

The handwritten notes of the scan [Ms A] reviewed with [Mrs F] showed 'good pockets [of liquor/fluid] around limbs' and decreased but not oligohydramnios (which I understand to be under 4; in this documentation it was noted as 'decreased', not oligohydramnios); dopplers in the normal range; and 6/8 biophysical profile — I understand this in itself is acceptable. I believe the tone score relates to the sonographer noting baby stretching out and flexing [against] a limb, or opening or closing of a hand. I assume this is an opportunistic observation and may simply not be noted, rather than it not occurring. This is not accepted as a viable form of assessment by the radiological services in Canterbury so I am not confident about addressing this.

Fetal movements were good.

Once again, in retrospect, it may have contributed to a fuller picture to have included the actual AFI, although there were good pockets of fluid noted, and the more telling information of dopplers was reassuring.

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

It was also reasonable to accept the radiologist's implied acceptance of the measurements as satisfactory. Midwives are not expected to be cognisant of the finer details of scanning, reasonably relying on advice from the expert in this field.

<u>Recordings and pain:</u>
It is important to assess the care given in the light of what was known at the time, in context. It is easy to criticise care in retrospect when the outcome is known.

It appears clear from the documentation at the time of care that none of the four staff involved (core and LMC midwives) at the birthing centre, not the core midwife at WAU (initially), detected [Mrs F] was in continuous pain.

There is no clear obvious point in the notes of a time when [Mrs F] began experiencing what we know in retrospect was an abruption. It may have occurred at any stage, from at home through to her time at the public hospital.

Initially, [Mrs F] tolerated an abdominal palpation, although, not unusually, she didn't like lying on her back. None of the staff involved in [Mrs F's] care, from her arrival at the birthing unit, and in the initial time at the public hospital, appear to have observed [Mrs F's] pain to be other than labour pain. Labour is inherently painful. The midwives repeatedly noted contractions (with explicit timing and length of contractions), but not constant pain. It was not until the core midwife at the public hospital actually got to the stage of abdominal palpation that she became aware of other than labour like pain.

It would appear it was not obvious that [Mrs F] was experiencing constant pain, but appeared to be having intermittent contraction like pain — something to be expected with labour. Women's response to pain is variable, and women can be quite distressed with pain even though their labour may not be well established. Indeed, [Mrs F] had made good progress in the time she was in the unit — initial internal examination showed a cervix so posterior it was difficult to feel it completely. By the time she was reassessed an hour and three quarters later, the cervix had come forward to midline and, although closed, was 80% effaced. She was obviously establishing in labour.

[Ms A] has recognised that [Mrs F] was not finding the pain easy to cope with, and this was part of the decision making about transferring to the public hospital.

In retrospect, assessment of [Mrs F's] pulse and/or blood pressure may have shown changes if they had been assessed on admission to the birthing unit or to WAU. However, Terryll Muir's 2006 study shows 14–16% of midwives never make these assessments, or only if clinically indicated, in established labour, so it is difficult to criticise the practice of each of these practitioners in this regard when attending a woman who appeared to be in early labour.

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Documentation accuracy:
While it is not ideal there are at times, and especially on night duty, occasional errors in notation of time, aggravated by the tendency for subsequent entries to be led by the time above. While accuracy is the expected standard, this error would not be uncommon, and correction has occurred. [Ms D's] notes and CTG recordings would support the corrected times.

Transfer:
Initially, it was quite appropriate to assess [Mrs F] at the birthing unit. As time progressed and ongoing assessments indicated an increasing number of possible uncertainties, it was appropriate to plan for transfer. It appears [Ms A] was proactive in getting [Mrs F] transferred to the public hospital. Although booked there, from her letter to Midwifery Council, [Ms A] recalls needing to be reasonably insistent that [Mrs F] needed assessment and care at the public hospital — they were not accepting women unless there was a clear need for them to be there.

Scans, radiologist's reports and fetal movements had been reassuring about baby's well being. The CTG was interpreted as adequate (satisfactory baseline, good variability). [Mrs F] was distressed with contractions, and finding it difficult to cope with an apparently establishing labour. This could have well been within the normal range of responses to labour, but did need addressing with options of pain relief being able to be offered.

Once again, while in retrospect it may have helped to have transferred earlier, it was not overtly apparent that needed to occur significantly earlier.

CTG:
The trace is labelled with the woman's name and NHI number; it is dated and timed, and the gestation noted.

Grossly the CTG could be seen as a reassuring CTG. It shows a baseline between 110–160 with brief periods down to 100; variability is greater than 5 throughout; with the possible exception about 5.10am there are no overt decelerations. The absence of accelerations in an otherwise normal CTG is of uncertain significance. I believe this CTG of fetal heart rate could have been reasonably read as a reassuring CTG.

In retrospect, the possibility could be raised that some, or all, of it could have been maternal pulse.

Mode of transport
I understand from [Ms A's] letter to the Midwifery Council that she considered ambulance transfer and opted for car as it was quicker and vaginal assessment had shown she was not close to birthing. Although [Mrs F] was distressed with pain, there was no clear indication to go against car transport. Women

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

transferring from home to birthing facility are often in more advanced labour, distressed by contractions, and travel by car.

