Midwife, Ms B

A Report by the

Health and Disability Commissioner

(Case 07HDC03243)

Parties involved

Mrs A	Complainant/Consumer
Baby A	Consumer
Mr A	Complainant/Mrs A's husband
Ms B	Provider/Midwife
Ms C	Independent midwife
Ms D	Hospital midwife
Ms E	Independent midwife
Ms F	Independent midwife
Dr G	Anaesthetist
Dr H	Obstetrician and gynaecologist
Dr I	Obstetric registrar
The Midwifery Service	An independent midwifery service
Hospital 1	Regional Hospital at DHB 1
DHB 1	District Health Board 1
Hospital 2	Large Hospital at DHB 2
DHB 2	District Health Board 2

Complaint

In March 2007, the Commissioner received a complaint from Mr and Mrs A, forwarded by Health and Disability Advocacy Network Services, about the services provided by independent midwife Ms B. The following issues relating to the care provided to Mrs A were identified for investigation:

- *The appropriateness of the care provided by midwife Ms B to Mrs A during and after her pregnancy in 2005*.
- *The adequacy of communication between midwife Ms B and Mrs A during and after her pregnancy in 2005*.

An investigation was commenced on 15 March 2007.

Information reviewed

Information was received from:

- Mr and Mrs A
- Ms B
- Midwifery Council of New Zealand
- District Health Board 1
- District Health Board 2
- Accident Compensation Corporation

Independent expert advice was obtained from midwife Kay Faulls.

Information gathered during investigation

Background

Antenatal care
Mrs A first met Ms B by chance in the changing rooms of a local pool and gym around September 2004. Ms B recalls that she mentioned that she was a midwife, and Mrs A said that she and her husband were planning to start a family in the near future. During their conversation, Ms B told Mrs A that she worked at an independent midwifery service (the Midwifery Service). Mrs A stated that Ms B was "full of information and seemed very friendly".

In February 2005, Mrs A attended the Midwifery Service and midwife Ms E performed a pregnancy test, which was positive. Mrs A's general practitioner ordered an obstetric ultrasound scan which confirmed that she was six weeks pregnant. While driving home after collecting the scan images, Mrs A called into the Midwifery Service to seek advice as she had been feeling unwell and was vomiting excessively. She was advised to purchase an isotonic drink preparation from a pharmacy. Two days later, Mrs A was again feeling unwell and was vomiting excessively, so she contacted Ms B at the Midwifery Service for advice. Ms B took a urine sample from Mrs A, and advised her to continue drinking isotonic fluids.

Three days later, Mr and Mrs A attended Ms B's private rooms for their first official antenatal visit, where Ms B began Mrs A's Pregnancy Record Cards,[1] and recorded that Mrs A was "miserable with nausea". Ms B also recorded that Mrs A's urine was

[1] The Pregnancy Record Cards document all antenatal appointments and results of tests, and the antenatal care plan, and record the decisions made between midwife and mother along the course of the pregnancy. The Cards contain the complete record of the antenatal care provided to Mrs A by Ms B.

negative for sugar and protein[2] and that her blood pressure was 90/50mmHg.[3] The gestational age was estimated to be seven weeks. Ms B noted that Mrs A had a history of depression, which had been treated with Prozac in the past, and suffered from migraine headaches and excessive vomiting during early pregnancy.

The following week, Mr and Mrs A attended another antenatal appointment with Ms B. Ms B reported that the urine sample was again negative for sugar and protein and recorded an estimated gestational age of eight weeks. Ms B also recorded that the scan was "okay" and that Mrs A was improving.

Mr A telephoned Ms B early in April 2005. He reported that his wife was suffering abdominal pain and diarrhoea. Ms B suggested that they visit their GP. The next day, Ms B telephoned Mrs A and recorded that she had attended a local medical centre and had been offered, but declined, pain relief.

Mr and Mrs A attended another antenatal appointment three days later. Again, Mrs A's urine sample was negative for sugar and protein, and her blood pressure was 90/50mmHg. Ms B ticked the space provided for recording the fetal heart rate (FHR), and recorded that Mrs A was "a little better". The clinical gestational age was recorded as 14 weeks. Ms B also confirmed that that she was acting as Mrs A's Lead Maternity Carer (LMC).[4]

Later in April Ms B referred Mrs A for a nuchal translucency scan, to estimate the risk of trisomy 21 (Down syndrome). The report calculated the risk of trisomy 21 at 1: 949, showed normal fetal growth, and confirmed the estimated date of delivery.

In June, Ms B referred Mrs A for an anatomical ultrasound, which confirmed that she was 20 weeks pregnant. Fetal growth, placenta position and liquor volume were normal, although the right renal pelvis of the fetus was reported to be enlarged.

Three days later, Ms B recorded that Mrs A's urine sample was negative for sugar and protein, but did contain some leucocytes (white blood cells). Mrs A's blood pressure was 80/50mmHg, and the gestational age was recorded as 20 weeks. Ms B ticked the space provided for recording the FHR, and recorded that "flutters" were reported by Mrs A. Mrs A was reported to be feeling "wonderful". Ms B referred her for blood tests and requested a mid-stream urine test.

Ms E, who had performed the pregnancy test, saw Mr and Mrs A instead of Ms B. Mrs A was now 24 weeks pregnant. Her urine samples were clear, and her blood

[2] Sugar or protein in the urine may indicate diabetes or kidney dysfunction respectively.

[3] Blood pressure of about 110/70mmHg is average for a pregnant woman, but a reading between 90/50mmHg and 135/80mmHg is acceptable.

[4] A Lead Maternity Carer refers to the general practitioner, midwife or obstetric specialist who has been selected by the woman to provide her complete maternity care, including the management of her labour and birth.

pressure was 100/70mmHg. Mrs A was reported to be well, and her blood results (reported the following day) were satisfactory. Ms E referred Mrs A for a polycose screening test.[5]

In mid July, Ms B contacted Mrs A to report that her polycose test results were raised, and she needed to have a gestational glucose tolerance test.[6] Mrs A's glucose tolerance test, performed four days later, was normal.

In mid August, Ms B recorded a normal urine sample and blood pressure of 100/70mmHg, and also ticked the spaces provided for recording the FHR and movements. Ms B recorded the gestational age as 28 weeks, and noted "background to birth plan".

