Obstetrician, Dr B

A District Health Board

A Report by the

Health and Disability Commissioner

(Case 12HDC00846)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. In 2011 Ms A, aged 46 years, was pregnant with her fourth child. She had an uncomplicated pregnancy.

2. At 37+5 weeks' gestation, Ms A experienced a spontaneous rupture of the membranes. She went to the delivery suite at the public hospital, arriving at 6.30am. An assessment showed a cephalic presentation and no evidence of fetal compromise. A decision was made to await spontaneous onset of labour.

3. Two days later, because of her failure to progress into spontaneous labour, the decision was made to commence Syntocinon. This was started at 10.45am. From about 1pm Ms A's contractions became stronger.

4. At 5.50pm, decelerations were noted on the cardiotocograph (CTG). Ms C, the hospital midwife who was responsible for Ms A, informed the clinical charge midwife (CCM), Ms E, of the decelerations. Ms E recommended continued monitoring.

5. At 6.50pm, further decelerations were noted on the CTG. Ms A was moved into a different position and the CTG returned to normal.

6. At 8pm a deceleration was noted lasting seven minutes. Ms C and Ms E considered that this was because the CTG was recording the maternal pulse. The CTG belt was repositioned and the CTG returned to normal.

7. At 8.20pm an epidural was inserted, after which there were decelerations on the CTG. Ms E and Ms C considered that the decelerations were associated with the epidural. Ms A was moved into a different position and the CTG improved.

8. At 9pm, further decelerations were noted and the fetal heart rate was slow to recover. A vaginal examination (VE) was carried out and a fetal scalp electrode was attached. The cervix was noted to be 3cm dilated and the baby's head was at station –1. At that stage the midwives considered that the decelerations might be associated with head compression.

9. At 9.15pm, there was a further deceleration down to 60 beats per minute (bpm), which did not recover. Ms A was moved into different positions with no improvement in the CTG. The on-call obstetrician, Dr B, was called.

10. Dr B arrived at 9.20pm and noted significant decelerations on the CTG. The Syntocinon was stopped and Dr B requested an increase in IV fluids.

11. Dr B carried out a VE, which showed the cervix to be 5cm dilated, with the fetal head at station –1. Dr B decided to obtain a fetal blood sample to establish the fetal condition, but opted to await the arrival of the obstetric registrar, Dr D, so that she could collect the sample.

12. Dr D documented that Ms A was experiencing pain between contractions, and that a Caesarean section was indicated, but that Dr B had requested fetal blood sampling be done first.

13. At 9.40pm, the fetal blood sample showed severe acidosis and Dr B decided to proceed with a Caesarean section.

14. Dr B performed a further VE in the operating theatre and noted that the cervix was 7–8cm dilated.

15. The baby was delivered at 9.58pm, pale and unresponsive. Resuscitation attempts were unsuccessful. A concealed placental abruption was diagnosed.

Decision

16. Dr B failed to provide services to Ms A with reasonable care and skill by failing to respond appropriately to the abnormalities on the CTG, and by delaying the emergency Caesarean section. Accordingly, Dr B breached Right 4(1) of the Code.[1]

17. Dr B's manner was unprofessional and he failed to treat Ms A with respect and, accordingly, was found to have breached Right 1(1) of the Code.[2]

18. In addition, for failing to heed the concerns raised by his colleagues, Dr B breached Right 4(5) of the Code.[3]

19. For failing to inform Ms A fully about her condition and his management plan, Dr B was found to have breached Right 6(1)(a).[4]

20. Dr B's failure to proceed with an urgent Caesarean section when severe fetal compromise became apparent was an individual clinical error and cannot be attributed to any systemic deficiencies at the district health board (the DHB) Accordingly, the DHB is not vicariously liable for Dr B's breaches of the Code.

21. Adverse comment was made about the adequacy of the care provided by Ms E and her responses to the changes on the CTG.

22. Consideration was given as to whether Ms C, Ms E and Dr D should have taken any further steps to raise their concerns about Dr B's decision to obtain a fetal blood sample and delay the Caesarean section. It was concluded that their actions taken to voice their concerns were reasonable in the circumstances.

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[1] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."
[2] Right 1(1) states: "Every consumer has the right to be treated with respect."
[3] Right 4(5) states: "Every consumer has the right to co-operation among providers to ensure quality and continuity of services."
[4] Right 6(1)(a) states: "Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including — (a) an explanation of his or her condition …"

Complaint and investigation

23. The Commissioner received a complaint from Ms A and her partner, Mr A. The following issues were identified for investigation:

- *The appropriateness of the care provided to Ms A by Dr B in late 2011.*
- *The appropriateness of the care provided to Ms A by the District Health Board in late 2011.*

24. An investigation was commenced on 8 February 2013.

25. The parties directly involved in the investigation were:

Ms A	Mother/consumer
Mr A	Father/complainant
Dr B	Provider, consultant obstetrician
Ms C	Provider, hospital midwife
Dr D	Provider, registrar
Ms E	Provider, clinical charge midwife

Also mentioned in this report:

Dr F	Obstetric registrar

26. Independent expert advice was obtained from a consultant obstetrician, Dr Michel Sangalli (**Appendix A**), and a midwife, Robyn McDougal (**Appendix B**).

Information gathered during investigation

Background

27. Ms A was aged 46 years at the time of these events. In 2011 Ms A became pregnant with her fourth child. She had had three previous uncomplicated vaginal deliveries, and a second trimester fetal loss.

28. Ms A's pregnancy progressed normally and her care was managed by the DHB's antenatal team. Ms A was considered high risk because of her advanced maternal age, so monthly ultrasound scans were performed from 28 weeks' gestation to monitor the fetal growth.

29. At 32+4 weeks' gestation, Ms A had an ultrasound scan to assess the fetal growth and well-being. The scan revealed normal fetal growth, the presence of "generous" amounts of liquor (amniotic fluid), and that the baby was in a breech position.[5] At 35+4 weeks' gestation, a further scan was performed, which revealed that the baby remained in breech position. Following a discussion with the obstetrician, an external

[5] The baby is positioned with the head facing upwards.

cephalic version[6] (ECV) was planned for the following week. At 36+4 weeks' gestation, a further scan was performed to check the fetal position prior to the planned ECV. This revealed that the baby was positioned in a transverse lie[7] with liquor volume towards the upper limit of normal. The ECV was not performed owing to the position of the fetus, and Ms A was advised of the risk of cord prolapse[8] if she had a spontaneous rupture of membranes (SROM).

37+5 weeks' gestation — spontaneous rupture of membranes

30. At 5.45am, at 37+5 weeks' gestation, Ms A telephoned the delivery suite at the public hospital and advised that she had experienced a SROM. The delivery suite staff advised Ms A to come to the delivery suite immediately. She arrived at 6.50am, was assessed by a hospital midwife, and a CTG[9] was commenced. The CTG showed no evidence of fetal compromise. Clear draining liquor was noted and the obstetric registrar was asked to assess Ms A.

31. At 7.25am, the obstetric registrar, Dr F, assessed Ms A. Dr F noted that Ms A was draining "copious amounts of clear [liquor]" and the fetus was in a cephalic presentation.[10] Dr F recommended that the CTG continue and to await spontaneous onset of labour. Ms A was advised that she could return home. Ms A told HDC that she continued to leak excessive amounts of fluid, and that every time she stood up her clothes would become saturated, so she remained on the ward.

32. At 11.15am, Ms A noted a small amount of blood on her sanitary pad and in the toilet. The clinical charge midwife sighted this and reassured Ms A that it was normal but asked her to advise staff if the bleeding increased.

33. A VE was then carried out by a student midwife under the supervision of a hospital midwife. This showed that the cervix was 1cm dilated[11] and not effaced. The fetal head was positioned at station –2.[12] The CTG was normal. Ms A decided to go home after she had had lunch. Ms A left the hospital at 2.55pm. She was advised to return "when she want[ed]".

34. At 9.53pm, Ms A returned to the hospital. She was assessed by a hospital midwife and noted to be draining clear/pink-stained liquor. Ms A was complaining of a backache. Observations and a CTG were recorded as being within normal limits.

35. At 10.15pm the hospital midwife contacted Dr F, who advised that IV antibiotics should be commenced. At 11.15pm IV antibiotics were commenced and Ms A was given sedation to help her sleep.

[6] The process of manually turning the baby.
[7] The baby is positioned lying sideways.
[8] Umbilical cord prolapse happens when the umbilical cord precedes the fetus's exit from the uterus. It is an obstetric emergency that endangers the life of the fetus.
[9] A cardiotocograph records the fetal heart rate.
[10] Baby in head down position.
[11] As the cervix prepares for delivery it dilates and shortens (effaces).
[12] The position of the baby's head in relation to the ischial spines of the mother's pelvis. Station 0 means that the head is in line with the ischial spines (the top of the pelvis).

37+6 weeks' gestation

36. At 6.30am the following day, Ms A was assessed by Dr F. Ms A had not progressed into labour, so augmentation with prostaglandin gel[13] was commenced.

37. Throughout the day, fetal and maternal monitoring continued and remained within normal limits.

38. At 2.30pm, one deceleration[14] was noted on the CTG, which was thought to be due to a loss of contact of the CTG sensor.

39. At 3pm, a further dose of prostaglandin gel was administered. Monitoring continued and remained within normal limits.

