Midwife, Ms B

Midwife, Ms C

A District Health Board

A Report by the

Health and Disability Commissioner

(Case 11HDC00521)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. This report is about the adequacy of care provided to Mrs A during the labour and delivery of her first child in late 2010.

Background

2. In the evening, Mrs A, accompanied by her husband, was admitted to the public hospital (the hospital) as she had started having contractions. Registered Midwife Ms B was assigned to her care, and undertook an assessment at 11.20pm. The fetal heart rate (FHR) was noted to be 154–158 beats per minute (bpm). At 11.45pm Ms B examined Mrs A, noting that her cervix was 2–3cm dilated and 50% effaced,[1] and the FHR was 146–154bpm. As Mrs A was assessed to be in latent labour, Ms B suggested that Mr and Mrs A might wish to return home and come back to hospital when the contractions were three to four minutes apart, lasting 45 seconds, or if her waters broke. Mr and Mrs A decided to stay in hospital.

3. At 12.45am, Ms B documented that Mrs A's contractions were approximately four minutes apart. She offered Mrs A water and heat packs and left Mr and Mrs A to rest.

4. Ms B left the delivery room at 1.30am, instructing midwife Ms E to respond if the bell was rung by Mr and Mrs A.

5. Sometime between 1.30am and 2am, Mr A rang the call bell as Mrs A was unable to cope with the pain. Ms E attended initially and began to run a bath for Mrs A. Ms B returned to the room and listened to the FHR using a Sonicaid at 2am.[2] The notes record that the FHR was 102bpm. After attempting to listen several times, Ms B decided to commence a cardiotocogram (CTG).[3] She positioned the cardio transducer, and a trace at 2.15am showed a potential FHR of between 60 and 105bpm. One of the transducers was not working so Ms B left the room to retrieve a second transducer and seek assistance from Assistant Charge Midwife (ACM) Ms C.

6. Ms B and Ms C returned to the room together. The CTG machine appears to have been turned on at 2.22am. Ms C attempted to listen to the fetal heartbeat with the Sonicaid while Mrs A was standing, but could not hear one. Ms C asked Mrs A to lie down and palpated Mrs A's abdomen. Ms C then attempted to find a fetal heartbeat with the CTG machine but could not. Ms C left the room, and paged the obstetric registrar at 2.31am.

7. There is some confusion as to whether Ms C or Ms B retrieved an ultrasound scanner, and whether this was used by Ms C before or after she paged the obstetric registrar. Ms C asked Ms B to perform a vaginal examination, rupture the membranes and apply a fetal scalp electrode. Ms B was unable to rupture the membranes.

[1] Effacement is the gradual softening and thinning of the cervix, measured from 0% to 100% effaced.
[2] A handheld ultrasound transducer used to detect the fetal heart rate.
[3] Measures the FHR.

8. The obstetric registrar, Dr D, arrived between 2.35am and 2.44am. He ruptured the membranes and applied a fetal scalp electrode but no fetal heartbeat was detected. Dr D also confirmed the absence of a fetal heartbeat with the ultrasound scanner. He decided to expedite delivery with forceps, as delivery seemed imminent, and asked Ms C to call the neonatal team and the obstetrics and gynaecology consultant. Baby A was born at 2.50am with no audible heartbeat. Sadly, immediate resuscitation was unsuccessful.

Decision summary

Ms B

9. Ms B failed to take appropriate action as soon as she suspected that the FHR was inadequate. In addition, Ms B communicated poorly with Mr and Mrs A, did not carry out adequate reviews in accordance with an individual assessment of Mrs A's needs, and did not complete documentation to an acceptable standard. The combination of these factors points to a pattern of inadequate care. By failing to provide services to Mrs A with reasonable care and skill, Ms B breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[4]

Ms C

10. Sometime between 2.15am and 2.22am Ms B asked Ms C to assist her. They returned to Mrs A's room together and Ms C attempted to listen to the FHR with the Sonicaid. When she did not hear a fetal heartbeat, she asked Mrs A to lie down, palpated Mrs A's abdomen, and then tried to find a fetal heartbeat with the CTG machine. Ms C paged the obstetric registrar at 2.31am.

11. Ms C failed to request medical assistance sufficiently promptly when this was indicated. In addition, Ms C's documentation was brief and did not describe her examinations of Mrs A. By delaying contacting the obstetric registrar for at least nine minutes and not completing documentation to an acceptable standard, Ms C did not provide services to Mrs A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

The District Health Board (the DHB)

12. Ms B and Ms C's failures to take the appropriate action in response to a situation of possible fetal distress are fundamental clinical failures which cannot be attributed to any alleged systemic deficiencies at the DHB.