In late August, Ms B recorded Mrs A's blood pressure to be 100/70mmHg, and ticked the spaces provided for recording the FHR and fetal movements. She also palpated the abdomen and recorded that the baby's presentation was cephalic and positioned to the right. The gestational age was recorded, and Mrs A was reported to be well.

In mid September, Ms B visited Mr and Mrs A at home. Mrs A's urine samples were clear, and her blood pressure was 90/50mmHg. Ms B palpated her abdomen and recorded that the baby's presentation was cephalic and positioned to the left (it is not unusual for a baby's position to change). Ms B recorded the gestational age as 32 weeks, reported that they "looked at [the] birth plan", and noted that Mr and Mrs A had an antenatal "pink kit", which was provided by a friend, and included a video and written information about the birthing process.

Later in September, Ms B recorded that Mrs A's urine samples were clear, and her blood pressure was 100/60mmHg. Ms B recorded the gestational age, ticked the spaces provided for recording the FHR and movements, and recorded that the baby's presentation was cephalic and positioned to the right.

In mid October, Mrs A's urine sample was clear, her blood pressure was 110/70mmHg, and the spaces provided for recording the FHR and movements were ticked. The gestational age was recorded as 36 weeks, and the baby's presentation was recorded as cephalic and positioned to the right. Mrs A was reported to be well, and Ms B noted that she finished antenatal classes that week.

Ms B saw Mrs A one week later. Mrs A's urine sample was clear, and her blood pressure was 110/60mmHg. The baby's presentation and position were unchanged. The gestational age was recorded, the spaces provided for recording the FHR and movements were ticked, and Mrs A was reported to be tired but otherwise well. Ms B

[5] The polycose test is a measure of blood glucose levels, and is used as a screening test for gestational diabetes.

[6] The gestational glucose tolerance test measures the (pregnant) body's ability to metabolise glucose, and is a diagnostic tool for gestational diabetes.

requested blood tests, and later that day recorded normal results for iron levels and haematology and a negative result for antenatal antibodies.

Late in October, Mrs A's urine sample was clear, her blood pressure was 110/70mmHg, and the spaces provided for recording the FHR and movements were ticked. The gestational age was recorded as 38 weeks, and the baby's presentation and position were unchanged. The baby was 2/5th engaged[7] and Mrs A was reported to be "sleeping lots", but feeling well.

A few days later, Mrs A's urine sample was clear, her blood pressure was 100/80mmHg, and the spaces provided for recording the FHR and movements were ticked. The baby's presentation, position, and engagement were unchanged, and Mrs A was well, although her hands and feet were "a little" oedematous.[8]

Ms B saw Mr and Mrs A on the estimated day of delivery. Mrs A's urine sample was clear, and the spaces provided for recording the FHR and movements were ticked. Ms B noted the gestational age of 40 weeks, and recorded that the baby's presentation, position, and engagement were unchanged. Ms B referred Mrs A to an obstetrician, requested blood tests, and recorded that Mrs A was feeling upset, with headache and nausea. Mrs A does not recall feeling unwell at this stage of her pregnancy.

Events of the day of the birth

Ms B's documented accounts of the birth
Ms B provided six different accounts of Mrs A's labour and the birth of Baby A. Some accounts also included details of antenatal care. The various accounts are referred to as follows:

- Contemporaneous account: This is dated the day of the birth and includes a hand-written record of the labour and birth, including hospital stamps on the upper right corner, on the reverse of the partogram graphs. Ms B described the document as a "partogram". In her response to the provisional opinion, Ms B stated that all entries were contemporaneous, except for the notes at 4.45pm, which were written up shortly after the birth.

- Partogram graphs: These are the partogram graphs recording the FHR, cervical dilation, fetal descent, contractions, and maternal blood pressure, on the reverse of the contemporaneous account. In her response to the provisional opinion, Ms B stated that the graphs were completed at the same time as the written contemporaneous notes.

[7] Engagement of the head refers to the position of the fetal head in the pelvis. The degree of engagement is assessed by the degree of fetal movement upon palpation of the abdomen, with 1= completely disengaged and 5= completely engaged.

[8] Oedema is the accumulation of excess fluid under the skin. Minor oedema in the extremities is common in late pregnancy.

- Midwifery Council account: This is a letter typed by Ms B and dated March 2007 to the Midwifery Council of New Zealand, outlining the care Ms B provided to Mrs A and her daughter Baby A. No times are given in this account.

- Hospital account: These are Mrs A's clinical notes dated the day of the birth, including the labour and delivery worksheet completed shortly after the birth, and the pregnancy and delivery record completed at 7.30pm on the same day.

- Retrospective account: Ms B completed this account on the morning after the birth, and has described it as "reflections written 24 hours afterwards".

- Quality Assurance Activity (QAA) account: This is a handwritten note completed by Ms B as a prompt when presenting the case to the DHB 1 adverse events Committee Meeting in November 2005.[9]

Video recording
Mr and Mrs A also supplied a video recording of the labour and birth. The video camera was turned on for brief periods of time during Mrs A's labour, and was recording from 4.23pm to approximately 4.50pm. The camera remains focussed on Mrs A throughout.

Labour
Unless specified otherwise, all "recordings" reflect what was written in the contemporaneous record.

Mrs A's contractions began spontaneously at 2am. Mr A contacted Ms B at 5am to advise that his wife was in labour, and the membranes had not ruptured. Ms B advised Mrs A to stay at home until the contractions became more frequent, and confirmed that Mr and Mrs A were happy to do so. At 7am, Mr A contacted Ms B to advise that contractions had increased to three in ten minutes. Ms B agreed that Mrs A ought to proceed to Hospital 1.

Mrs A was admitted to hospital at 8am, and Ms B arrived shortly afterwards. Ms B recorded "FH√ "[10] at 8am and 8.30am, although Mr and Mrs A stated that Ms B was not at the hospital until after 8am, and so could not have taken a FHR recording then. They also do not recall Ms B ever listening to the FHR before, through, and after a contraction and take exception to the number of times she documented measuring the FHR.

[9] Ms B consented to the disclosure of this information, but submitted that its purpose was simply as a prompt when she presented the case as part of the DHB 1 QAA process, not as an official record for an investigation, and that it should not be used to show any inconsistencies or "differing accounts".
[10] Ms B stated that she wrote FH√ to mean "a baseline of between 120 and 160 beats per minute, variability heard and no decelerations during or after the contraction".