I understand from previous cases reviewed that ambulance transfer is not always available in [the city] at time of request, often resulting in delay. Even when it is available promptly there is the time for getting to the unit to be added to car transport time. [Ms A] recalls notifying WAU of [Mrs F's] impending arrival by car, and requested they meet her with a wheelchair.

The radiological assessments had acknowledged a smaller baby, but that baby was growing consistently.

The CTG did not overtly show a distressed baby (acceptable baseline, good variability, no pattern of or prolonged decelerations).

From [the public hospital's] notes it appears the staff did not meet [Mrs F], but she was first attended when she was heard by [RN H], who attended her promptly at that stage.

[RN H's] retrospective notes made the next day, describe her helping [Mrs F] change into a nightie before beginning an assessment. It would appear that initially she did not appreciate the cause of [Mrs F's] distress. She checked the baby's heart-rate, and a subsequent midwife called to assist, found the maternal pulse and what was assumed to be the baby's heart-rate to be very similar.

When assessing the care given by [Ms A] and [RN H], and [Ms A's] decision making, (from the notes) the cause of [Mrs F's] distress was reasonably thought to be in response to her establishing labour.

Given what was known at the time, it was reasonable for her to use car transport.

It is very difficult to look back at a situation and not to expect each aspect that could have possibly influenced a change of management to have been addressed. In reality it is not so clear at the time, and each of those facets could have presented and the woman and baby had a satisfactory outcome.

In providing advice to you, it is important to look at the context of what was happening at the time. This may well leave the family feeling something was missed or not managed appropriately as they are able to review everything in retrospect, and for [Mrs F] to know that her pain had a cause other than labour.

I have reviewed the notes carefully and given advice based on these, particularly those written before the outcome was known, and believe the overall care was reasonable."

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Advice received on 27 January 2012

"*[Ms A] and [Ms G] did not have a system to ensure non-urgent results that were emailed or faxed to [Ms G], were accessible, or passed on, to [Ms A].*

This is not related to an inadequate standard of care — [Ms A] followed up on the results and discussed them with [Mrs F] at her visit. Where the results may make an immediate change in plan of care, it is usually possible to access the results verbally from the radiology service, or they will be relayed promptly from the service.

My suggestion is to consider a system to streamline access to non-urgent results.

No staff checked [Mrs F's] pulse when applying the CTG to ensure a differentiation between maternal pulse and fetal heart.

If this is to be seen as a departure from ideal standard of care, it would be of a mild nature and an action other practitioners would frequently overlook.

Was it reasonable for any of the midwives to take [Mrs F's] pulse or blood pressure at any point during her time at River Ridge?

Through [Mrs F's] time at the birthing unit, it appeared she was establishing in early labour.

As I have previously discussed, where labour is normal, and in this case, early labour, it is not always necessary to do these recordings.

Once a plan was made for transfer it could have been an opportunity to have done them.

As an acute admission to WAU it would be expected they would have been part of the full assessment by the core staff.

In this situation, there was no indication to give this a priority until after [Mrs F] was changed into a gown, when, at the time of palpation, [Mrs F's] pain was found to be constant and her abdomen too tender to palpate. The fetal heart was assessed, assistance was provided by a second midwife, and shortly after pulse (raised) and blood pressure (slightly raised — commonly low with bleeding and shock) were recorded.

It was not until this stage that her being acutely unwell became apparent.

In the context of early labour care it was not unreasonable care. With the plan to transfer it would have been wise to have recorded them, but it was not a breach of standards."

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Advice received on 21 August 2012

"As well as my previous reports, I have read

- The initial complaint to Midwifery Council and response
- Clinical notes and CTGs (intermittent sections covering about an hour) from River Ridge
- Letter and scan results from the radiology service
- [The public hospital's] clinical notes
- Letter from [Ms A] to Midwifery Council
- [Ms A's] clinical notes
- Letter from [Ms A] to HDC dated 19.9.11
- Reports of interviews with yourself and …
  - [Ms A] dated 4.5.12
  - [Ms C] and retrospective notes of care
  - [Ms B] and retrospective notes
  - [Ms D] and notes of her reflections
  - [Mrs F] dated 20.3.12 and 15.6.12
  - [Mr E] dated 5.3.12 and 13.6.12
  - [Mr F] dated 7.6.12

General

Women respond to pain and labour in different ways. The experience of pain is very subjective. It is not whether someone has a low or high pain threshold. Pain just is, and is experienced by any individual in their unique way.

In labour a few women will show minimal signs of distress, most will become increasingly distressed as their labour progresses, a few will be distressed from the earliest contractions.

Distress may be shown with movement, agitation, position changes, heavy breathing, restlessness and/or difficulty moving. They may find one position more comfortable than others and commonly being upright is the most comfortable. They are often distracted, noisy, or may 'withdraw' into themselves.