13. Accordingly, I do not consider that the DHB is liable for Ms B's or Ms C's failings.

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

Complaint and investigation

14. On 23 April 2012, the Commissioner commenced an investigation into the following issues:

- *The appropriateness of the care provided by midwife Ms B to Mrs A in 2010.*
- *The appropriateness of the care provided by midwife Ms C to Mrs A in 2010.*
- *The appropriateness of the care provided by the District Health Board to Mrs A in 2010.*

15. This report is the opinion of Anthony Hill, Health and Disability Commissioner.

16. The parties directly involved in the investigation were:

Mrs A	Consumer/Complainant
Mr A	Complainant
Ms B	Midwife
Ms C	Associate Charge Midwife Manager
Dr D	Obstetric Registrar

17. Information was reviewed from:

The DHB
Ms B
Ms C
Ms E (midwife)
Ms F (midwife)

18. Independent expert advice was obtained from midwife Thelma Thompson, and is included as **Appendix A**.

Information gathered during investigation

19. In 2010, Mrs A, aged 31 years, was pregnant with her first child. Her pregnancy was normal and she had received regular antenatal care from the midwives at the hospital.

20. At about 6pm, when Mrs A was 39 weeks' gestation,[5] she started having contractions. At 10.15pm, Mr A telephoned the hospital and spoke with Assistant Charge Midwife (ACM) Ms C, who advised Mr and Mrs A to come to the hospital for a check. They arrived at the delivery suite at 11.08pm.

[5] Gestation indicates the age of the fetus. Delivery normally occurs at 40 weeks' gestation +/– 2 weeks.

21. That night, there were four women in the delivery suite and five midwives on duty. Ms C assigned Registered Midwife Ms B to the care of Mrs A.

22. Ms B graduated in 2009 and joined the Graduate Midwifery Programme at the hospital that year.

Initial assessment

23. At 11.20pm, Ms B assessed Mrs A and documented that her blood pressure was 100/56mmHg,[6] temperature 36.6°C,[7] and pulse 68 beats per minute (bpm). Ms B observed that the fetal heart rate was 154–158 bpm.[8] Mrs A reported fetal movements. She told Ms B that while she was at home her contractions had been coming every five minutes, lasting for 30 seconds. These were documented as having slowed at the hospital. Ms B documented a plan that included performing a vaginal examination and queried whether Mrs A needed pain relief.

24. Ms B discussed with Mrs A the possibility of her returning home. Mrs A told HDC that at that time she was in too much pain to walk to the car.

25. At 11.45pm, Ms B carried out a vaginal examination, which revealed that Mrs A's cervix was 50% effaced and dilated to 2–3cm. The FHR was documented as being 146–154bpm. Ms B again suggested that Mrs A return home and come back to the hospital when the contractions were three to four minutes apart, lasting 45 seconds, or if her waters broke. Ms B left the room to allow Mrs A to discuss this with Mr A.

26. At approximately midnight, Ms B discussed her initial findings with Ms C. Ms C recalled Ms B saying that "all appeared to be normal" and that Mrs A was in the latent phase of labour.[9]

27. At 12.05am, Ms B returned to the room and Mrs A said she had decided to remain in hospital. Ms B recorded in the progress notes: "They don't want to go home as feel a little unsure."

28. At 12.45am, Ms B documented that Mrs A's contractions were approximately four minutes apart but Mrs A was unsure how long they were lasting. Mrs A was again given the option of returning home but the records note that she "still would like to stay; this is ok if wants to". Ms B offered water and heat packs, discussed other pain relief measures, and left Mr and Mrs A to rest.

29. Mr and Mrs A said that Mr A was given instructions to monitor the contractions. They said that Mrs A's pain was constant rather than coming in waves, which made it difficult for Mr A to report on the length of the contractions. Mr A said he struggled to decide how bad his wife's pain had to be before he pressed the call bell. He said:

[6] Adult blood pressure is considered normal between 90/60mmHg–145/90mmHg.
[7] Normal temperature varies between approximately 35.5°C and 37.5°C.
[8] Normal range for a fetal heart rate is 120–160bpm.
[9] The latent phase of labour is characterised by the beginning of contractions and dilation of the cervix to 3–4cm.

> "I'd been to all the antenatal classes but I couldn't tell when one contraction started and one finished … I didn't know what the pain was supposed to be like."

30. Ms C said that the hospital's standard practice was for midwives to listen to the FHR every couple of hours when the woman appeared to be a normal, healthy mother in the latent stage of labour.

31. Ms B told HDC that she looked in on Mr and Mrs A from the doorway some time between 1am and 1.30am and did not disturb them as they were resting quietly. Mr and Mrs A did not see Ms B look in, and deny that they were resting quietly at that time.