The first recording of the FHR in the partogram graph was made at 8.30am, as 140bpm. At 9.15am, Ms B assessed Mrs A and the contemporaneous record and partogram show than her cervix was 4–5cm dilated, and the FHR was 140 beats per minute (bpm). "FH√ " was recorded at 9.30am, and the partogram graph recorded 130bpm.

At 9.45am, Mrs A moved into the birthing pool and continued to labour. "FH√ " was recorded at 10am and 10.30am. A FHR of 140bpm was recorded on the partogram graph at 10.15am, and 145bpm at 11am, as well as her blood pressure showing 140/80mmHg. "FH" was recorded at 11.30am, and "FH√ " at noon. Ms B re-examined Mrs A at 12.15pm, and recorded that her cervix was now 7cm dilated and the FHR was 140bpm. This was also recorded on the partogram graphs. "FH√ " was recorded at 12.30pm, and Mrs A got out of the pool so that fresh water could be run. She returned to the pool at 12.45pm. Ms B recorded the FHR as 140bpm, with no decelerations[11] in the contemporaneous and QAA accounts, and as 155bpm in the partogram graph.

"FH√ " was recorded at 1pm, and "FH" at 1.15pm. The partogram graph shows the FHR to be 145bpm at 1.15pm. At 1.30pm Ms B recorded "urge to push gaining strength". Ms B examined Mrs A and recorded that her cervix was 10cm dilated, the baby's head was presenting with some localised swelling, and the FHR was satisfactory. Mrs A's labour continued while she was in the pool, and she began pushing at approximately 1.30pm. Ms B recorded "FH after every second contraction good".[12] At 2.15pm, the FHR was recorded as 155bpm on the partogram graph.

At 2.30pm, Ms B suggested that Mrs A leave the pool to begin "active serious pushing". At 3pm, Ms B assessed Mrs A and recorded the FHR as 120–140bpm. It was recorded as 145bpm on the partogram graph. There was uncertainty over whether Mrs A's membranes had ruptured or not. Mrs A was unsure, so Ms B attempted to artificially rupture the membrane. She was unsuccessful, and concluded that it had previously ruptured.

At 3.20pm Ms B had to leave the room for 20 minutes to attend to an urgent page from an antenatal patient, and midwife Ms C relieved her. Ms C encouraged Mrs A to try different positions, and recorded in the contemporaneous notes that the FHR was 120–140bpm, and Mrs A was contracting every two minutes.

[11] Decelerations or "dips" are periodic decreases in the FHR, which may result from pressure on the fetal head during contractions. The deceleration usually follows the pattern of the contraction, beginning when the contraction begins and ending when the contraction ends. The tracing of the deceleration wave usually shows the lowest point of the deceleration occurring at the peak of the contraction. The rate rarely falls below 100bpm and returns quickly to 120 to 160bpm at the end of the contraction.

[12] Mr and Mrs A dispute Ms B's claim that she measured the FHR after every second contraction.

From this point, Ms B's notes differ as to whether the FHR was recorded again. In Ms B's contemporaneous notes, the last record of the FHR was at 3.20pm, although the FHR was recorded as 150bpm at 3.45pm in the partogram graph, together with a blood pressure of 140/80mmHg. In her retrospective account, the last FHR recording was at "1605/1610 approx", and in the QAA account, the FHR was last recorded at 4.10pm.[13] Only the partogram graph states a precise FHR, at 3.45pm.

Upon her return at 3.40pm, Ms B discussed the possibility of an epidural to help Mrs A, as she was becoming exhausted. Although Mrs A's birth plan stated that she wished to avoid pethidine, gas, and epidural in favour of natural pain relief, it also outlined a preference for a low-dose epidural that would wear off once fully dilated, if one was necessary. In each of her accounts, except the Hospital account, Ms B reported that Mrs A did not initially agree to the epidural. In her retrospective account, Ms B stated: "[Mrs A] is very distressed about [intervention] and reluctant to have an epidural." In contrast, Mr and Mrs A deny that they were reluctant to agree to the epidural. Mrs A stated: "[Ms B] started talking about an epidural and I felt the relief wash over me ... I was desperate to get on with any assistance." Mr A reported that he did not oppose the intervention, but merely asked Ms B if the epidural would be "to relax the muscles (i.e., a light one) or to go to c-section". After gaining consent, Ms B left the room again at 3.45pm to contact obstetrician and gynaecologist Dr H and seek permission to proceed with an epidural, before contacting anaesthetist Dr G to arrange for epidural administration.

Ms B returned and inserted an intravenous line and took blood samples to send to the laboratory in preparation for the epidural. Ms B reported that she intended to do a cardiotocograph (CTG),[14] but did not manage to do so before Dr G arrived at 4.10pm.

At 4.15pm, before Dr G inserted the epidural, Ms B and Dr G noted that the birth was imminent, and Dr G left.

Ms B measured the FHR once more at 4.24pm. Although not documented in any of Ms B's accounts, it is in the video recording. After checking the FHR, Ms B told Mr A that the FHR was "absolutely fine". At this point, Mrs A was contracting every two minutes.

At 4:26pm, Ms B can be seen, in the video recording, to adjust the bed three times, and drink from a sports drink bottle directly after taking the FHR.

[13] I also note that a video recording of the birth shows Ms B listening to the FHR at 4.24pm. However, this observation was not recorded in any of the accounts.

[14] A cardiotocograph or CTG is the external electronic monitoring of the FHR. A CTG can indicate abnormalities in the fetal heart rhythm, which may indicate fetal distress. The Doppler unit converts fetal heart movements into audible beeping sounds and records this on graph paper.

Delivery and resuscitation

Baby A's head birthed at 4.30pm, with thick meconium-stained[15] liquor draining from her nose. Ms B rang the bell for help and, because the wall suction would not reach the bed, used a mucus extractor to suction Baby A's mouth. About 4.32pm, midwife Ms D arrived and requested further assistance by ringing the emergency bell.

Baby A was delivered at 4.33pm in the next contraction. Ms B clamped the umbilical cord, and allowed Mr A to cut it. Baby A was described as floppy, pale, and without heart or breathing rates. Ms B began emergency resuscitation, but Baby A's Apgar[16] score was 0 at three minutes. At 4.35pm, Dr G and obstetric registrar Dr I responded to the emergency bell and took over the resuscitation. Following resuscitation, Baby A was transferred to the Special Care Baby Unit (SCBU).