40. Ms A's partner was not able to be present to support her, and Ms A advised HDC that she was left alone for most of the day. She said that a student midwife assigned to look after her provided good support, but Ms A found this day particularly upsetting because nothing was happening and she felt that she was essentially forgotten about.

38 weeks' gestation

41. The next day, because Ms A had still not progressed into labour, the decision was made to commence Syntocinon.[15] Syntocinon infusion was subsequently started at 10.45am. Continuous CTG monitoring continued and remained reassuring.

42. At 11.15am, the Syntocinon infusion was increased in accordance with hospital protocol, and further increased at 11.30am, 12pm, and 12.40pm. It is documented that Ms A was experiencing regular contractions from 1.50pm.

43. At 2.30pm, consultant obstetrician Dr B[16] reviewed the CTG, which he noted to be normal.

44. Observations of Ms A continued throughout the afternoon and remained within normal limits. The Syntocinon infusion continued to be increased in accordance with protocol.

45. At 5.20pm, some blood was noted after Ms A went to the toilet. At 5.50pm, some decelerations were noted on the CTG. The hospital midwife looking after Ms A, Ms C, informed the clinical charge midwife, Ms E. Ms E recommended continued monitoring and that a VE be conducted.

46. At 6pm, Ms C conducted a VE, which revealed the cervix to be 1–2cm dilated and 0.5cm thick.

47. At 6.25pm, Ms A observed a small amount of blood in the toilet.

[13] Prostaglandin gel is a hormone gel used to promote labour.
[14] Slowing down of the fetal heart rate which, depending on the type and pattern, may indicate fetal distress.
[15] Syntocinon is a synthetic version of the hormone oxytocin. It is used to stimulate labour.
[16] Dr B is a consultant obstetrician and gynaecologist employed by the DHB. Dr B has worked in this position since 2006. On this day, Dr B was covering the role of the first registrar on call.

48. At 6.50pm, two decelerations down to 80–85bpm were noted on the CTG.[17] Ms A was moved to a left lateral position and the CTG returned to normal.

49. At 7.25pm, pain relief options were discussed with Ms A. At this stage she was experiencing four contractions every 10 minutes.

50. At 7.32pm, Ms C noted a possible deceleration or loss of contact on the CTG trace. Ms C discussed this with Ms E, who recommended turning the Syntocinon infusion down. Ms C did so.

51. At 8pm, Ms A was noted to be feeling pelvic pressure and she requested an epidural. Ms C carried out a VE and noted that the cervix was 2–3cm dilated and the fetal head at station –2 to –1. Ms C then left the room to call the anaesthetist to insert the epidural. Ms C advised that, when she returned, she noted that the CTG was showing a baseline reading of 80–90bpm, which had lasted for seven minutes. Ms C called Ms E, who came to assist Ms C.

52. Ms E advised HDC that when she entered Ms A's room, Ms A was in "active labour" and the CTG trace was showing a change in the baseline reading. Ms E advised HDC that the maternal pulse was 80bpm, and she considered that it was possible the CTG was measuring the maternal pulse. Ms C adjusted the position of the CTG belt and the baseline reading returned to 120–130bpm with accelerations and normal variability.

Epidural and decelerations

53. At 8.20pm, the anaesthetist arrived to insert the epidural. Ms E advised HDC that at this time she left the room and planned to review the CTG again following the epidural insertion.

54. Following insertion of the epidural a further deceleration was noted on the CTG trace, which recorded a baseline recording of 80–90bpm. Ms C advised HDC that she reapplied the CTG belt and restarted the Syntocinon. Ms C documented:

> "Intermittent F[etal] H[eart] R[ate] decels ↓77bpm ↑125bpm called CCM to room. Changed position from [left] lateral to lying on back. FH improved …"

55. Ms E said she answered the call bell at 8.20pm. When she entered the room she reviewed the CTG. Ms E stated:

> "I noted that the CTG was not picking up a good foetal heart trace and the abdominal trace was not showing a good contraction picture. The epidural had been sited between 8.10pm and 8.20pm. The Syntocinon infusion was paused during the epidural insertion. I advised a position change for [Ms A] and then advised [Ms C] to observe the foetal heart, following the insertion of the epidural, and inform me if she was at all worried about the CTG tracing."

[17] Normal is between 110 and 160bpm.

56. In her retrospective note in the clinical records Ms E documented:

> "2020 — answered bell, having decelerations, epidural just been sited, to observe and wait."

57. Ms E then left the room. Ms C advised HDC that, for the next 15 minutes, the CTG trace showed that Ms A's contractions were becoming progressively longer with some decelerations down to 100bpm.

58. At 8.40pm Ms E answered the call bell in Ms A's room and Ms C advised her that she had noted further decelerations on the CTG trace. The Syntocinon infusion was turned down and Ms A was moved into a different position. At that time the CTG was showing a baseline reading of 130–140bpm with early variable decelerations and variability of greater than 5bpm. Ms E advised HDC that she and Ms C discussed the situation and decided to wait and see whether the position change and decreasing the Syntocinon infusion would help. Ms E again left the room.

59. Ms C said she called Ms E again at 8.51pm, because there had been about seven minutes of loss of contact and she was having difficulty interpreting the CTG.

60. Ms C advised HDC that up until that point, although decelerations had been observed, she was satisfied that the fetal heart rate was recovering with position change, and the decelerations were most likely associated with head compression, which is common at that stage of labour.

61. At 9pm, Ms C documented:

> "FHR ↓78bpm called CCM. Plan: [vaginal examination] [fetal scalp electrode[18]]."

62. Ms E said that she conducted a VE and attached a fetal scalp electrode. She noted that the cervix was 5cm dilated and the fetal head was at station –1. Ms C and Ms E both advised HDC that, at this stage, they considered that the decelerations could be associated with head compression. Ms A was moved into a different position and the CTG baseline returned to 140–145bpm with decelerations. Ms E then left the room.

63. Dr B advised HDC that, at approximately 9pm, he asked Ms E about all patients on the delivery suite, including Ms A, and Ms E told him that there were no issues. Dr B did not review Ms A at that time.

64. Ms E confirmed that she did provide a handover to Dr B at approximately 9pm, but said that at that time she did not have concerns about Ms A.

Call to Dr B

65. Ms C said that she noted a further deceleration down to 60bpm and pressed the call bell, and Ms E attended. Ms A was moved into a right lateral position. The fetal heart rate recovered to 80bpm, with no variability and no accelerations, and further decelerations. Ms C then turned off the Syntocinon infusion.

[18] An electrode attached to the fetal head to measure the fetal heart rate directly.

66. Ms E stated:

> "At 9.10pm I answered a call bell and was told that the foetal heart rate had deteriorated and there was a deceleration down to 60bpm on the CTG. The Syntocinon infusion was stopped and [Ms A's] position was changed to right lateral, but the foetal heart was slow to recover to 80bpm, with loss of variability, no accelerations present and deceleration continued. This was a very abnormal CTG tracing so I immediately notified [Dr B] of the situation by phone. He said that he would come immediately."

67. At 9.10pm, Ms E documented: "2110 answered call bell, fetal heart dropped to 60bpm, turned [Ms A] from side to side, FH slow to recover. Called Registrar/cons."

68. Ms E outlined the situation to Dr B and requested that he assess Ms A immediately. Ms E told HDC that she was not happy with the CTG trace at that stage and considered it needed urgent obstetric review.

69. In contrast, Dr B advised HDC that Ms E contacted him by telephone at approximately 9.14pm and advised him that the CTG had shown one deceleration, which had since recovered. Dr B stated:

> "By telephone I was informed by the CCM that the CTG of the fetus had shown a deceleration which had since recovered. There was no urgency or even mention that they wanted me to attend but I did so immediately."

Dr B's involvement

70. Both Ms C and Ms E advised HDC that following Dr B's arrival he asked for the IV fluids to be increased. At that time the fetal heart rate was between 80–100bpm.

71. Ms A advised HDC that when Dr B arrived he appeared "very grumpy" and angry. She said that he did not say anything to her, was very "aggressive" and made her feel "very uncomfortable". She recalls that he then became angry because she had not been given any fluids, and he proceeded to squeeze the fluid bag to force the fluid, which she found very painful and upsetting. Ms A said that she was not told anything about the management plan.

72. Ms C stated that when Dr B arrived in the room he reviewed the CTG trace and requested increased IV fluids. Ms C said that Dr B directed her to squeeze the fluid bag, which she did. Ms C said that this is not usual practice but she understood that the reason for doing so was because dehydration can cause the fetal heart rate to drop. Ms C does not recall Dr B speaking to Ms A at that time, nor did he discuss a management plan with Ms A or Ms E.

73. Ms E recalls Dr B directing Ms C to push the IV fluids by squeezing the fluid bag. Ms E commented that this was "highly unusual" and that at that stage she was very concerned about the fetal well-being.

74. Dr B said that he noted that Ms A was being "carefully and professionally" monitored by Ms C. He noted that Ms A "was distressed with contractions at this time despite the epidural analgesia that had been established at 2020 hrs". Dr B stated:

> "Sometime following [his earlier discussion with Ms E] I realised that there was in fact an issue and assessed the overall situation and ordered an accelerated clear fluid infusion, confirmed the syntocinon infusion was stopped, and suggest[ed] a lateral position and mask oxygen to continue."