32. At approximately 1.30am Ms B asked Registered Midwife Ms E to respond if Mr and Mrs A rang the bell, as she would be away from the delivery suite for a short time. Ms B visited another ward and then did routine checks in the Delivery Suite Recovery Room.

Call bell

33. Ms E advised HDC that the call bell was pressed "sometime between 0130 and 0200 hours". Mr A recalls that at approximately 2am, while Ms B was away from the delivery room, he pressed the call bell. The Adverse Event Review Report prepared by the DHB noted that the call bell was activated while Ms B was away from the delivery suite. The DHB advised HDC that Ms E was alerted to the call bell "just before 0200hrs" and that it is not clear from the documentation when Mr A activated the call bell, "but it is likely to have been around 0150hrs based on interviews with the midwives".

34. Mrs A said she had been "struggling in severe pain for some time" and was "unable to cope with the pain any longer". Mr and Mrs A were concerned that they had been left alone for a long period of time without any observations or monitoring.

35. Ms E responded to the bell and went to assist Mrs A. Ms E told HDC that Mr and Mrs A asked what Mrs A could use for pain relief and whether she could have an epidural. Ms E explained to Mr and Mrs A that an epidural was one of the options available, but encouraged them to "start with the least invasive options first", such as a bath or Entonox.[10] Ms E encouraged Mrs A to try a bath because Mrs A did not want to use Entonox. Ms E began filling the bath. She told HDC that she did not assess Mrs A because she had been assessed at about midnight and was less than 4cm dilated.

36. Ms E did not record this interaction with Mr and Mrs A but she met Ms C and Ms B outside Ms C's office as Ms B was returning from the Delivery Suite Recovery Room. Ms E advised them that she had attended Mrs A's request for assistance, and had started filling a bath. Ms B said she would check on Mrs A.

[10] Entonox is an anaesthesia gas, commonly known as "gas", and is frequently used by women in labour.

37. Ms B returned to the delivery room at 2am as is recorded in the contemporaneous note: "Returned to room to check on bath started by fellow midwife." Ms B recalls that Mrs A was walking around the room. Ms B recorded that Mrs A had pain in her front and back. Ms B told Mrs A that she would need to have satisfactory observation recordings before she entered the bath. These observations are not documented, but Ms B advised HDC that they were within normal limits.

38. Mrs A then used the toilet, passing what Ms B described as a "mucousey and slightly bloody show".[11] The notes record that Mrs A reported fetal movements. However, Mrs A does not recall feeling fetal movements at this time. When Mrs A returned from the toilet, Ms B used a Sonicaid to listen to the fetal heart rate while Mrs A was standing.

39. The notes record that a Sonicaid was used to detect an FHR of 102bpm at 2.10am. Ms B advised HDC that she made this note contemporaneously. Ms B was unhappy with the assessment and asked Mrs A to lie down. Ms B told HDC that she tried using the Sonicaid in different positions because the position of the baby could have changed, and repeated her abdominal palpation. She advised that these reassessment actions took place between 2.10am and 2.15am. Ms B described her reassessment actions as "listening in, changing position, repeat listening in, repeating abdominal palpation, repeat listening in".

40. Ms B told HDC that she decided to perform a CTG. The CTG machine was in a storage area inside the delivery room. Ms B retrieved the CTG machine and positioned the cardio transducer. A trace recorded at 2.15am[12] shows a potential FHR of between 60 and 105bpm. However, it cannot be verified whether this was the FHR or maternal heart rate. Ms B wrote in the notes: "[I]nsufficient FHR; 102; [maternal pulse] 100bpm." She advised HDC that one of the transducers was not working.[13] She left the room to retrieve a second transducer from the storeroom, which she advised was past Ms C's office, and to request Ms C's assistance. Ms B told HDC that she left the room at 2.15am.

Request for assistance

41. On her way back to the delivery room from the storeroom, Ms B passed Ms C's office and told Ms C that she was having difficulty picking up the FHR. Ms C said she recalls Ms B having a transducer in her hands. Ms B asked Ms C to assist her and they returned to the delivery room together. Both midwives recall that they walked back to the delivery room immediately. Ms C initially stated that this occurred at 2.30am. In response to my provisional opinion, Ms C submitted that she in fact entered the delivery room at 2.27am.

[11] A "show" is the common term for the release of the cervical plug that forms during pregnancy. It consists of a mucous, often blood-streaked vaginal discharge and indicates the beginning of cervical dilation.

[12] It has not been possible to verify the times indicated on the CTG machine. However, the time between traces is accurate.

[13] Two transducers are required for a CTG — one to measure uterine contractions and the other to measure the fetal heart rate.