Ms B stated:

> "I was deeply shocked … [a]t no level had I expected this baby to be so profoundly compromised. All fetal heart recordings had been satisfactory and no meconium had been [sighted] nor had anything else alerted me. I know three hours of second stage in a primiparous[17] woman is at the edge of normal midwifery practice but this baby had not alerted me to any problems being apparent. ..."

Meanwhile, midwife Ms F arrived with the doctors and took over care of Mrs A. Ms F delivered the placenta, and noted that Mrs A had suffered a first-degree perineal laceration[18] that would need suturing. She offered to suture Mrs A's perineal tear, although Mrs A indicated that she would like this done later. Ms F left at 4.45pm to attend another client.

Ms B was "too shaken" to suture Mrs A's perineal tear, so telephoned midwife Ms E to come in to assist her, as none of the available nursing staff on the obstetric ward were experienced in suturing, and medical staff were involved in an emergency Caesarean section. Ms B advised that she is sorry she was not able to carry out the suturing at the time.

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[15] Meconium is the first faecal material evacuated from the fetus's or newborn's rectum, and appears green to very dark green. Meconium can be present in the amniotic fluid as a green staining. Although not always a sign of fetal distress, meconium in the amniotic fluid is highly correlated with its occurrence. Meconium in the amniotic fluid reveals that the fetus has had an episode of loss of sphincter control.

[16] An Apgar score is used to ascertain and record the condition of the baby, looking at colour, respiratory effort, heart rate, muscle tone and reflex response, with a maximum/optimal score of 10.

[17] A woman experiencing her first pregnancy.

[18] Perineal lacerations are classified in four categories, depending on the extent and depth of tissue involved. First degree = least serious; fourth degree = most serious.

While waiting for Ms E to arrive, Ms B watched the video recording of the birth with Mr and Mrs A. Mr and Mrs A reported that they did not wish to watch the video, but felt "bullied" into doing so by Ms B. In response, Ms B said that she is "extremely sorry that the [couple] feel that they were bullied".

Ms E arrived at 5.15pm, but she assessed the perineum to be too oedematous for suturing. Ms E instituted conservative management of a pressure pad, ice and pain relief, along with a urinary catheter.

Hospital 1 Special Care Baby Unit
Baby A's temperature and oxygen saturation were initially unstable. She was ventilated upon arrival at the Special Care Baby Unit, and was placed on CPAP[19] later that night. Arterial and venous cord blood testing demonstrated significant hypoxia (low oxygen levels) at birth. The next morning, staff recorded seizure activity, and Baby A was transferred to Hospital 2 for investigation and management of her seizures. Baby A's diagnoses on the transfer summary were convulsions, severe birth asphyxia, congenital renal failure, hyponatraemia, and hypotension.

Transfer to Hospital 2
On the morning after the birth, Mrs A was being prepared to be transferred to Hospital 2, in order to be close to Baby A. Ms B examined Mrs A's perineum and removed the pad.

Ms B stayed with Mr and Mrs A until they boarded the ambulance to take them to the airfield. Ms B provided her mobile telephone number to Mr A and encouraged him to call her any time. Ms B rang the hospital and Mr and Mrs A's cell phones over the next three days, before being told by a hospital staff member, at Mr and Mrs A's request, to discontinue calling the hospital and them.

Subsequent diagnoses and events
At Hospital 1, Mrs A was examined and diagnosed as having a second-degree perineal tear. For several weeks after returning home, Mrs A experienced faecal incontinence, which resolved with physiotherapy treatment.

Baby A was diagnosed with hypoxic ischaemic encephalopathy[20] at Hospital 1. She suffered ongoing seizures and secondary renal and hepatic impairment. Baby A is now 20 months old and making good progress, although she requires ongoing assessment.

[19] Continuous positive airway pressure or CPAP is the administration of positive pressure to the airways of the spontaneously breathing patient throughout the respiratory cycle. A nasal mask (CPAP) provides heated and humidified continuous oxygen flow to prevent the airways from collapsing and reduce the effort required to breathe.

[20] Damage to cells in the central nervous system (the brain and spinal cord) from inadequate oxygen.

Both Mr and Mrs A were considerably traumatised by Baby A's difficult birth, and have received counselling.

Postnatal midwifery care
Mrs A changed to another LMC, and Ms B had no further contact with the family. A community midwifery service provided postnatal care to Mrs A and Baby A.

Additional information

ACC
In June 2006, ACC obtained independent advice from midwife Sue Lennox. Ms Lennox advised:

> "The last recorded fetal heart [rate] was 4 pm. The rate was reassuring but the baby was not born for another 33 minutes; there should therefore have been at least another five or six recordings. The problem appears to be one of omission of appropriate treatment. This lack of fetal heart rate observation and the surprise arrival of this severely compromised baby seem to be inevitably connected.
>
> ...
>
> My conclusion is based on the fact that if an indication of the baby's distress had been identified earlier intervention might have reduced the injury. … In my experience it would be very unusual to have a baby born with Apgar 0 (i.e. no heart beat) if there had been no prior warning signs."

ACC accepted Baby A's treatment injury claim for hypoxic ischaemic encephalopathy "as a result of omission of care".

Ms B's response
Ms B advised that she has made the following changes to her practice in light of this case:

> "The major change … has been within my written reports. Previously I would write FH√ (tick), which I took to mean a baseline of between 120 and 160 beats per minute (bpm), variability[21] heard and no decelerations during or after the contraction. I now write this long hand. I also utilise the CT machine for

[21] FHR variability is considered to be one of the most reliable indicators of fetal well-being. Baseline variability (the normal variation of the FHR within the normal range) increases when the fetus is stimulated, and slows when the fetus sleeps. If no variability is present, it indicates that the natural pacemaker activity of the fetal heart has been affected. The cause may be a response to narcotics or barbiturates administered to the woman in labour, but the possibility of fetal hypoxia and acidosis must be investigated. Decreasing variability indicates the development of fetal distress. Absent variability is considered a severe sign, indicating fetal compromise.

auscultation[22] because then I have a document to attach to the notes showing the rate and variability on the graph along with the time taken.

….

I have made a commitment to utilise a CTG as part of the planning for intervention rather than like in [Mrs A's] case, where intervention had already been agreed to … In future, I would have the CTG information prior to consulting with the obstetrician.

…

Another change in my practice will be the routine use of CTG if the second stage is longer than expected."

Independent advice to Commissioner

The following expert advice was obtained from midwife Kay Faulls.