75. At 9.15pm, Dr B documented:

> "Significant [deceleration]
> Has had 1.5L's fluid all day/pu'd 2020
> ↑IV fluids at present
> [Syntocinon] off."

76. Dr B stated:

> "My assessment at this time was that vaginal delivery may in fact be imminent. It was difficult to reach a conclusion on this matter by observation only as [Ms A] was in pain with her contractions. The Syntocinon infusion had been discontinued. I asked that the epidural was not 'topped up' at this stage[19] — and also asked that an IV fluid bolus was made. Abdominal examination revealed an engaged cephalic presentation. Between uterine contractions the uterus was found to be soft."

77. Ms C advised HDC that after she had increased the IV fluids, Dr B turned to leave the room. She asked him when he would be back and he replied that he would be coming and going. Dr B then left the room. Ms C said that at that stage she was very concerned about the fetal well-being but was reassured that both Dr B and Ms E were involved.

78. Ms E said she asked Dr B if he wanted a "lactate" done. Dr B replied that he would wait for it to be done by the night registrar, whose shift commenced at 9.30pm. Ms E said she was concerned by this decision, and she prepared the equipment so that the fetal blood sample[20] could be obtained as soon as the registrar arrived. Ms E said that she did not consider seeking a second opinion or overriding Dr B's decisions because Dr B was the on-call consultant and he was responsible for the clinical decision-making.

79. Ms E documented:

> "2115 Registrar/Consultant present. IV fluids increased. FH recovering slowly 80bpm, asked if wanted to do lactate."

[19] Because an epidural may affect sensation and the woman's ability to push, an epidural is stopped prior to the woman commencing pushing.

[20] A blood sample taken from the fetal head, also referred to in this report as a "lactate". Fetal scalp blood testing is a technique used during labour to confirm whether fetal oxygenation is sufficient. Lactate is an indicator of acid–base homeostasis. A high level of lactate indicates that there is acidosis, which in turn is associated with hypoxia. Analysis of lactate requires only 5 µl of blood.

Vaginal examination

80. Dr B stated that he then spoke to Ms E in the nurses' station and informed her of his management plan and enquired about the findings of the previous VE. Dr B then returned to Ms A's room to perform a VE. Dr B told HDC that he conducted the VE in order to assess the cervical dilation, and the descent and position of the fetal head, as well as to exclude the presence of meconium and blood-stained liquor. Dr B advised that this examination took place as a uterine contraction occurred.

81. Dr B said he informed Ms A that, although there was no current indication of imminent vaginal delivery, this remained a strong possibility. Dr B did not document this conversation with Ms A.

82. Ms A told HDC that Dr B did not explain why he needed to do a VE, that he kept his hand "inside" her for a long time, it was very painful and she felt "dirty".

83. Dr B documented in the clinical records that he carried out the VE at 9.30pm, and that the cervix was 5cm dilated, the fetal head was positioned at station –1, and the liquor was clear. Dr B also noted that the fetal heart rate was 90–96bpm and that the plan was "for lactate".

84. Dr B advised that at that stage he was awaiting the arrival of the night registrar, Dr D.[21] Dr B stated:

> "I expected that [Dr D] would have been immediately directed to our room but in fact I found [Dr D] unaware of the significance of our events in the B[irthing] Suite office. That is to say, there was no sense of urgency conveyed in the B[irthing] suite at this time."

Dr D

85. Dr D advised HDC that she arrived on the ward ready for the 9.30pm handover and, as she walked into the handover room, Dr B asked her to review Ms A's CTG with him. Dr D said that Dr B was clearly very concerned about Ms A, as they did not have time to discuss any of the other patients on the ward. Dr D explained that the reason Dr B requested her involvement was because she was the night registrar and would be assuming responsibility for Ms A at 9.30pm.

86. Dr D arrived in Ms A's room somewhere between 9.35pm and 9.40pm.

Fetal blood sample

87. Dr D recalls that, when she arrived in Ms A's room, she observed that Ms A was uncomfortable and in pain between contractions. Dr D reviewed the CTG trace and noted that it had been showing a baseline fetal heart rate of between 90–100bpm for the past 15 minutes. Dr D said she was concerned that the baby was bradycardic[22] and asked if she could call for an emergency Caesarean section, but Dr B requested that a fetal blood sample be obtained first to assess the lactate. Dr D advised HDC that she

[21] Dr D was a registrar in her fourth year of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists' training programme.
[22] Slow heart rate.

told Dr B that she disagreed with this decision. In her retrospective notes, Dr D documented:

> "At handover asked by Dr B to visit [Ms A]. He noted that the baseline of CTG had been 90–100 for 15 mins at this stage. Noted patient was very uncomfortable and appeared to be in pain between contractions. Suggested immediate [Caesarean section] but consultant wanted lactate first. VE 5cms dilated, lactate taken = 7.2 @ 21.40."

88. In her statement to HDC, Dr D said:

> "I told [Dr B] that I disagreed that I should perform the lactate first because I was of the view that the lactate would be abnormal.
>
> I deferred to [Dr B's] instructions as the consultant and performed the lactate at around 9.40pm. I estimate that the lactate would have taken between two to three minutes."

89. Dr D said that seeking a second opinion or arguing with Dr B's request for a fetal blood sample "was only going to waste more time", and it was quicker for her to obtain the blood sample. Dr D said: "I knew doing the lactate would actually be a lot quicker than trying to have an argument in front of the patient and the family …" Dr D said that she obtained the sample as quickly as possible, while Ms A was on her side, rather than repositioning her into a more optimal position. Dr D said that obtaining the blood sample took a couple of minutes at most.

90. Dr B stated:

> "At the time of my initial assessment on Birthing Suite at 2115 hrs I was expectant of rapid progress to vaginal delivery. This did not happen. The [fetal] heart rate did show significant bradycardia but otherwise was of reasonable characteristics. I therefore decided to be expectant — this decision proved wrong. When I became concerned that [Ms A] was not progressing rapidly to vaginal delivery, as I had anticipated, I took measures to assess/confirm [fetal] wellbeing — by asking that a [fetal] scalp blood lactate level was performed."

91. Dr B also stated:

> "My management plan was to closely monitor [Ms A] for an imminent vaginal delivery. However, a repeat vaginal examination revealed no significant change to cervical dilation. I therefore became concerned that my plan to await an anticipated imminent vaginal delivery was no longer actionable or correct and as such I requested a fetal scalp blood sample. I did so with the intention of providing reassurance of fetal wellbeing and therefore time to establish control of maternal physical and emotional distress."

92. Dr B said: "[Dr D] expressed concern regarding the CTG and suggested an immediate caesarean but I asked that the [lactate] results be received first."

93. The blood sample obtained by Dr D showed that the lactate level was 7.2.[23] Dr B then immediately made the decision to perform a Code Red[24] Caesarean section.

Caesarean section

94. Dr D stated:

> "At around 9.43pm, [Dr B] considered that [Ms A] was a code red caesarean section. I wheeled [Ms A] to the operation theatre with her midwife, [Ms C]."

95. Ms A was given a general anaesthetic and an indwelling catheter was inserted.

96. At approximately 9.45pm, immediately prior to undertaking the Caesarean section, Dr B performed a further VE and noted that the cervix was 7–8cms dilated. Dr B explained that he performed a VE at this time because he wanted to assess whether vaginal delivery was imminent. Dr B advised that he does not consider that this assessment caused any delay to the operative procedure.

97. Dr D scrubbed for theatre while Dr B performed the VE.

98. Ms A was then draped and prepared for the procedure. At 9.55pm, Dr D performed the uterine incision. At this point Dr B took over the operation. Dr B advised HDC that he delivered the baby because Dr D had difficulty disengaging the fetal head from the maternal pelvis.

99. At 9.58pm the baby was delivered, pale and unresponsive. The paediatric team was called and resuscitation commenced. Sadly, a heart rate was never established and resuscitation was stopped after 19 minutes.

100. A placental abruption was noted with a blood clot estimated to be covering 40% of the placental surface, containing about 600mls of blood.

101. Dr D completed the stitching of the incision. She estimated that the total blood loss was approximately 1.5 litres.

Action taken by the DHB

102. Following this incident the DHB carried out an incident review, which identified concerns with Dr B's competence to practise in acute obstetrics.

103. The DHB asked Dr B to cease acute obstetric practice, and a supervision plan was implemented.

104. In addition, the DHB organised for an external review to be carried out.

105. Meetings were held with Ms A and Mr A following completion of both the internal incident review and the external review to discuss the findings.

[23] Normal is < 4.2mmol/L, acidosis is present if the result is >4.8mmol/L.
[24] Clinical emergency call.

106. The DHB advised that since this incident it has employed a number of new obstetric registrars.

Medical Council of New Zealand

107. In March 2012, as a result of the internal and external reviews of this incident, the DHB formally referred Dr B to the Medical Council of New Zealand (MCNZ) with regard to the competency of his acute obstetric practice.

108. The MCNZ undertook a performance assessment of Dr B and determined that conditions should be placed on his practice, and that he should undergo an educational programme.

Further comment from the DHB

109. The DHB advised that at the time of this incident it did not have any concerns about Dr B's clinical decision-making or technical performance.

110. The DHB advised that issues arose in relation to Dr B's communication skills in early 2011. Dr B subsequently underwent further training in this area in July 2011.