42. Ms C recalls that Mrs A was walking around when she entered the room. Ms B said she turned on the CTG again at about 2.20am. The CTG machine shows that it was turned on at 2.22am, but there is no trace because the CTG machine was not used at that time.

43. Ms C noted:

> "It is not uncommon for midwives to experience difficulties in getting an accurate FHR during labour and I am often called upon to assist in these situations and an accurate FHR is found."

44. Ms C attempted to listen to the fetal heartbeat using the Sonicaid while Mrs A was standing, but could not hear one. She asked Mrs A to lie down so she "could palpate and try to get a FHR with a CTG machine". In her response to HDC, Ms C described her findings:

> "On palpation the baby appeared to be in the Left Occiput Anterior position and the head was 3/5 palpable. The baby did not appear to move at all whilst I palpated and it felt like there was very little fluid around the baby. It also felt solid and a very good size baby."

45. Ms C attempted to detect the fetal heartbeat with the CTG but could not find a fetal heartbeat. At 2.28am the CTG showed a potential heart rate between 80 and 160bpm. Ms C told HDC:

> "I am required to perform my own checks before escalating a matter […] If I had found a healthy FHR, nothing further would have occurred and a 777 call would have been inappropriate."

46. Ms C recalls that she was in the delivery room for approximately five minutes before calling the obstetric registrar.

47. Ms B's retrospective note,[14] which refers to events after 2.15am, records the following sequence:

> "— non-reassuring CTG trace
> — FHR attempted by ACM with sonic aid and further with CTG
> — U/S[15] retrieved and attempted by ACM …"

48. At 2.30am, Ms C wrote in the clinical notes:

> "ACM present could not get FHR so told [Ms B] M/W to do VE and ARM and fetal scalp [electrode] on and would call Reg."

[14] This record does not indicate the time of writing. Ms B advised HDC that she made notes of times and procedures on a piece of paper that was in her pocket, then transcribed them into her retrospective note.
[15] Abbreviation for "ultrasound scanner".

49. In the margin beside this note is an additional note reading: "Retrospective scanner[16] brought in." Ms C said that while she was writing the 2.30am note, she instructed Ms B to perform a vaginal examination, rupture the membranes and apply a fetal scalp electrode, and said that she would page the obstetric registrar.

Ultrasound scanner

50. The ultrasound scanner was retrieved from outside Ms C's office. It is unclear exactly when the scanner was retrieved and by which midwife, and whether it was used before or after the emergency calls were made. Ms B recalls retrieving the scanner herself, at the request of Ms C, and "vividly" recalls the cord dragging on the floor and remembers looking at the clock as she was pushing it down the corridor at 2.26am. As mentioned above, her retrospective note in the clinical record records that the ultrasound scanner was used by Ms C after Ms C tried to detect a fetal heartbeat with the Sonicaid and CTG.

51. In contrast, Ms C recalls collecting the ultrasound scanner as she made the emergency calls. Ms C said that she then placed the ultrasound scanner in the position where Ms B had last successfully detected the fetal heartbeat, but Ms C did not hear or see a fetal heartbeat. Mr A recalls that after Ms C used the CTG, she left the room to retrieve the ultrasound scanner and then used it to assess Mrs A.

52. Ms C said that if a fetal heartbeat cannot be detected, retrieving an ultrasound scanner is the usual process as it would be required by the doctor. However, Mr A recalls Ms C saying that it was not what she would normally do. Mr A said that "it was when [Ms C] was using the ultrasound that I sensed there was an emergency". Mr A did not know whether Ms C paged the obstetric registrar before or after she used the ultrasound scanner.

Emergency calls

53. Ms C said that once she had confirmed the absence of a fetal heartbeat she decided that the quickest response would be to page the obstetric registrar. She told HDC that she knew the registrar was "just down the hallway". She walked out of the room and, at 2.31am, paged the obstetric registrar, Dr D.

54. Ms C advised HDC that she then paged the anaesthetic registrar and trainee intern. She also called the Assistant Charge Midwife Manager in another unit and asked for her team of midwives to be available if necessary.

55. The emergency wall bell was not activated. Ms B said that this was because "all response teams (obstetric, anaesthetic and neonatal) were already alerted to the situation and on their way to the room, adequate midwifery and medical staff were present within approx 5 minutes and the only difference of [sic] pushing the bell would have made was a clanging bell".

[16] The ultrasound scanner.

Further vaginal examination

56. While Ms C made the emergency calls, Ms B did a further vaginal examination. Ms B's retrospective note records that the vaginal examination revealed that Mrs A's cervix was 4 to 5cm dilated and was stretchy and thin. It also records that they continued to attempt to listen to the fetal heart, but could not detect a heartbeat.