"General Comments on Care, Information and Standards

In my professional opinion some of the services provided by Midwife [Ms B] to [Mrs A] were appropriate, others were not.

The Midwives Handbook for Practice ISBN0-476-011728, Updated Version published by the New Zealand College of Midwives–2005 Christchurch, is written for midwives, women and the general public, and identifies the beliefs that midwives hold about midwifery.

Contained within this handbook are.

1. Definition of a midwife
2. The Scope of Practice of the midwife
3. Standards for Midwifery Practice
4. Decision Points for Midwifery Care.

I have used this handbook as the basis for my professional opinion.

Standard Two of the Midwives Handbook states, **The midwife upholds each woman's right to free and informed choice and consent throughout the childbirth experience.**

[22] The act of listening for sounds within the body; in this case, the FHR.

Amongst the criteria the midwife **develops a plan for midwifery care together with the woman and documents decisions and her midwifery actions.**

I received two copies of the Independent Midwifery Service Pregnancy Record Card. One was provided by [Mrs A] and the other was provided by Midwife [Ms B]. These documents appear to be one version for the midwife and one version for the [couple].

Midwife [Ms B] provided frequent and timely visits to [the couple]. I can find no comprehensive antenatal care plan contained within these notes. There is a Birth Plan for [Mrs A and Mr A] which is comprehensive and written by [Mrs A and Mr A] and dated Spring 2005.

There is no documentation which supports any decisions made or midwifery actions undertaken.

Standard Three of the Midwives handbook states, **The midwife collates and documents comprehensive assessments of the woman and/or baby's health and wellbeing.**

Amongst the criteria in this standard the midwife **documents her assessments and uses them as the basis for on-going midwifery practice.**

Midwife [Ms B] has documented all her assessments — blood pressure, urinalysis, fetal heart, fetal movements. I note that the fetal heart is always ticked in the appropriate column, but no rate is documented.

However there is no documentation in the hospital notes of any midwifery care or recordings undertaken by Midwife [Ms B] on [the day of the birth]. The only documentation sighted by me was written after the birth of [Baby A] when Midwife [Ms B] filled in the partogram and wrote the hospital birth summary.

Standard Five of the Midwives handbook states, **Midwifery care is planned with the woman.**

The midwife **provides access to a variety of information sources, ensures the care plan is woman-centred and involves and respects the woman's significant others in care as desired by the woman.**

There is no supporting documentation to know if [Mrs A] read or was given any information on pain relief in labour. The New Zealand College of Midwives (inc.) also publishes a leaflet titled 'Labour Pains-making choices', NZCOM 2003. This is a valuable resource for women and midwives offering information on pain relief in labour. There is no documentation to suggest [Mrs A] read this leaflet.

There is no documentation to support the claim that epidural analgesia was discussed with this family in any depth or form prior to [the day of the birth].

This standard also states the midwife **sets out specific midwifery decisions and actions in an effort to meet the woman's goals and expectations and documents these.**

This appears not to have been done.

Standard Six of the Midwives handbook states, **Midwifery actions are prioritised and implemented with no midwifery action or omission placing the woman at risk.**

The midwife **ensures assessment is on going and modifies the midwifery plan accordingly.**

There is no midwifery documentation contained within the hospital notes (other than the contemporaneous notes) that I can find written by Midwife [Ms B]. According to Midwife [Ms B] she filled in the partogram after [Baby A] was admitted to the Special Care Baby Unit. In my opinion all of the documentation provided was written retrospectively, and this has been confirmed by Midwife [Ms B] in her letter to the Health and Disability Commissioner.

Standard Seven of the Midwives handbook states, **The midwife is accountable to the woman, to herself, to the midwifery profession and to the wider community for her practice.**

The midwife **clearly documents her decisions and professional actions.**

As mentioned before, Midwife [Ms B] provided frequent antenatal visits to [Mrs A]. It appears recordings of blood pressure, urinalysis and fetal heart [rate] were documented. There are some written comments as to what was discussed but these are too brief to be of value. Documentation within the hospital notes is inadequate.

Comments on Specific Questions

Whether Midwife [Ms B] sought specialist medical intervention at the appropriate time?

Midwife [Ms B] did seek medical intervention at an appropriate time i.e., after [Mrs A] had been pushing for approximately 1½ to 2 hours. She sought the services of the anaesthetist for the purposes of providing [Mrs A] with an epidural anaesthetic to provide some pain relief for [Mrs A] and expedite delivery of [Baby A].

Midwife [Ms B] also called for medical assistance once she realised that [Baby A] was going to be born in less than ideal condition. Maybe if the fetal heart had been listened to more frequently once [Baby A's] birth was imminent this may have been diagnosed.

Adequacy of monitoring during the birth

I have examined both the contemporaneous notes from [the day of the birth and the following day]. Both these sets of notes are inadequate especially those written on [the day of the birth]. There is no recording of a fetal heart beat apart from 'intermittent auscultation thru & after contractions throughout labour. No decels heard.'

According to the notes written by Midwife [Ms B] on [the day following the birth], she writes 'fill in notes and write up partogram' after birth of [Baby A].

There appears to be no documentation of [Baby A's] fetal heart rate being listened to during labour other than on the partogram which was completed once she had been transferred to the Special Baby Unit.

I was able to view a DVD recording of a video taken by [the couple] during the birth of [Baby A]. The video camera was set up in the corner of the room and left running for 40 minutes. This showed Midwife [Ms B] listening to the fetal heart 9 (nine) minutes before the birth. It does not show Midwife [Ms B] documenting that recording which was very hard for me to hear. It is usual for a midwife to document the rate of a fetal heart both on the partogram and also on the clinical notes provided by the hospital where the woman is birthing. This does not appear to be so in this case.

I agree with Midwife Sue Lennox who provided an opinion to ACC. **She states 'It is unusual in my experience to have no signs of fetal distress with a compromised baby. Not taking the fetal heart recordings regularly would not in itself cause injury, however not picking up the signs of distress could mean that appropriate obstetrical referrals would not be made and that omission could exacerbate any spontaneous pre-existing conditions.'**

I do not believe there was adequate monitoring of [Baby A's] fetal heart during the last 30 minutes prior to her birth, i.e., between 1600–1633, [the day of the birth]. It is usual midwifery practice to monitor a fetal heart beat after every contraction or at least every second contraction during the 'pushing' or second stage of labour.