Response from Dr B

111. In his response to HDC, Dr B advised that the fact that he did not send Ms A for a Caesarean section earlier continues to be "a continuing regret" for him. He expressed his sincere regret and apologised to Ms A and her family that they were unhappy with his management and care of Ms A and her baby. He advised HDC that his apology was "genuine and unreserved".

Response to Provisional Opinion

Dr B

112. In response to the Provisional Opinion, Dr B submitted that at the time of this incident he was working extremely long hours to cover staff shortages, and that this was a very busy period on the delivery suite. Dr B stated that he "does not offer this up as an excuse" but asks that this be considered as a contributing factor and noted accordingly.

113. Notwithstanding the above comments, Dr B stated with regard to the findings of the Provisional Opinion: "I respect your opinion and accept your recommendations …"

The DHB

114. the DHB agreed to make the following changes in accordance with the recommendations of the Provisional Opinion:

a. Include in its training to all staff that "[the DHB's] expected and accepted practice from all members of the multidisciplinary team is one of open disclosure; asking of questions and reporting of concerns". The DHB advised that this

expectation will be included in the corporate orientation undertaken by all new staff.

b. Include in its orientation training to all medical and midwifery obstetric staff the use of the ISBAR (Identity, Situation, Background, Assessment and Recommendation) communication tool. The DHB advised that this tool will "improve safety in the transfer/handover of critical information".

115. In addition, the DHB has reviewed its maternity orientation handbook and drafted the following for inclusion in the handbook:

> "**Speak up**
> [The DHB] has systems in place to ensure that appropriately qualified staff are available for consultation and advice as required. Maternity staff and Maternity Access Holders should escalate problems to the appropriate clinician as needed. If at any time the advice received places the woman or infant at increased risk, [the DHB] supports clinicians to escalate the problem to a more senior clinician or manager as required.
>
> Midwives have a professional responsibility to escalate concerns in order to advocate for women and protect the safety of their clients. …"

Opinion

Introduction

116. Ms A was entitled to receive care provided with appropriate care and skill. She was a high-risk patient who was induced into labour following a spontaneous rupture of membranes. Her labour progressed very slowly. When the CTG trace showed significant abnormalities, there was a failure to respond in a timely manner.

117. This report considers the actions of the consultant who was called to review Ms A, as well as the system within which he was working.

Opinion: Dr B

Initial review — No breach

118. Dr B's first involvement with Ms A was at 2.30pm when he was asked to review the CTG. At that stage the CTG was normal and the labour was progressing satisfactorily. I am satisfied that Dr B's involvement at that stage was appropriate.

Response to abnormal CTG — Breach

119. Dr B's next involvement was at approximately 9.15pm when he was called by the clinical charge midwife, Ms E, following a prolonged fetal bradycardia.

120. Dr B noted that Ms A was "distressed with contractions". He assessed the CTG trace, noting a "significant [deceleration]". He considered that the CTG was otherwise of "reasonable characteristics". He requested an "accelerated clear infusion" and for the Syntocinon to be turned off. Dr B advised HDC that his assessment at the time was that vaginal delivery might be imminent. He decided that a VE was warranted to assess Ms A's progress, and discussed with Ms E the findings of the previous VE.

121. Dr B performed a VE, noting that Ms A's cervix was 5cm dilated, the fetal head was positioned at station –1, and the liquor was clear.

122. Dr B advised HDC that, after he performed the VE and noted that Ms A had not progressed as quickly as hoped, he decided to obtain a fetal blood sample. Dr B stated that he made that decision "with the intention of providing reassurance of fetal wellbeing and therefore time to establish control of maternal physical and emotional distress". Dr B decided to await the arrival of the night registrar, Dr D, to obtain the fetal blood sample.

123. According to my expert advisor, obstetrician Dr Michel Sangalli, when a CTG is mildly to moderately abnormal and the likelihood of successful vaginal delivery is high, it is reasonable to continue to monitor the CTG closely and check the fetal condition by measuring the fetal blood lactate. However, Dr Sangalli advised that the CTG at 9.15pm was indicative of "severe, non-controversial fetal compromise" and, therefore, in accordance with the RANZCOG[25] Intrapartum Fetal Surveillance Clinical Guidelines (2006), fetal blood sampling was contraindicated. Dr Sangalli stated:

> "Fetal blood sampling is contraindicated if the CTG is consistent with severe fetal compromise or if the clinical scenario suggests a likely rapidly progressive condition (e.g. obvious placental abruption, cord prolapse etc.) as this would lead to a delay in delivery and potentially increase the risk of fetal problems.
>
> …
>
> There is, under these circumstances, no place for a fetal blood sample to check the fetal wellbeing as the CTG shows severe, non-controversial fetal compromise. When such a bradycardia is diagnosed urgent delivery is a matter of life or death. I can only conclude that the decision to proceed to an emergency caesarean section was not made in a timely manner consistent with expected obstetric care standards."

124. Dr Sangalli considered that Dr B's failure was a severe departure from expected standards. I agree and consider that the decision to proceed to a Caesarean section was not made in a timely manner.

125. Furthermore, Dr B's decision to delay obtaining the blood sample by awaiting the arrival of Dr D so that she could perform the procedure raises significant concerns. I note that after Dr D's review of the CTG she immediately recommended an

[25] Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

emergency Caesarean section but Dr B insisted that the fetal blood sample be obtained first.

126. Accordingly, I consider that Dr B failed to provide Ms A with services with reasonable care and skill by failing to respond appropriately to the abnormalities on the CTG and delaying the decision to perform an emergency Caesarean section. Accordingly, Dr B breached Right 4(1) of the Code.

Emergency Caesarean — No breach

127. Following receipt of the lactate result Dr B agreed to proceed with a Caesarean section. Immediately prior to commencing the surgery Dr B performed a further VE. Dr B explained that the reason was to assess whether Ms A had progressed further and vaginal delivery was imminent. Dr B noted that Ms A was then 7–8cm dilated and confirmed the decision to proceed with the Caesarean section.

128. I note Dr Sangalli's advice that, given Ms A's slow progress to this point, it was unlikely that the cervix would be fully dilated and the fetal head in a position such that an instrumental delivery would be more appropriate than a Caesarean section. However, I accept Dr Sangalli's advice that given that this examination did not delay delivery for more than a few seconds, the decision to perform the VE was reasonable in the circumstances.

Communication — Breach

Patient communication

129. Ms A complained that Dr B did not communicate with her, that he appeared very angry and was "aggressive", and that, as a result, the experience was very distressing. Ms A said that when Dr B first arrived in the room he appeared grumpy and did not say a word to her. This made her feel very uncomfortable. Then, when Dr B performed his initial VE at around 9.15pm Ms A said that she did not understand what he was doing, he did not explain why he needed to do a VE, that he kept his hand "inside" her for a long time, it was very painful, and she felt "dirty". When Dr B requested an accelerated fluid infusion, Ms A found the forced fluids painful and upsetting. Ms A told HDC that Dr B did not tell her anything about his assessments or his proposed management plan.

130. I note that it is also the recollection of both Ms C and Ms E that Dr B's communication with Ms A was minimal.

131. Effective communication requires good interaction between the provider and the consumer. This is particularly important when, as in this case, the situation is stressful and the patient is understandably very distressed and anxious.

132. In my view, Dr B's actions and manner were unprofessional and disrespectful. Accordingly, Dr B breached Right 1(1) of the Code. Furthermore, Dr B failed to provide Ms A with information that a reasonable consumer, in Ms A's circumstances, would expect to receive, that is, information about her condition and his management plan. Accordingly, Dr B also breached Right 6(1)(a) of the Code.

Communication with colleagues

133. In this case, despite having concerns about the fetal well-being, both Ms C and Ms E chose not to raise their concerns directly with Dr B, deferring the clinical decision-making to him as the consultant. When Dr D became involved she questioned Dr B's decision to perform a lactate rather than to proceed with an emergency Caesarean section. However, when Dr B disagreed she chose not to seek a second opinion or argue with Dr B further because she knew it "was only going to waste more time" and she "knew doing the lactate would actually be a lot quicker than trying to have an argument in front of the patient and the family". This raises concerns about the team dynamics in this case and, more specifically, the impact of Dr B's attitude in making staff feel unable to speak up.

134. As the consultant, Dr B took ultimate responsibility for the care provided to Ms A. However, team work is an important part of any working environment, particularly in a situation such as this when clinical decisions needed to be made quickly and the impact of poor decision-making was significant.

135. In my view, Dr B failed to heed the concerns raised by Dr D. Had Dr B listened to his colleague, it may have raised sufficient doubt in his mind for him to question his decisions. In my view, in failing to respond to the concerns raised by Dr D, Dr B failed to cooperate sufficiently with another provider to ensure the quality of services provided to Ms A. Accordingly, Dr B breached Right 4(5) of the Code.

Conclusion

136. While I acknowledge that Dr B said that he was working long hours at the time of events, in my view he must still take responsibility for his actions at that time.

137. I conclude that Dr B failed to provide Ms A with services with reasonable care and skill by failing to respond appropriately to the abnormalities on the CTG and delaying the decision to perform an emergency Caesarean section. Accordingly, Dr B breached Right 4(1) of the Code.

138. Dr B's actions and manner were unprofessional and caused Ms A unnecessary distress. I therefore conclude that Dr B failed to treat Ms A with respect and breached Right 1(1) of the Code.

139. Ms A was entitled to an explanation of her condition. By failing to inform Ms A adequately about her condition and his management plan, Dr B breached Right 6(1)(a) of the Code.