57. Ms B attempted to rupture the membranes, but was unable to do so. Ms C instructed Ms B to re-apply the CTG. As Ms C was putting on gloves in preparation to rupture the membranes, Dr D arrived and took over.

Registrar's actions

58. Dr D's retrospective note states that he arrived at approximately 2.44am. Mr and Mrs A recall that Dr D was present for only a few minutes before their baby was born at 2.50am.

59. The midwives recall that Dr D arrived at 2.35am. A fetal heart rate is documented as 80bpm at 2.35am and both midwives deny having recorded this.

60. Dr D ruptured the membranes (noting that old meconium was present) and applied the fetal scalp electrode, but no fetal heartbeat was detected. He found Mrs A's cervix to be 6cm dilated. Dr D used the ultrasound scanner, which showed no FHR. He completed a further vaginal examination and found that the cervix was almost fully dilated. He noted that delivery "seemed imminent" and decided to expedite the delivery with forceps.

61. On Dr D's direction, Ms C called the neonatal team (a "777" call) and then at approximately 2.48am called the obstetrics and gynaecology consultant.

62. At 2.50am, Baby A was born. She was covered in meconium, was pale and floppy, and had no audible heartbeat. Immediate resuscitation was, sadly, unsuccessful.

63. The post-mortem report indicates that there may have been a hypoxic environment in utero[17] for a minimum of three days prior to Baby A's birth.

Internal review

64. An Adverse Event Review Report was completed. It concluded that the care provided met expected standards and guidelines.

65. The Review Team made incidental recommendations that the DHB:

- align their fetal monitoring policies with National Maternity Standards;
- use Mrs A's case in staff education to illustrate the importance of managing parental expectations; and
- develop an information brochure for parents who wish to remain in hospital during latent or early labour.

[17] Reduction in oxygen supply to the fetus.

Changes to practice

66. Ms B stated that this incident "has been a challenging and saddening time for [her] and has affected [her] personal and professional life significantly". Ms B advised HDC that she:

- has sought advice on artificial rupture of membranes;
- has started using the "SOAP" structure (subjective information, objective information, assessment, plan) for her documentation;
- regularly talks with clinical midwifery managers and educators;
- attends professional supervision;
- has participated in documentation audits; and
- is booked to attend a recommended "Dotting the I's and Crossing the T's" seminar on documentation standards.

67. Ms B has provided a written apology to Mr and Mrs A.

68. Ms C said she has been "deeply affected" by the death of Mr and Mrs A's baby. She advised HDC that she has:

- completed an NZCOM course on documentation; and
- changed her practice to review notes at the relevant time to ensure they are adequate and comprehensive.

Response to provisional opinion — Ms B

69. Ms B submitted that her assessment of Mrs A and her actions were specific to Mrs A's individual needs. Ms B advised that an example of care in response to Mrs A's specific needs was when Ms B allowed Mrs A to remain standing throughout her assessment. Ms B also submitted that the alerting of senior staff and subsequent investigation and notification of an emergency was carried out in accordance with the DHB's standard procedures.

Response to provisional opinion — Ms C

70. In response to my provisional opinion, Ms C questioned the timing of events.

71. Ms C argued that, as Mr A rang the call bell at 2am and Ms E responded and then assessed Mrs A, Ms B must have arrived in Mrs A's room at 2.10am rather than 2am. Ms C stated that after Ms E's interaction with Mr and Mrs A, Ms E met with Ms B and Ms C outside Ms C's office at 2.10am. Ms C argued that Ms B's notes made at 2am and 2.10am incorrectly record the time that the events took place.

72. Ms C further submitted that:

> "[Ms B] entered the room at approximately 2.10am, spoke to [Mrs A] and performed her first assessments before turning on the CTG for the first time at 2.15am and using it for a period of minutes. [Ms B] then left the room to get equipment for the device, returned to the room and turned the CTG on for a second time at 2.22am before using it for a further number of minutes. It is then

more likely that [Ms B] did not leave the room to seek my assistance until 2.25–2.26am at the earliest."

73. Ms C submitted that she entered the room at 2.27am and used the CTG at 2.28am, gave instructions to Ms B and left the room to call the registrar at 2.31am. She submits that this is supported by her note on the CTG trace, which states: "ACM called to Room — Reg called", which she says she wrote after she used the CTG at 2.28am.[18]

Relevant standards

74. The relevant professional standards from the New Zealand College of Midwives (NZCOM) *Midwives' Handbook for Practice* (2008) state:

"**Standard One**
The midwife works in partnership with the woman.

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

Standard Four
The midwife maintains purposeful, ongoing, updated records and makes them available to the woman and other relevant persons.