Many women also vocalise their distress. This may be from relatively quiet moaning to screaming hard. They may cry, 'rant' or swear. They will often verbalise that they cannot cope any longer, or ask for the pain to be taken away, that it's too painful, or beg for help/epidural or pain medication.

Expression of pain/distress can be influenced by expectations, knowledge of others' experiences, anxiety, awareness of the labour process, emotion, stress, past experiences, fear, excitement, tension, culture, tradition, ability to relax, ability to adopt the most comfortable position, support people and surroundings.

Overt signs of distress alone do not indicate where a woman is in her labour, although it is one of the significant signs of what is happening. It is supported by noting the character, timing (length and frequency) and progression of contractions. Abdominal palpation and internal examinations also contribute to

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

the assessment of labour. It is normal for pain to increase as labour establishes and progresses. It is common for women to show significant signs of distress in a normal labour. It is normal to support women through their labour, pain and distress, however they express that.

Midwives working with labouring women can generally work with them to support them through particularly the earlier parts of labour without medical forms of pain relief. If these comfort measures, and the reassurance of the support to reduce fear and anxiety, are insufficient to meet the woman's needs, the next option is generally the use of pain reducing gas (nitrous oxide and oxygen mixture). There is quite a skill in using this effectively and it is hard for women who are feeling overwhelmed with pain to coordinate its use. It generally takes some time and 'coaching' to get the full benefit from its use.

If this is insufficient, then more involved forms of pain relief (for example, pethidine or epidural) need to be considered.

Advice

Further to my earlier advice, you have asked me to comment on care in each of the two versions of care.

1. [Ms C's] retrospective notes recall she felt [Mrs F's] pulse as strong and steady at 120 beats per minute. She was confident this differed from the fetal heart. She said she expressed her concern to [Ms B] and planned for an internal assessment.

   My earlier reports address the situation if it was as described by the clinical notes, and similar to that recalled by your interviews with [Ms C] and [Ms B], the core midwives, and [Ms A] and [Ms D] (LMCs) who provided care for [Mrs F].

   The exception is that in her interview with you and in her retrospective notes, [Ms C] recalls [Mrs F's] pulse was 120 — this is rapid for a maternal pulse. It was not recorded in the notes. While this could be related to solely maternal distress, or perhaps dehydration, it is a significant finding that required further investigation and monitoring. It is unclear if she shared this particular finding with [Ms B], or the LMC midwives.

   Her action of further assessment (by vaginal examination and fetal monitoring) was appropriate. However, it should have also prompted her to take [Mrs F's] blood pressure and further monitor the pulse rate. If there were no other untoward signs, frequent monitoring of [Mrs F] would have been appropriate, with the expectation her pulse would settle as she settled into the unit. Non improvement should have been an alert for further consideration of the cause, and close and frequent comparison with the fetal heart should have been made. In failing to do this, [Ms C] has missed a potential warning sign. This care would be viewed with moderate disapproval by her peers.

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

2. [Mrs F] recalls getting no respite from pain which she told the core staff was constant and prompted her to want to go to [the public hospital]. She said it felt as if her 'uterus was being ripped apart with a knife'. She was too distracted by the pain to talk to her husband on the phone for more than a short time.

   Her support person, friend [Mr E], recalls [Mrs F] being in pain from when he picked her up from her home. He recalls her not getting pain relief from the gas, and her asking to go to the hospital (the public hospital). He recalls [[Mrs F]] was never quiet; she was talking throughout the ordeal as well as crying, screaming and moaning. He recalls her saying the pain was not going away.

   [Ms D] recalls in her interview [Mrs F] was standing on the bed, and her behaviour was extreme. She recalls [Mrs F] calming enough for the internal examination to occur. She does not recall [Mrs F] saying the pain was constant. She recalled she and [Ms A] agreed [Mrs F] should be transferred to the public hospital; she recalls saying to [Ms A] [Mrs F] should go by ambulance and be accompanied.

   [Ms D's] notes at the time make no mention of the above, noting instead that [Mrs F] was distressed with contractions every three minutes, had a reactive CTG, and she ([Ms D]) was planning analgesia after internal assessment.

   It would not necessarily be the first course of action to transfer someone distressed with labour to the tertiary hospital. Seeing [Mrs F] at the primary unit to assess if she was in established labour, and then providing care for what appeared at the time to be early labour, was reasonable.

   If [Mrs F] was saying the pain wasn't going away, it could be reasonable to interpret this to mean what most women refer to with this statement — not that the pain was there constantly, but that the intensity of the pain was not lessening during the contractions, especially if pain relief was in use.

   If the pain was obviously constant, severe and unrelieved then it would be essential the midwives involved assessed the situation fully, and if they noted a tender or tight abdomen or uterus, vaginal blood loss, or abnormal recordings, initial treatment and urgent transfer would be appropriate, by ambulance, and accompanied by a midwife.

   All of the midwives who saw [Mrs F] would be responsible for actioning this if there was constant pain accompanied by any of the above symptoms. If they failed to do this with obvious symptoms, their care would be viewed with severe disapproval."

Names have been removed (except River Ridge East Birth Centre Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.