140. For failing to respond to the concerns raised by his colleague, Dr B failed to cooperate with another clinician to ensure the quality of services provided, and also breached Right 4(5) of the Code.

Opinion: The District Health Board

Vicarious liability — no breach

141. Under section 72(2) of the Health and Disability Commissioner Act 1994 (the Act), an employing authority may be vicariously liable for acts or omissions by an employee.

142. As Dr B is an employee of the DHB, consideration must be given as to whether the DHB is vicariously liable for his breaches of the Code. Under section 72(5), it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent acts or omissions leading to an employee's breach of the Code. This Office has previously found a provider not liable for the act or omission of its staff when the act or omission clearly relates to an individual clinical failure made by the staff member.[26]

143. Dr B made the decision to delay delivery and obtain a fetal blood sample despite the clinical presentation clearly indicating the need to perform an emergency Caesarean section. As stated above, this decision was a clear departure from accepted standards.

144. In my view, Dr B's failure to proceed with an urgent Caesarean section when severe fetal compromise became apparent was an individual clinical error and cannot be attributed to the system within which he was working. The DHB did not have any previous concerns about Dr B's clinical performance and was entitled to rely on Dr B, as a consultant obstetrician, to provide an appropriate standard of care. While the DHB has a responsibility to have in place structures to ensure that all its patients are provided with an appropriate standard of care, there is no evidence in this case that the systems at the DHB were such that Dr B was unable to perform his duties appropriately.

145. Accordingly, the DHB is not vicariously liable for Dr B's breaches of the Code.

146. I note that following this incident the DHB asked Dr B to cease acute obstetric practice and implemented a supervision plan. In addition, the DHB notified the MCNZ of the facts of this case.

Advocating for patients — adverse comment

147. Ms C, Ms E, and Dr D all had significant concerns about the fetal well-being. I note that Ms E documented at 9.15pm that she had asked Dr B whether he wanted to "do a lactate". Ms E advised HDC that Dr B told her that he was awaiting the arrival of Dr D. Because Ms E was concerned about that decision she prepared the equipment needed to obtain the fetal blood sample, so that it could be collected as soon as Dr D arrived.

148. Similarly, Dr D stated that, following her arrival at approximately 9.30pm, she was concerned that the baby was bradycardic and asked if she could call for an emergency Caesarean. When Dr B requested that a fetal blood sample be obtained first, Dr D told Dr B that she disagreed with this decision. Dr D retrospectively documented in the

[26] Opinion 11HDC00521.

patient records: "Suggested immediate [Caesarean Section] but consultant wanted lactate first." Dr D advised HDC that she was significantly concerned at that stage and disagreed with the decision to obtain a fetal blood sample because she knew that it would be abnormal. However, she considered that it was quicker to obtain the sample than to argue with Dr B, thereby delaying the delivery further. In an interview with HDC, Dr D commented that the gravity of the situation meant that she did not have time to argue with Dr B and instead took the sample the quickest way possible. Dr D said: "I knew doing the lactate would actually be a lot quicker than trying to have an argument …"

149. Both Ms C and Ms E told HDC that they did not consider they were in a position to argue with Dr B as he was the consultant and ultimately the decision-making lay with him as the expert.

150. The New Zealand College of Midwives publication *Handbook for Practice 4th edition* (2008) defines a Code of Ethics that provides: "Midwives are autonomous practitioners regardless of the setting and are accountable to the woman and the midwifery profession for their midwifery practice … Midwives take appropriate action if an act by colleagues infringes accepted standards of care." Furthermore, it provides that "[m]idwives have a responsibility to uphold their professional standards and avoid compromise just for reasons of personal or institutional expedience".

151. Similarly, the MCNZ publication *Good Medical Practice in New Zealand* (2011) states that a doctor must "act with integrity by … acting without delay if you have good reason to believe that a colleague may be putting patients at risk".

152. I refer to my comments in a previous opinion where a midwife failed to contact the consultant when she disagreed with the view of the registrar. I stated:[27]

> "[W]hen [the midwife's] concerns were not heeded and she still believed that there was a problem, she should have told [the registrar] that she intended to contact the on-call consultant, … directly for a second opinion and done so."

153. In that case the midwife was found in breach of the Code for failing to do so. I consider that any provider should voice his or her view to another provider and be prepared to act on his or her concerns. However, what distinguishes these two cases is the fact that Dr B was a consultant, rather than a registrar, and seeking a second opinion may have resulted in significant delay. I note also that in this case neither midwife considered the situation to be seriously concerning until approximately 9.15pm. At that time Ms E was sufficiently concerned to prepare the equipment necessary for the fetal blood sample as she was concerned with Dr B's decision to delay obtaining this until Dr D's arrival. Ms E did not, at that time, express her concerns to, or ask any questions of, Dr B.

154. As already expressed, I have concerns about the team dynamics in this case. Although I accept that it is reasonable for a midwife to rely on the knowledge of an experienced consultant, I consider that Ms E should have expressed her concerns to Dr B at that

[27] See Opinion 09HDC01592.

time. If faced with a similar situation in future, I trust that she will. Dr D did voice her concerns to Dr B without success. She was right to do so.

155. I take this opportunity to emphasise the importance of any provider who has concerns about a patient doing everything possible to voice his or her concerns and advocate for the patient in accordance with professional and ethical duties. The DHB should encourage a culture where it is acceptable to voice concerns and ask questions to and from any point in the hierarchy.

Interaction after spontaneous rupture of membranes — other comment

156. One of the issues Ms A raised with HDC related to being left with very little input from staff for three days following the rupture of her membranes. Ms A said that she found this period very distressing.

157. I note that this issue was previously raised with the DHB during a meeting following these events. At that time, the DHB acknowledged that three days was a long time, and the clinical rationale was explained.

158. I trust that the DHB will use this case as a reminder to staff of the importance of clear communication with patients. In this case, had staff communicated effectively with Ms A, she may have found those days less distressing.

Opinion: Adverse comment — Ms E

159. Ms C called for assistance from the clinical charge midwife, Ms E, on a number of occasions because of concerns about the CTG trace. Ms E said that she did not have concerns about Ms A's condition until 9.10pm, at which time she called Dr B.

160. When the decelerations were initially noted, Ms E recommended that the Syntocinon infusion be turned down. Ms E advised that when she was next called shortly after 8.00pm she noted that there had been a seven-minute deceleration down to 80–90bpm. However, because the maternal pulse was also 80bpm she considered it possible that the CTG was measuring the maternal pulse. She therefore recommended repositioning the CTG belt and noted a subsequent return in the baseline to 120–130bpm.

161. When further decelerations were noted at 8.20pm following insertion of the epidural, and again at 8.40pm, Ms E recommended changes in the maternal position and turning down the Syntocinon infusion. There was then a period when the CTG was difficult to interpret owing to loss of contact, so Ms E attached a fetal scalp electrode. When the CTG trace did not improve, Dr B was called.

162. Robyn McDougal, my midwifery advisor, said that when the seven-minute deceleration was observed shortly after 8pm, applying the DHB Fetal Assessment in

Labour policy, consideration should have been given to contacting Dr B.[28] Ms McDougal also advised that, applying the DHB policy, the Syntocinon infusion should have been stopped when there were several periods of short fetal decelerations from 5.20pm to 8pm.

163. In contrast, I note that it is the view of my obstetrics advisor, Dr Sangalli, that at 8pm the CTG was showing the maternal heart rate for seven minutes but was otherwise normal. Dr Sangalli advised that, in his opinion, the CTG was slightly abnormal from about 8.20pm, but was clearly abnormal from about 8.40–8.45pm, and Dr B should have been called at that time. The CTG progressed into a pathological trace at approximately 9.15pm, when Dr B was called.

164. When asked to comment specifically on Ms A's management from 8.40pm, Ms McDougal advised that, in her view, while the actions taken by Ms E were "entirely acceptable practice … [r]easonable midwifery practice would have been to inform the Obstetrician of the irregularities with the CTG after the insertion of the epidural especially from 8.40pm". Ms McDougal considered that Ms E's failure to do so would be viewed as a mild departure from midwifery standards.

165. It appears inconclusive whether the CTG was showing a prolonged bradycardia or reading the maternal pulse at 8pm. I note the differences in professional opinion of Ms McDougal and Dr Sangalli. However, I am concerned that Ms E did not recognise that the CTG was abnormal at approximately 8.40pm, and that she did not call Dr B at that time. In addition, Ms E should have clearly documented her interpretation at 8pm that the CTG was measuring the maternal pulse, and her decision not to contact Dr B in the circumstances. CTGs are an area of ongoing challenge. I note the advice of Dr Sangalli that while a CTG is very sensitive for the diagnosis of fetal compromise, it is not very specific in that most abnormal CTGs are not associated with fetal compromise. Despite this, a cautious approach should be taken. In this case, I consider that Ms E should have taken steps to verify whether her interpretation was correct.

166. I am also concerned that Ms E adhered to the DHB's Fetal Assessment in Labour policy only partially. I am critical of Ms E's failures in this case, and take this opportunity to remind her of the importance of documenting clinical decisions clearly and adhering to DHB policies fully.

Recommendations

Dr B

167. In accordance with the recommendations of my Provisional Opinion, Dr B has:

- provided a written apology to Ms A and Mr A; and
- undertaken further training with regard to shared decision-making and fetal surveillance.