Criteria [under this standard include]

The midwife:

- reviews and updates records at each professional contact with the woman
- ensures information is legible, signed and dated at each entry

…

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

Criteria [under this standard include]

The midwife:

- identifies deviations from the normal, and after discussion with the woman, consults and refers as appropriate

…

[18] There is no date, time or signature on this note.

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

Criteria [under this standard include]

The midwife:

- clearly documents her decisions and professional actions.

…"

75. Midwives must maintain their competencies at the level of entry to the Midwifery Register. The relevant competency for entry to the Register of Midwives as outlined by the New Zealand College of Midwives *Midwives' Handbook for Practice* (2008) states:

"**Competency Two**

The midwife applies comprehensive theoretical and scientific knowledge with the affective and technical skills needed to provide effective and safe midwifery care.

Performance criteria [under this competency include]

The midwife:

2.8 recognises and responds to any indication of difficulty and any emergency situation with timely and appropriate intervention, referral and resources

2.15 shares decision making with the woman/wahine and documents those decisions

2.16 provides accurate and timely written progress notes and relevant documented evidence of all decisions made and midwifery care offered and provided."

Opinion

Introduction

76. Ms B and Ms C owed Mrs A and her baby a duty of care. Both midwives were responsible for the care of Mrs A, according to the information they had and the assessments they performed.

77. The clinical notes record a fetal heart rate of 102bpm at 2.10am. The DHB has provided evidence that Ms C's call to the obstetric registrar was at 2.31am.

78. My independent expert advised that 21 minutes from the initial recognition of an unsatisfactory FHR being noted, to calling a registrar, does not meet expected and usual practice.

Breach — Ms B

Initial assessment

79. At 11.20pm, after Mrs A arrived at the hospital, Ms B assessed her, documented her blood pressure, temperature and pulse, as well as the position of the fetus, and recorded an FHR of 154–158bpm. Ms B obtained Mrs A's consent for a vaginal examination, and carried out the examination at 11.45pm. During the examination the FHR was noted to be 146–154bpm. My midwifery expert advisor, Thelma Thompson, said that the initial assessments of Mrs A at 11.20pm and 11.45pm were of an acceptable standard. The assessments were consistent with Mrs A being in the latent phase of labour, so Ms B suggested that Mrs A return home, and left Mr and Mrs A to discuss this.

Need for support

80. Ms Thompson advised that a midwife works in partnership with the woman in labour, and expected practice includes making a plan with the woman as to further assessment times.

81. By choosing to stay in hospital, Mrs and Mr A were indicating that they wanted intermittent support. Ms Thompson advised that there is no research to validate the timing of assessments during the latent phase of labour, with usual practice ranging between one to four hours based on the individual assessment of the woman's needs. Ms C advised that the hospital's standard practice was that midwives would listen to the FHR every couple of hours when the woman appeared to be a normal, healthy mother in the latent phase of labour.

82. Ms B listened to the fetal heartbeat at 11.45pm. She discussed Mr and Mrs A's plans with them at 12.05am and again at 12.45am when Mrs A confirmed her choice to stay at the hospital. Ms B gave Mrs A heat packs and left Mr and Mrs A to rest. Mr A commented that at that stage he did not know how long his wife's contractions were lasting and it seemed as if they were constant.

83. Ms B did not listen to the fetal heartbeat between 11.45pm and 2.10am. Mr and Mrs A stated that the next time Ms B checked on them after 12.45am was when they pushed the call bell at approximately 2am. However, Ms B said that she looked in on them from the doorway sometime between 1.00am and 1.30am and noted that they were resting quietly. I note that Ms B did not document her observation. Mr and Mrs A deny this occurred and state that they were not resting quietly. Ms Thompson advised that a walk past the door would not be a sufficient review, whereas an assessment for a minimum of five minutes with good visibility and sound could assess a woman without disturbing her. In this case, I consider that the latter kind of assessment did

not occur, and Ms B did not review Mrs A sufficiently when she looked in from the doorway.

84. Ms Thompson advised that Ms B's monitoring of Mrs A, at this stage, was of an acceptable standard. However, I am concerned that Mr and Mrs A, who were having their first baby, felt they were left alone for a long period of time without any monitoring or support. This indicates that Ms B did not communicate adequately with Mr and Mrs A about the monitoring, or make an agreed plan. I consider that Ms B did not review Mrs A adequately from the doorway. In my view, Ms B did not work in partnership with Mr and Mrs A or communicate effectively about the monitoring they could expect during the latent phase of labour.

Action in light of unsatisfactory FHR

85. At 2.10am, Ms B recorded the FHR as 102bpm. She was concerned and initially tried to hear the FHR while Mrs A was in different positions, which Ms Thompson advised is an acceptable action to take. However, Ms Thompson advised that when Ms B was not able to detect the fetal heartbeat within the normal range, "the first action expected would be to call for help". Ms Thompson further advised that "[a]t the point of recognition of foetal distress, it would be expected that an emergency call be done immediately to enable the appropriate action to be taken as soon as possible".