I note that Midwife [Ms B], in her report to Midwifery Council, states 'I agree that if there had been a CTG during the second stage of labour it may have changed the outcome. It may not have but it may have.'

Both arterial and venous cord blood was taken from [Baby A] and this was tested to determine the level of hypoxia (low oxygen level) sustained prior to delivery. The results of this test show [Baby A] was severely compromised at birth. This is demonstrated by the

1. arterial cord ph of 6.89. Normal level should be 7.35–7.45units.

2. arterial pCO2 of 52. Normal level should be 35–45mmHg.

3. arterial pO2 of 38. Normal level should be 85–100 mmHg.

Effectiveness of Midwife [Ms B's] communication with [Mrs A and Mr A].

It is my opinion that Midwife [Ms B] could have had better communication with the [couple]. Antenatally communication seems to have been appropriate and Midwife [Ms B] did attend [Mrs A] promptly once hospital admission was organised.

Contained within the retrospective notes written [at the end of] November 2005 there is a gap of some 20 minutes when Midwife [Ms B] is out of the room. Midwifery cover was organised by a midwife the [couple] had never met. According to [Mrs A's] recollections of this midwife ([Ms C]), [Mrs A] found her care helpful and did not want her to leave once Midwife [Ms B] returned. This was not communicated to either midwife by either [Mr A or Mrs A] at the time.

Postnatally there was limited opportunity for Midwife [Ms B] to communicate with the [couple] as they were transferred to [Hospital 2] on [the day following the birth]. The [family] returned [home] on [10 days later] and postnatal care was undertaken by a midwife from the [Midwifery Service] at [DHB1]. This was done at the request of the [couple].

Whether Midwife [Ms B] adequately managed [Mrs A's] vaginal tearing?

Midwife [Ms B] did not manage the second degree tear of [Mrs A's] perineum appropriately. She did not inspect the perineum once [Baby A] had been birthed. Midwife [Ms F] did this and suggested that perineal repair be undertaken.

Midwife [Ms B] felt unable to do this repair, no hospital midwife was available to help and Midwife [Ms B] then asked Midwife [Ms E] to inspect [Mrs A's] perineum.

This was done at 1715hrs, 45 minutes after the birth of [the baby].

Midwife [Ms E] also felt unable to repair the perineum and a decision was made to leave it unsutured, insert a urinary catheter and apply an ice-pack. There was documentation written by Midwife [Ms E] to support this decision and some pain relief was given.

Midwife [Ms B] did ask for help to repair [Mrs A's] perineum but this was not forthcoming from the hospital midwives and Midwife [Ms E] felt unable to do the suturing required due to the perineal swelling.

It would have been appropriate to request assistance from the [Hospital 1] Obstetric Medical Staff as no midwife felt able to repair [Mrs A's] perineum.

The adequacy of Midwife [Ms B's] contemporaneous notes of [the day of the birth].

It has been difficult to ascertain exactly what occurred and when on the [the day of the birth] because there is no documentation written by Midwife [Ms B] during the hours 8am–5pm and contained within any notes viewed by me.

All the information I have read has been written retrospectively and therefore is subject to recall. Whether this can be as accurate as documentation done at the same time as the events (contemporaneously), is always open to wide debate.

I have read [Mrs A's clinical] notes dated [the day of the birth] and find these inadequate. Midwife [Ms B] does not mention in these notes whether the baby born was a boy or a girl, the state of the perineum or time of third stage. Also not mentioned is blood loss, apgars of the baby or any fetal heart rate written as a number, i.e., 120 bpm.

Are there any aspects of the care provided by [Ms B] that you consider warrant additional comment?

I agree with the Midwifery Council of New Zealand, who in a letter to Midwife [Ms B] stated:

'It does not appear that you are using any standardised notes and Council suggests that the use of MMPO notes may be a useful tool as they will help provide structure to your documentation.'

Although Midwife [Ms B] reiterates in all her 'contemporaneous' notes that frequent fetal heart rate recordings were done, the documentation seen by me does not support this claim.

It is my professional opinion that if more frequent fetal heart rate recordings had been done on [the day of the birth] [Baby A] may not have been born in such a compromised condition. Undertaking and documenting more frequent

fetal heart rate recordings would have given Midwife [Ms B] better information upon which to base her clinical decisions.

Summary

Midwife [Ms B's] documentation is not of an adequate standard for a New Zealand Registered Midwife.

This documentation should be based on the Care Plan outlined in Appendix III of Ministry of Health (2002) which states that a 'Care Plan' means the process by which the Lead Maternity Carer (Midwife [Ms B]) and the woman ([Mrs A]) develop a plan of care for the woman and her baby and the documentation of this plan throughout the individual clinical notes pertaining to the woman.

This care plan should cover, as a minimum,

(a) schedule and location of visits for pregnancy care;
(b) how continuity of care will be achieved;
(c) how to access the Lead Maternity Carer in urgent situations;
(d) cultural safety requirements;
(e) education plan during pregnancy and following birth;
(f) referral to other midwifery, medical, social and diagnostic services;
(g) smoking cessation options;
(h) screening for infectious diseases;
(i) assessment of risk of family violence;
(j) location of birth and other services including booking in to a facility or arrangements for home birth;
(k) presence of others at birth;
(l) birth environment and position for birthing;
(m) options and preference for monitoring, intervention and treatments;
(n) handling of placenta;
(o) breastfeeding or other feeding arrangements;
(p) likely stay in the Maternity facility and planning to go home;
(q) requirements for postnatal care;
(r) risk of postnatal depression and support options;
(s) advice regarding contraception and sexuality; and
(t) referral to Well Child provider and the timing of this.

I believe that Midwife [Ms B's] professional peers would view the lack of documentation and therefore the midwifery services provided by Midwife [Ms B] with moderate to severe disapproval."

References

New Zealand College of Midwives (2005) Midwives Handbook for Practice

New Zealand College of Midwives (2003) Labour Pains — Making Choices

> **Ministry of Health (2002)** Maternity Services Notice Pursuant to Section 88 of the New Zealand Public Health & Disability Act 2000. This notice is issued by the Crown and is effective from 1 July 2002."

Additional expert advice

On 27 June 2007, Ms Faulls was asked to indicate how many times the FHR should have been measured throughout Mrs A's labour. Ms Faulls stated that the FHR should be recorded every half hour once labour is established, and a minimum of every 15 minutes once pushing commences, although after every second contraction is ideal.