[28] The Fetal Assessment in Labour policy states that a prolonged bradycardia (<100bpm for >5 minutes) is very likely to be associated with fetal compromise and requires immediate management.

- I recommend that Dr B undertake further training with regard to communication with patients. Dr B should provide evidence of his attendance or enrolment in a relevant seminar or workshop within three months of the date of release of this report.

168. The Medical Council of New Zealand will be asked to provide a report to this Office outlining Dr B's compliance with its educational programme at its completion.

169. The Medical Council of New Zealand will also be asked to provide a report to this Office of any further performance assessment it decides to take and/or when the restrictions on Dr B's scope of practice are reviewed.

The District Health Board

170. In accordance with the recommendations of my Provisional Opinion, the District Health Board has:

- included in its training and induction for all staff, information that the DHB's practice is that asking of questions and reporting of concerns is expected and accepted from all members of the multidisciplinary team;
- introduced a clinical communication handover tool (ISBAR) to improve safety in the transfer/handover of clinical information; and
- proposed changes to its maternity orientation package to include information about the DHB's expectation with regard to escalating clinical concerns.

Follow-up actions

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

Addendum

171. The Director brought disciplinary proceedings against Dr B in the Health Practitioners Disciplinary Tribunal which resulted in a finding of professional misconduct. Dr B appealed the Tribunal's finding of professional misconduct in the High Court. The High Court dismissed Dr B's appeal and upheld the Tribunal's decision. The Director did not take HRRT proceedings against Dr B.

Appendix A: Expert obstetric advice — Dr Michel Sangalli

The following preliminary expert advice was obtained from obstetrician Dr Michel Sangalli:

"Thank you for your request for advice regarding the obstetric care provided by [Dr B] at [a public] Hospital to [Ms A] [in late] 2011.

My name is Michel Robert Sangalli. I am a specialist in obstetrics and gynaecology and a sub-specialist in maternal fetal medicine. I work between Wellington Hospital (Capital and Coast District Health Board; fetal medicine and ultrasound with on call duties for Obstetrics & Gynaecology) and a busy private obstetric practice. I am an RANZCOG expert witness and an independent advisor for ACC/HDC and coroners. My qualifications include: MD (Geneva), FRANZCOG, CMFM, DDU. I am also a member of the RANZCOG Fetal Surveillance Guideline Review Working Party 2012 and of the Fetal Surveillance Education Program Steering Committee (New Zealand representative).

Summary of advice

1. [The baby] was stillborn because of intrapartum hypoxia due to a concealed placental abruption. The occurrence of a placental abruption is not predictable and is a relatively rare event during labour.

2. Fetal monitoring was appropriate during labour. Between 20.20–20.30hrs the CTG trace became abnormal and progressively more pathological. Severe fetal compromise was obvious shortly after 21.12hrs (terminal bradycardia).

3. [Dr B's] interpretation of the CTG and his request for a fetal lactate level were inappropriate. Fetal compromise was evident and severe. Vaginal delivery was not imminent. The decision to proceed to an emergency caesarean section was not made in a timely manner consistent with expected obstetric care standards. The departure from expected standards of care is severe.

Clinical Summary

[Ms A] was aged 46 at the time of the events. She had [three uncomplicated normal vaginal deliveries and a second trimester (16 weeks) fetal loss]. She had no obstetrically significant past medical or family history. She was seen in the specialist clinic at the DHB. Her pregnancy progressed normally. An induction of labour was planned at 38–40 weeks due to the advanced maternal age.

[In late] 2011 at 5.45hrs, at 37+5 weeks gestation, [Ms A] reported spontaneous rupture of the membranes with clear fluid draining. She arrived in delivery suite at 6.50am. Observations were within the normal range. Some mild uterine activity was noted but this was not felt by [Ms A]. There was no evidence of fetal compromise. Cardiotocography (CTG) was unremarkable. Clear liquor was noted.

07.25hrs: Patient examined by the registrar on call, Dr F. Copious amounts of clear liquor, no cord seen. Baby cephalic. Plan: CTG and patient may be sent home to return when in established labour.

11.l5hrs: Vaginal examination (VE). Cervix 1cm dilated, no effaced, head station –2cm. Decided to go home and told by staff to come back as required. CTG normal.

21.53hrs: [Ms A] returned from home. Draining clear/pink stained liquor and having a backache. Observations stable and CTG normal.

23.l5hrs: Antibiotics commenced.

[The following day], at 06.30hrs, patient seen by registrar on call [Dr F]. Ruptured membranes for 24 hours. Given 1mg of Prostaglandin gel because the cervix remained unfavourable. CTG normal.

14.30hrs: A further dose of Prostaglandin gel is given because the cervix remains unfavourable. Observations stable. CTG normal.

CTG and antibiotics continued during evening. All observations of patient are satisfactory.

[The following day], at 7.00hrs, the CTG is normal and [Ms A] is draining pink liquor with minimal contractions.

10.45hrs: Oxytocin infusion started.

11.15hrs: Oxytocin increased as per protocol. CTG normal.

13.50hrs: All observations are satisfactory

14.30hrs: CTG normal, seen by [Dr B].

15.00hrs: CTG normal, antibiotics as per protocol

17.05hrs: Oxytocin now up to l0mu/min. Patient experiencing mild to moderate contractions (3–4:10 min). Mild to moderate contractions.

17.20hrs: Some blood seen in the toilet, pink on sanitary pad. Normal CTG. Seen by Clinical Charge Midwife (CCM). CCM suggested VE.

18.00hrs: Cervix 1–2cm dilated, 0.5 cm thick.

18.25hrs: Small amount of blood seen in the toilet.

19.25hrs: Pain relief options discussed. Four contractions in every 10 minutes, lasting 90 seconds. CCM suggested reducing Oxytocin infusion down to 8mu/min.

20.00hrs: [Ms A] felt pelvic pressure. Cervix 2–3 cm dilated, station –2 to –1cm. [Ms A] requests an epidural. CTG shows maternal heart rate (around 100 bpm) for about 7 minutes. CTG otherwise normal.

20.10hrs: Oxytocin stopped.

20.20–20.30hrs: Epidural inserted without problems. Contractions not recorded during insertion of epidural. Some decelerations (?) on CTG.

20.30–20.40hrs: Intermittent decelerations down to 77bpm with recovery to l25bpm after insertion of epidural. CCM came to view CTG. [Ms A's] position changed from left lateral. BP 110/70–100/60 mmHg following insertion of epidural. Temperature 37.4C. Maternal pulse 80 bpm. Oxytocin restarted.

20.40–20.50hrs: CTG shows baseline around l40bpm with normal variability and decelerations with slow recovery to baseline.

20.50–21.00hrs: Poor quality CTG. Decelerations/prolonged fetal deceleration (?) down to 60 bpm continue with slow recovery to baseline. Fetal scalp electrode applied by CCM. Cervix 3cm dilated, head station –1cm, clear liquor.

21.00–21.l0hrs: No improvement in CTG.

21.12hrs: Start of a prolonged fetal bradycardia with absent variability and no return to baseline heart rate until delivery (terminal bradycardia). The rate returns to 90–100 bpm with absent variability and multiple decelerations to 80 bpm. Uterine contractions not appropriately recorded from then on.

21.l5hrs: Oxytocin stopped.

21.15–21.20hrs: [Dr B] & CCM in delivery room. [Dr B] noted significant decelerations. [Ms A] had only received 1.5 litres of intravenous fluids all day. Fetal heart rate reported as satisfactory at present (as per Incident management — Maternity Timeline document the DHB). Oxytocin stopped. VE 5cm/station –1cm, clear liquor. [Dr B] ordered IV fluids and a fetal blood sampling (lactate) to establish the fetal condition. Fetal heart rate was 90–96 bpm, very slow recovery from 60bpm.

21.30hr: At handover the registrar was asked by [Dr B] to see [Ms A]. The registrar, [Dr D], noted that the CTG had been abnormal for some time and that [Ms A] was very uncomfortable and appeared to be in pain between contractions. [Dr D] suggested an immediate caesarean section but [Dr B] wanted a lactate level first. Cervix 5cms dilated.

21.40hrs: Lactate 7.2 mmol/L. Severe acidosis[29] (normal <4.2 mmol/L, acidaemia if >4.8mmol/L).

21.45hrs: [Dr D] present in delivery room with [Dr B] & CCM. Decision by [Dr B] to proceed for immediate CS with a general anaesthesia.

In operating theatre, VE performed by [Dr B]. Cervix 7–8 cm dilated. [Ms A] is given a general anaesthetic. [Dr B] delivers [baby boy] at 21.58. [The baby] is born pale and unresponsive A concealed placental abruption of about 600ml is diagnosed.

22.15hrs: Unsuccessful neonatal resuscitation stopped. [The baby] is anatomically normal. Weight: 3240 grams, length 53.5cm head circumference 35cm. Mildly reduced adipose tissue.

Placenta histology: unremarkable.

No post mortem examination was performed as per parent's wishes.

Advice

My advice is based on my clinical experience, the intrapartum fetal surveillance clinical guidelines (RANZCOG 2006), Uptodate® and the documents made available to me … [here Dr Sangalli lists the documents he reviewed] …

[29] Acidosis in this context is generally caused by a lack of oxygen in the blood.

I do not know [Dr B] and have no personal or professional conflict of interest.