86. Ms B did not make an emergency call. She left the room to retrieve another cardio transducer as there was only one working transducer in the room. On her way back to the room, Ms B saw Ms C and asked her to assist. I am concerned at the approach taken by Ms B to a possible emergency. I note Ms Thompson's advice that Ms B's failure to seek assistance as soon as she suspected an unsatisfactory FHR was a moderate departure from expected standards.

Documentation

87. Accurate documentation of services provided is important to quality and continuity of care. Standard 4 of the *Standards of Midwifery Practice* requires midwives to ensure that information is legible, signed and dated at each entry, and Standard 7 requires midwives to document their decisions and professional actions clearly. Ms B advised that her documentation of the events after 2.15am were written in retrospect. There are no timeframes or approximate timeframes noted as to when actions occurred. I note Ms Thompson's advice that the documentation was not of an acceptable standard.

88. Ms B explained that "during the time of the emergency [she] made bullet points of times and procedures on a piece of paper that was in [her] pocket and then transcribed them into [the] retrospective notes". I consider that Ms B should have noted that the entry at 2.15am was written in retrospect, and she should have ensured that the timing of events was more accurately recorded.

Conclusion

89. I consider that in this case there was a series of episodes of poor care provided by Ms B. Ms B communicated poorly with Mr and Mrs A, did not carry out adequate reviews in accordance with an assessment of Mrs A's needs, failed to seek assistance

as soon as she suspected a possible emergency, and did not complete documentation to an acceptable standard. The combination of these factors points to a pattern of inadequate care. In my opinion, Ms B failed to provide services to Mrs A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

Breach — Ms C

Call bell

90. I have received different responses from all of the parties about when Mr A rang the call bell. Ms E advised HDC that the bell was rung between 1.30am and 2am. The DHB advised that it was rung when Ms B was away from the delivery suite, and it was likely to have been at 1.50am. Mr A recalled that he rang the bell at approximately 2am. I am mindful that Ms B made a contemporaneous note in the clinical record at 2am that she "returned to the room to check on the bath started by fellow midwife". On the basis of all of the evidence, I consider that it is more likely than not that Mr A rang the call bell between 1.30am and 2am.

Response to possible fetal distress

91. Shortly after 2.15am, Ms B left the room to retrieve a second cardio transducer, as the one on the CTG machine was not working. On her way back, Ms B walked past Ms C's office and asked for her assistance. Both midwives agree that they returned to the room together.

92. I have received differing accounts of when the midwives returned to Mrs A's room and the events thereafter. Ms B stated that she left the room at about 2.15am to get the new transducer and reattached the CTG to Mrs A at about 2.20am. The CTG trace shows cardiac markings at 2.15am and 2.22am. Ms B said that when she and Ms C returned to the room, Ms C listened to the fetal heartbeat and then commenced the CTG. Ms B said that Ms C asked her to get the ultrasound scanner, and she remembers returning with it at 2.26am. This sequence of events is supported by Ms B's retrospective note, which records that Ms C attempted to find the fetal heartbeat with the Sonicaid and then with the CTG, and that the ultrasound scanner was then retrieved, and was used by Ms C.

93. However, Ms C stated that she entered the room at 2.27am (after initially advising HDC that she entered at 2.30am) and that she used the Sonicaid to hear the fetal heartbeat while Mrs A was standing. Ms C said she then asked Mrs A to lie down and she palpated Mrs A's abdomen, and then used the CTG to try to detect a fetal heartbeat. Ms C said she wrote the 2.30am note in the clinical record at that time, while she was telling Ms B what to do next. Ms C said that she told Mr and Mrs A that she could not hear the fetal heartbeat, then she called the obstetric registrar, while fetching the ultrasound scanner.

94. The records from the DHB show that a page was sent to the obstetric registrar at 2.31am.

95. I do not accept that Ms B left the delivery room twice, as asserted by Ms C in her response to the provisional opinion, given Ms B's evidence that the CTG machine was located in a storage area inside the delivery room. I am not satisfied that the contemporaneous notes made by Ms B have the wrong times recorded. In my view, it is more likely than not that Ms B left the room only once, shortly after the trace at 2.15am, to obtain a new transducer, and that Ms B and Ms C returned with the transducer. Ms C agrees that Ms B had the transducer with her when she requested Ms C's assistance, and that they returned to the delivery room together.

96. At 2.22am, the CTG machine was switched on, but there is no trace until 2.28am, which suggests that it was turned on when Ms B and Ms C returned together with the second transducer, and used some minutes later.