On 21 November 2007, Ms Faulls provided the following report after reviewing her advice in light of Ms B's response to the provisional opinion:

> "I, Kay Beverly Faulls, have been asked to provide an opinion to the Commissioner on case number 07/03243 and have read and agreed to follow the Commissioner's Guidelines for Independent Advisors.
>
> I reviewed a letter on 7 November 2007, from [the HDC] Investigator and have been asked to review my advice to the Health and Disability Commissioner sent to them on 21 May 2007.
>
> After reading the additional information from [the] Legal advisor for the New Zealand College of Midwives, I wish to add this advice.
>
> **FETAL HEART DOCUMENTATION**
>
> When I received photocopies of [Mrs A's] hospital records, the partogram was in two separate pieces and did not have the handwritten notes dated [the day of the birth] on the reverse. This page was submitted separately and I did not realise that it was on the reverse of the partogram.
>
> Nevertheless, no fetal heart rate is documented anywhere, on either side of the partogram, or on the retrospective notes written [the day following the birth], after 1600. Midwife [Ms B] did listen to the baby's heart 9 minutes before the birth. This recording is not documented anywhere I could find.
>
> I realise that Midwife [Ms B] had her gloves on at the time of this recording but this should not mean that the heart rate could not be documented.
>
> It is still my expert opinion that Midwife [Ms B's] documentation falls below that of a New Zealand Registered Midwife.

PERINEAL INJURY

In regard to the perineal laceration sustained by [Mrs A], there is some discrepancy in the hospital notes with regard to this.

The birth summary documents the perineal tear as first degree but on the labour and delivery worksheet it is unclear whether the laceration is first of second degree and the sutured line has been crossed out.

I realise that first and second degree tears fall within the competency of the midwife but if a midwife feels unable to suture a woman's perineum it is appropriate to ask for medical assistance to repair the perineum.

The unsutured perineal tear, whether first or second degree, had obviously caused [Mrs A] a lot of anguish. The fact that the tear took some time to heal points towards it being a second degree tear rather than a first degree laceration.

A first degree tear is defined as involving perineal skin only.
A second degree tear is defined as involving perineal skin, vaginal wall and perineal muscles.
(Pairman et al., 2006 — Midwifery preparation for practice)

A second degree tear will heal by itself given time and this appears to be the case in this instance. The question whether or not suturing the fresh tear was achievable, given the degree of oedema, I am unable to answer."

Ms Faulls also advised that Ms B's failure to engage medical staff to review Mrs A's perineal tear would be viewed with mild to moderate disapproval by her peers.

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint.

RIGHT 4
Right to Services of an Appropriate Standard

(1) Every consumer has the right to have services provided with reasonable care and skill.

(2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

...

(5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

Relevant Standards

The relevant standards from the New Zealand College of Midwives *Midwives' Handbook for Practice* (2005) state.

"Standard two
The midwife upholds each woman's right to free and informed choice and consent throughout the childbirth experience.

Criteria
The midwife

…

- Develops a plan for midwifery care together with the woman.

Standard three
The midwife collates and documents comprehensive assessments of the woman and/or baby's health and wellbeing.

Criteria
The midwife

…

- documents her assessments and uses them as the basis for on going midwifery practice.

Standard five
Midwifery care is planned with the woman.

Criteria
The midwife

…

- facilitates the opportunity for the woman to experience continuity of care.

Standard six
Midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk.

Criteria
The midwife

...

- ensures assessment is ongoing and modifies the midwifery plan accordingly.

...

- has the responsibility to refer to the appropriate health professional when she has reached the limit of her expertise.

Standard seven
The midwife is accountable to the woman, to herself, to the midwifery profession and to the wider community for her practice.

Criteria
The midwife

…

- clearly documents her decisions and professional actions.

Opinion: Breach — Ms B

Introduction

Under Rights 4(1) and 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code), Mrs A was entitled to services provided with reasonable care and skill, and in compliance with professional standards. Mrs A was also entitled to co-operation between providers to ensure quality and continuity of care, in accordance with Right 4(5) of the Code.

For the reasons set out below, I have concluded that Ms B breached the Code by her substandard midwifery care and documentation.

Care

Fetal heart rate monitoring
Although all of Ms B's accounts record that the FHR was monitored during Mrs A's labour, I do not consider that monitoring was as frequent as it ought to have been, particularly in the last hour before Baby A was born. Ms Faulls advised:

> "It is usual midwifery practice to monitor a fetal heart beat after every contraction or at least every second contraction during the 'pushing' or second stage of labour."

Although Ms B claims that she monitored the FHR every three to six minutes (after each, or every second contraction), once Mrs A began pushing at 1.30pm, none of her accounts support this claim. If Ms B monitored the FHR every six minutes from 1.30pm to 4.33pm, she should have made a minimum of 30 recordings.

In the contemporaneous account, FHR monitoring was documented only four times once Mrs A began pushing, at 1.30pm, 2.30pm, 3pm, and 3.20pm. There is no record of FHR monitoring between 3.20pm and 4.33pm, when Baby A was born.

The partogram graph records the FHR three times during the second stage of labour, at 2.15pm, 3pm, and 3.45pm.

The retrospective account refers to six FHR recordings during the second stage of labour, at 2pm, 3.20pm, 3.30pm, 3.50pm, 4pm and 4.05/4.10pm.

The QAA account (which I accept was prepared for a different purpose) records the most frequent FHR monitoring from 1.30pm, with eleven FHR recordings, at 1pm, 1.45pm, 2pm, 2.30pm, 3pm, 3.10pm, 3.35pm, 3.45pm, 3.50pm, 4pm and 4.10pm.

The video recording shows Ms B measuring the FHR at 4.24pm, nine minutes before Baby A was delivered.

None of the accounts of the birth demonstrates that the FHR was measured at an appropriate frequency during the second stage of labour. I am particularly concerned that, according to the contemporaneous written and video records, the FHR was monitored only once during the last 73 minutes before the birth. Furthermore, I do not agree with Ms B that the video record supports her claim that the FHR was monitored at an appropriate frequency.

While I cannot determine whether more frequent FHR monitoring would have alerted Ms B to Baby A's compromised state, I endorse Ms Faulls' comment that

"undertaking and documenting more frequent fetal heart rate recordings would have given midwife Ms B better information upon which to base her clinical decisions".

In my opinion, Ms B did not exercise reasonable care and skill when monitoring the FHR and therefore breached Right 4(1) of the Code.