Based on the clinical history and findings at birth, ultrasound reports and CTG recordings before and during labour there is no doubt that [the baby] was stillborn due to intrapartum asphyxia (hypoxia). There was no evidence of fetal compromise based on the intrapartum fetal monitoring (CTG) until [the third day] around 20.20–20.30hrs when the CTG became progressively more severely abnormal, culminating with a terminal fetal bradycardia (21.12) and resulting in a fresh stillbirth at 21.58hrs. A fetal scalp lactate result during labour at 21.40hrs was consistent with severe fetal acidosis/hypoxia (lactate 7.2 mmol/L).

The clinical scenario and the discovery of a large clot (600 ml) at the time of the caesarean section is consistent with a diagnosis of concealed placental abruption. This is the cause of the fetal hypoxia during labour which resulted in the stillbirth. There was no evidence of any other cause for the fetal compromise.

I have not identified any significant antenatal clinical issues and the induction of labour following spontaneous rupture of the membranes was performed in an acceptable manner. The fetus was overall appropriately monitored during labour including during the treatment with prostaglandin/oxytocin and the insertion of the epidural.

Placental abruption refers to bleeding at the decidual-placental interface that causes partial or total placental detachment prior to delivery of the fetus. It complicates 0.4 to 1 percent of pregnancies and is not predictable. The accumulating blood splits the decidua, separating a thin layer of decidua with its placental attachment from the uterus. The bleed may be small and self-limited, or may continue to dissect through the placental-decidual interface, leading to complete or near complete placental separation. The detached portion of the placenta is unable to exchange gases and nutrients; when the remaining fetoplacental unit is unable to compensate for this loss of function, the fetus becomes compromised (Uptodate 2012®).

Women with an acute abruption classically present with the abrupt onset of vaginal bleeding, mild to moderate abdominal and/or back pain, and uterine contractions. The uterus is often firm, and may be rigid and tender. Contractions are usually high frequency and low amplitude, but a contraction pattern typical of labour is also possible and labour may proceed rapidly. Vaginal bleeding ranges from clinically insignificant to severe and life-threatening. In 10 to 20 percent of placental abruptions, patients present with no or scant vaginal bleeding. In these cases, termed ‘concealed abruption,’ all or most of the blood is trapped between the fetal membranes and decidua, rather than escaping through the cervix and vagina (Uptodate 2012®).

In the case of [Ms A], the placental abruption was concealed as there was no significant bleeding from the vagina. The diagnosis is difficult to establish during induction/labour and after insertion of an epidural in the absence of bleeding or unusual uterine pain. The registrar mentioned in her retrospectively written notes that [Ms A] was very uncomfortable and appeared to be in pain between contractions, suggesting the diagnosis of placental abruption. Fetal compromise is diagnosed on CTG findings during labour and knowledge of the exact aetiology of

the compromise is not required to rescue the fetus. If conservative measures have failed (eg, changing the position of the mother, correcting maternal hypotension if present) and the CTG shows clear evidence of severe fetal compromise with no significant improvement, the appropriate action is to rescue the fetus by prompt and safe delivery.

Sometimes, after the insertion of an epidural, the mother's blood pressure drops and this leads to hypoperfusion of the uterus and the placenta and this can result in an abnormal CTG. The perfusion of the uterus is improved by moving the mother in the left lateral position and by correcting the hypotension (eg, IV fluids, vasoactive agent). [Ms A] was never significantly hypotensive after the insertion of the epidural and the above mentioned treatments did not improve the situation.

In general, if the fetus is suspected to be significantly compromised, delivery is indicated. If the cervix is fully dilated and the fetal head low enough in the birth canal, vaginal delivery can usually be achieved with either a brisk maternal effort or an instrumental delivery (forceps or ventouse). If the fetal head is not low in the birth canal or/and the cervix is not fully dilated, a prompt caesarean section is required.

If the woman, as in the case of [Ms A] has had multiple previous vaginal deliveries, the progress of labour can be very quick and it is sometimes possible to achieve a vaginal delivery (spontaneous or instrumental) very shortly after a diagnosis of fetal compromise is made even if the cervix is not yet fully dilated. Careful judgement is required as undue delays in delivery can result in more serious fetal compromise.

CTG monitoring is very sensitive for the diagnosis of fetal compromise (almost all cases of fetal compromise have an abnormal CTG) but it is not very specific (most women with an abnormal CTG in labour do not have a compromised fetus). When the CTG is mildly to moderately abnormal, the diagnosis of fetal compromise is uncertain. If the likelihood of a successful vaginal delivery is high, the CTG can be carefully observed for further deterioration/improvement or the fetal condition can be checked by measuring the pH or lactate in the blood obtained from the fetal scalp.

Fetal blood sampling is contraindicated if the CTG is consistent with severe fetal compromise or if the clinical scenario suggests a likely rapidly progressive condition (e.g. obvious placental abruption, cord prolapse etc.) as this would lead to a delay in delivery and potentially increase the risk of fetal problems (RANZCOG Intrapartum Fetal Surveillance Clinical Guidelines 2006, page 9,10).

In the case of [Ms A], there is evidence, in retrospect only, of a slightly abnormal CTG trace from about 20.20hrs. The trace becomes more pathological as time goes on and progresses rapidly to a frankly pathological trace. At 21.12hrs the fetus has a severe and very prolonged bradycardia with absent variability (called a terminal bradycardia). The duration of the prolonged bradycardia influences the fetal outcome.

I feel comfortable with the assertion that the decision to perform an urgent caesarean section should have been made with confidence and certainty very shortly after the beginning of the bradycardia which was very severe with absent

variability (RANZCOG Intrapartum Feta Surveillance Clinical Guidelines 2006, page 9,10). [Dr B] was present in the room shortly after the beginning of the bradycardia (21.15–21.20hrs). This bradycardia also followed a period of abnormal CTG trace in the absence of imminent maternal delivery (the cervix was then only 3–5 cm dilated). There is, under these circumstances, no place for a fetal blood sample to check the fetal wellbeing as the CTG shows severe, non-controversial fetal compromise. When such a bradycardia is diagnosed urgent delivery is a matter of life or death. I can only conclude that the decision to proceed to an emergency caesarean section was not made in a timely manner consistent with expected obstetric care standards.

The departure from expected standards of care is severe because of the severity of the anomalies on the CTG trace. It is very difficult to understand why, on that occasion, [Dr B] did not make the decision to perform the caesarean section in a timely manner.

The time, from decision for caesarean section to delivery, was appropriate and there were no issues with the operation. Excessive bleeding is common in case of placental abruption."

Further advice

"… [deleted as repeat of earlier advice]

What standards apply in this case?

RANZCOG Intrapartum Fetal Surveillance Clinical Guidelines, second edition, 2006 page 9, 10. The text is available from the RANZCOG website.

Were those standards complied with?

No

[deleted as repeat of earlier advice]

Whether it was reasonable in the circumstances for [Dr B] to perform a further vaginal examination immediately prior to commencing the CS [caesarean section].

Yes. Performing a vaginal examination can be very quick and this would most likely not have delayed delivery by more than a few seconds. Because of this, I believe that it was reasonable. If there was a significant delay because of the vaginal examination, then this would have been inappropriate. In my opinion, most practitioners would not have performed a vaginal examination under the circumstances. The likelihood of finding the cervix fully dilated and the head of the baby so low in the birth canal that an instrumental delivery was more appropriate than a CS in a situation of very severe fetal distress was very low.

Please comment generally on the standard of care provided by [Dr D], in particular, whether [Dr D] should have taken any additional steps to voice her view that an emergency CS was indicated or override [Dr B's] decision to perform a fetal blood sample.

[Dr D] was a registrar in the middle of her RANZCOG specialist training at the time of the events. She promptly and correctly identified the severe fetal distress and mentioned to [Dr B] that an immediate CS was indicated. [Dr B] wanted a fetal lactate

measurement first. [Dr D] did not question further [Dr B] about the management of the suspected fetal distress and promptly obtained a lactate level.

I have discussed the scenario with a number of registrars and delivery charge midwives in my unit. They all promptly recognised that the CTG was obviously severely pathological when the bradycardia started. The result of this informal survey reveals that under the circumstances of obvious severe fetal distress and a consultant inappropriately requesting a lactate level measurement, most felt that they should say something to make the consultant decide to do an immediate CS. However, they also felt that most registrars/midwives would not have confronted the consultant about his/her decision. The responses obviously varied with the seniority and personality of the registrar/charge midwife and the personality/mood of the consultant in the scenario, I therefore conclude that both [Dr D], and the midwives involved, have acted reasonably under the circumstances.

Any other comment you wish to make.

In my opinion, the CTG was clearly abnormal from about 20.40–20.45 and [Dr B] should have been called around that time. In case of a significantly abnormal CTG, the CTG trace is usually observed for some time while the woman is assessed and the likely need for a CS is explained. In my opinion, while many specialists would, under the circumstances, have organised a CS before the onset of the bradycardia, the nature of the fetal bradycardia, when it occurred and when [Dr B] was present (around 21.15–21.20) dictated the need to perform an immediate emergency CS. Waiting for the night registrar to arrive was inappropriate and requesting a lactate measurement was contraindicated as per RANZCOG Intrapartum Fetal Surveillance Clinical Guidelines."