Documentation

Antenatal period
Although Ms B saw Mrs A regularly during the antenatal period, her documentation of these visits in the pregnancy record cards is inadequate.

Ms B "ticked" the appropriate column relating to FHR, but she did not record the actual rate numerically, and did not record hearing the FHR at every appointment. The notes of each antenatal appointment are very brief and do not provide an adequate record of Ms B's discussions with Mr and Mrs A.

The Maternity Services Notice[23] outlines 20 points that ought to be addressed in a maternity care plan, and these points are included in the "care plan checklist" on Mrs A's pregnancy record cards. However, very few discussions between Ms B and Mrs A (about how to proceed with her pregnancy and birth) are recorded. I am particularly concerned to note that there is no record of Mrs A being provided with information about pain relief in labour, despite Ms B's claim that epidural analgesia was discussed prior to the birth.

In her response to the provisional opinion, Ms B stated that, although the care plan checklist on Mrs A's Pregnancy Record Cards was largely blank, most of the issues were comprehensively addressed in the birth plan. Yet Mrs A stated that the content of the birth plan was "absolute garbage" and "a near direct copy ... [made] in complete ignorance and [I] regret it". Ms B's assertion that "[Mrs A] shows a high degree of knowledge regarding pain relief and drug options" is inconsistent with the couple's deference to, and reliance upon, Ms B throughout the pregnancy and birth. In my view, it was inappropriate for Ms B to assume that a detailed birth plan evidenced detailed knowledge.

Ms Faulls advised that Ms B's documentation of antenatal visits was not sufficiently thorough to support the decisions made, or the actions taken, by her during the antenatal period, and was critical of her failure to document a thorough antenatal care plan for Mrs A.

[23] *Maternity Services Notice Pursuant to Section 88 of the New Zealand Public Health and Disability Act 2000* (Ministry of Health, 2002).

Perinatal period
I find that the handwritten account is the only record of the labour and birth that was completed contemporaneously and added to as the birth progressed from 5am to 4.15pm.[24] The authenticity of this account is evidenced by the hospital stamps in the upper right corner, and the entry made by Ms C at 3.20pm.

I do not accept Ms B's assertion that the partogram graphs on the reverse of the contemporaneous written account were recorded as the birth progressed. Many times and recordings do not match those of the contemporaneous written record, and the FHR was recorded at 3.45pm, when Ms B was out of the room according to the contemporaneous written record.

Because of the irreconcilable differences between the two accounts, I do not believe that they were recorded at the same time. On balance, I find that only the handwritten notes provide contemporaneous documentation of the labour and birth. All other accounts were completed after the labour and birth.

Although Ms B did keep a contemporaneous record, she nonetheless failed to maintain an adequate record of the labour and birth. Ms B did not complete the partogram graphs as the birth progressed, and only recorded the FHR numerically on five occasions in the contemporaneous record, instead writing "FH√ " to indicate a good heart rate with variability and no decelerations. The video recording provides evidence that, on at least one occasion, Ms B did not document a FHR recording in the contemporaneous notes.

In her response to my provisional opinion, Ms B stated that she was unable to document labour and birth details close to the birth because she was too busy, and had gloves on. I do not accept this, and note that in the video recording, Ms B is seen to raise and lower the bed three times, and drink from a sports drink bottle, after measuring the FHR at 2.24pm. Ms B did not offer a reason for the generally poor standard of her record-keeping.

Ms Faulls advised:

> "It is usual for a midwife to document the rate of a fetal heart both on the partogram and also on the clinical notes provided by the hospital.
>
> ...
>
> Although Midwife [Ms B] reiterates in all her 'contemporaneous' notes that frequent fetal heart rate recordings were done, the documentation seen by me does not support this claim."

[24] Ms B completed the entries for 4.30pm, 4.33pm and 4.45pm as soon as reasonably practicable after the birth.

I concur with Ms Faulls that Ms B's documentation for the antenatal and perinatal periods is not of an appropriate standard for a registered midwife. Accordingly, Ms B breached Right 4(2) of the Code.

Co-ordination

Although Ms B appropriately sought assistance from a skilled colleague when she was too upset to suture the perineal tear, she failed to inform the medical staff and seek assistance when Ms E advised that she was also unable to perform the repair. Ms Faulls advised:

> "It would have been appropriate to request assistance from the [Hospital 1] Obstetric Medical Staff as no midwife felt able to repair [Mrs A's] perineum."

Although Ms B was upset, she owed an ongoing duty of care to Mrs A. Ms B allowed her own emotions to compromise the care she provided to her client.

In failing to seek the assistance of medical staff to suture the perineal tear, Ms B did not ensure co-ordination of care for Mrs A and therefore breached Right 4(5) of the Code.

Communication

While Ms B appears to have communicated reasonably well with Mrs A during the antenatal period, and did not have an opportunity to communicate postnatally, I am critical of her communication with Mrs A during the labour and birth.

Ms B left the room on a number of occasions during Mrs A's labour "for a breather or to answer [her] phone". However, Ms B did not tell Mrs A why she was leaving the room, and Mrs A was distressed by her absences. At 3.20pm, Ms B left the room for 20 minutes and, although midwifery cover was organised, Mrs A did not know why Ms B left.

I accept that the distress caused to Mrs A was inadvertent, but remind Ms B of the importance of clear communication with her clients at all times.

Actions taken

Ms B advised that she has:

- undertaken a Special Review of this case with a Midwifery Standards Review Committee of the New Zealand College of Midwives, and will follow any recommendations on her professional development plan;
- agreed to attend a one-day New Zealand College of Midwives/Midwifery Council accredited workshop on documentation, to be run in 2008; and
- begun using Midwifery and Maternity Provider Organisation Ltd (MMPO) notes.

Follow-up actions

- Ms B will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purposes of deciding whether any proceedings should be taken.
- A copy of this report will be sent to the Midwifery Council of New Zealand, with a recommendation that the Council review Ms B's competence.
- A copy of this report, with details identifying the parties removed, will be sent to the New Zealand College of Midwives, the Maternity Services Consumer Council, and the Federation of Women's Health Councils, Aotearoa, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

The Director of Proceedings decided not to issue any proceedings, considering that while there had been a departure from accepted practice, it was unlikely to warrant a disciplinary sanction, or to attract an award of exemplary damages in the Human Rights Review Tribunal. Any claim for compensatory damages for injury to feelings at the time of the events would meet with very limited success.