Appendix B: Expert midwifery advice — Robyn McDougal

"Independent Advisor Qualification: I am currently working as a case-loading LMC midwife and have worked predominantly in a remote rural setting in the Central North Island; Raetihi/Ohakune (Waimarino), for 20 years.

I have had 5 years experience working in secondary maternity services; in Alice Springs, Australia, North Shore Auckland, and Wanganui. In 2007 I attained a Masters of Midwifery degree writing a research project looking at the comparison of Pethidine and Fentanyl opiates in labour related to neonatal outcomes.

I am an active member of the New Zealand College of Midwives and have held the position of the Sub-Regional Chairperson for the College of Midwives in Wanganui since 2005 but am now currently the Chair Person for the Central Region of the North Island: Napier/Hastings, Palmerston North, Wanganui and Horowhenua,

I am a Perinatal Maternal Mortality Review Committee (PMMRC) Agent and also assist with Neonatal Resuscitation and Obstetric Emergencies instruction to midwives nurses and medical staff at the Whanganui District Health Board regularly.

I currently assist individual rural midwives in a mentoring role as well.

Commissioner Request: I have been asked to provide an opinion to the Commissioner on the standard of care provided by midwife [Ms C] and Clinical Charge Midwife (CCM), [Ms E] to [Ms A]. I have been asked to provide advice about whether these practitioners should have taken any additional steps to voice their view on whether an emergency Caesarean Section was indicated or override [Dr B's] decision to perform a fetal blood sample.

I have read and agree to the guidelines for Independent Advisors and can declare I have no personal or professional conflict in this case.

… [Here Ms McDougal lists the information she reviewed.]

Complaint Background:

[Ms A's] pregnancy was considered high risk due to advanced maternal age and was managed under the care of [the DHB's] antenatal team from 28 weeks. Monthly ultrasound scans were performed to monitor fetal growth. At 37+5 weeks [Ms A] had experienced SROM and rang Delivery suite to be advised. [Ms A] subsequently had her pregnancy augmented two days later due to the absence of spontaneous onset of labour. The augmentation process progressed to a surgical birth due to the presence of foetal distress, and a lack of imminent signs to birth vaginally. The retrospective diagnosis was severe fetal acidosis and a concealed placental abruption. There is a question about the midwifery care delivered by [Ms C] and [Ms E] having had an impact on the timing for caesarean section.

Advisor Opinion:

I will address the concerns related to whether either [Ms C] or [Ms E] provided an acceptable standard of midwifery care. I will address the provision of midwifery care with regard to the interpretation of the cardio toco-graph machine (CTG) evidence in relation to the timing of the caesarean section performed for [Ms A].

DHB Policies with regard to CTG monitoring: CTG monitoring is a continuous electronic monitoring performed for women with high risk pregnancies in the third trimester[30] and the intrapartum period.

[Ms C] and [Ms E] are both employed by [the] DHB where the policy guiding midwifery practice for fetal assessment in labour defines expected practice with the use of CTG. This DHB also provides training as an expectation that the midwifery workforce can interpret CTG traces.[31] The 'Fetal Assessment in Labour policy' is supported by associated documents that assist with interpretation of it and associated care pathways. Two of these specific documents are:

1. National Institute of Clinical Excellence (NICE) guideline for Intrapartum care
2. Royal Australian New Zealand College Obstetricians & Gynaecologists (RANZCOG) Clinical Guidelines: Intrapartum fetal surveillance.

They provide specific guidance for all types of traces including suspicious traces[32] (NICE, 2008, RANZCOG, 2006). Both [Ms C] and [Ms E] were expected to follow these policy guidelines.

Fetal decelerations: While there were several periods of short fetal decelerations that were quick to recover, from 17.20 hrs up to 2000 hrs that were down to 80–90 beats per minute (bpm), [Ms C] and [Ms E] both partially adhered to the policy by providing procedures to improve fetal oxygen perfusion; changing maternal position, reducing the syntocinon infusion and maintaining hydration, however the syntocinon infusion should have stopped as per the policy. Prior to the epidural, 1932hrs there was a deceleration that was down to 80–90 bpm that lasted 7 minutes. According to the NIB Fetal Assessment in Labour policy, the prolonged bradycardia[33] or deceleration would be defined as pathological due to depth and length: < l00bpm for >5 minutes. The actions required:

According to the DHB Fetal Assessment in Labour Policy:

- Require immediate management, which may include fetal blood sample or urgent birth

According to supporting documents; NICE, 2008 & RANZCOG, 2006:

- Review of the trace by Obstetrician
- Cessation of syntocinon infusion
- Use of fetal blood sampling should be considered[34]
- Expedite delivery.

[Ms C] was seeking advice from her senior experienced midwife; [Ms E], CCM, during this episode of care, which is normal midwifery practice; 'Midwives support and sustain each other in their professional roles' (NZCOM, p 13, 2008). However

[30] Pregnancy from 28 weeks' to 42 weeks' gestation.
[31] Paper evidence of the CTG monitoring.
[32] Paper evidence of fetal compromise when CTG monitoring is used.
[33] A fetal heart rate below 100bpm where a normal heart rate would be 110–120 bpm.
[34] Testing in labour for fetal metabolic side effects of oxygen deprivation.

[Ms E] could have considered a consultation with the Obstetrician, [Dr B], at this point of care that may have resulted in an expedited delivery of [Ms A's] baby.

Fetal Blood Sampling: According to the guideline 12 of the RANZCOG Guideline: The Fetal blood sample for lactate should not be taken if the assessment indicates probable acidosis and therefore the need to expedite delivery. [Ms E] should have been able to override [Dr B's] decision to perform a fetal blood sample. I understand from the HDC interview notes that there were difficulties with communication styles during the emergency, but these difficulties should not have prevented the appropriate processes to be facilitated in a timely fashion.

Conclusion: The events that have led to the loss of [Ms A's] baby have been complex when considering the retrospective diagnosis of severe fetal acidosis a concealed placental abruption. However the policies that have been put in place have been written to safeguard not only women and babies but also practitioners so they can easily provide good care. In this instance I feel that [Ms C] and [Ms E] did not fully appreciate the requirements of consultation with the evidence of a pathological CTG trace prior to the epidural, as determined by the Fetal Assessment in Labour Policy. If consultation had occurred prior to the epidural due to the 7 minute deceleration, the diagnosis of an abruption may have been made earlier and surgical delivery may have occurred earlier.

Standard six of the NZCOM Midwives Handbook for practice states: 'Midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk', and goes on to say: 'identifies deviations from the normal, and after discussion with the woman, consults and refers as appropriate' (NZCOM, p 20, 2008). While [Ms C] certainly asked for guidance, [Ms E] did not consult in a timely fashion and both midwives should have recognised the abnormal degree of this deceleration in order to advocate for the woman, baby and family. I would suggest this aspect of care demonstrates a moderate deviation from standard midwifery care.

References:

National Institute of Clinical Excellence. (2007). *Intrapartum care: Care of healthy women and their babies during childbirth.* Retrieved 16TH August, 2013, from

http://publications.nice.org.uk/intrapartum-care-cg55/guideance#complcated-labour-monitoring-babies-in-labour

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

New Zealand College of Midwives. (2012). Consensus statement Foetal monitoring in labour Christchurch: NZCOM

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. (2006). *Intrapartum fetal surveillance guideline.* Retrieved 16th August, 2013, from

http://www.ranzcog.edu.au/component/docman/doc _view/1048-c-obs-17b-intrapartum-fetal-surveillance-clinical-guidelines-summary-and-good-practice-notes.html?Itemid=341"

Further expert advice

"I have been asked to add further comment to this report with reference to whether the actions taken by [Ms E] (CMM) were appropriate when decelerations were noted from 8.40pm, and whether the repositioning of [Ms A] and the application of the FSE at this time was reasonable and acceptable practice.

[Ms E] had already been called into the room 4 times between 8pm and 9pm to review the CTG trace by [Ms C] and as a consequence, [Ms A's] position was changed three times and the toco on the CTG machine had to be altered 3 times during this time due to poor tracing. These actions indicate that there was doubt about the reassuring nature of the foetal heart; enough doubt to apply a FSE at 9pm to confirm the foetal heart rate was foetal and not maternal heart rate. These actions are entirely acceptable practice. However reasonable practice would be to discuss these events with the Obstetrician on call to inform him to guide intrapartum management of [Ms A's] birth.

I understand … that the period of deceleration on the CTG trace prior to the epidural I have alluded to in my initial report was not conclusively recognised as pathological [by the HDC obstetrics advisor], however the high risk history of this client: age 46yrs & late midwifery care from 28 weeks, the continued non-reassuring foetal heart rate with the CTG in the intrapartum period, and multiple attempts to correct what were thought to be head compression with repositioning of [Ms A] as well as to validating foetal heart rate with an FSE would indicate consultation with the Obstetrician would have been reasonable midwifery practice.

Augmentation of labour, epidural anaesthesia [are] interventions, as well as foetal heart rate abnormalities, all of which occurred with [Ms A's] labour, require Obstetric consultation as stated in the Referral Guidelines (MOH, 2012). Reasonable midwifery practice would have been to inform the Obstetrician of the irregularities with the CTG after the insertion of the epidural especially from 8.40pm. While consultation may have not changed the management of this labour, nor the outcome, the obstetrician may have had an opportunity to intervene sooner.

I believe that there has been a mild departure from Midwifery standards of care in respect of [Ms E's] management of midwifery care for [Ms A]."