97. I agree with Ms C that she used the CTG at 2.28am. However, on the basis of the evidence I remain of the view that it is more likely than not that Ms C entered the delivery room some time between 2.15am and 2.22am and she was in the delivery room at 2.22am when Ms B turned on the CTG, after obtaining the replacement transducer. Ms C is clear that she did her own investigations to ascertain the FHR before she paged the obstetric registrar, and she made a note in the clinical records at 2.30am that she could not detect a fetal heartbeat.

98. When Ms C entered the room, she knew that there were problems with detecting a fetal heartbeat. She listened with the Sonicaid and then tried the CTG, but could not detect a fetal heartbeat. She also palpated Mrs A's abdomen. Ms C explained to Mr and Mrs A that she could not hear a fetal heartbeat and so she needed to get the doctor. It was only then that Ms C paged the obstetric registrar.

99. I am unable to determine whether Ms C used the ultrasound scanner to try to find a fetal heartbeat before or after paging the obstetric registrar. Ms C said that she went to retrieve the scanner after paging the obstetric registrar, but Ms B is adamant that Ms C asked her to retrieve it, which she did at 2.26am. Ms B's retrospective note records: "[Ultrasound] retrieved and attempted by ACM." Mr A recalls Ms C leaving the room to retrieve the ultrasound scanner, but he does not know whether this was before or after Ms C paged the obstetric registrar.

100. Although it is unclear who retrieved the ultrasound scanner, in my view the evidence points to Ms C spending at least nine minutes, but possibly up to sixteen minutes, trying to find a fetal heartbeat before calling the obstetric registrar. I note Ms Thompson's advice that a delay of nine minutes from being informed of a possible fetal bradycardia to requesting medical assistance does not represent appropriate care. Bradycardia is described as less than 110bpm, and Ms Thompson advised that a prolonged bradycardia of less than 100bpm for more than five minutes is "very likely to be associated with fetal compromise requiring immediate management". In the circumstances, Ms C should have contacted the obstetric team more promptly.

Documentation

101. Accurate documentation of services provided is important to enable quality and continuity of care. Standard 4 of the Standards of Midwifery Practice requires

midwives to ensure that information is legible, signed, and dated at each entry. Standard 7 requires midwives to document their decisions and professional actions clearly. Ms Thompson noted that considering Ms C's actions and involvement with Mrs A, Ms C's documentation is minimal, and does not record what actions occurred at what time. Ms Thompson considered that Ms C's documentation is not of an acceptable standard.

102. I agree that Ms C's documentation is not adequate. Her notes are brief, and do not describe her examination of Mrs A or the attempts she made to hear a fetal heartbeat. As mentioned previously, it was not clearly recorded when the ultrasound scanner was brought in and by whom, or when the scanner was used and when the registrar was paged.

Conclusion

103. I consider that Ms C failed to request medical assistance sufficiently promptly when this was indicated, and did not complete documentation to an acceptable standard. In my opinion, Ms C failed to provide services to Mrs A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

The District Health Board — Adverse comment

104. Under Section 72(2) of the Health and Disability Commissioner Act 1994 employers are vicariously liable for any breach of the Code by an employee. Under Section 72(5) of the Act it is a defence for an employing authority to prove that it took such steps as were reasonably practical to prevent the act or omission of employees who breached 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.[19]

105. In my view, Ms B and Ms C's failures to take the appropriate action in response to a situation of possible fetal distress are fundamental clinical failures that cannot be attributed to any alleged systemic deficiencies at the DHB. The DHB was entitled to rely on Ms B and Ms C, as qualified midwives, to provide an appropriate standard of care. While the DHB has a responsibility to have structures in place 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 Ms B and Ms C were unable to perform their duties appropriately.

106. Accordingly, I do not consider that the DHB is liable for Ms B's or Ms C's failings.

107. However, I am concerned that there was a pattern of inadequate documentation by the midwives in this case. Retrospective notes have not been marked as being

[19] Opinion 09HDC01146, Opinion 08HDC00469, and Opinion 02HDC17106.

retrospective, a number of actions do not have corresponding times or approximate times, not all notes are signed, and in parts documentation is minimal.

Recommendations

108. Ms B has provided a written apology to Mr and Mrs A for her breach of the Code. The apology will be forwarded to Mr and Mrs A.

- I recommend that Ms C provide a written apology to Mr and Mrs A for her breach of the Code. The apology should be sent to this Office by **1 July 2013** to be forwarded to Mr and Mrs A.

- The Midwifery Council of New Zealand will be requested to conduct competency reviews of both Ms B and Ms C.

- I recommend that the DHB review their training and refresher courses in documentation, and advise me of any changes made to improve midwifery documentation. The DHB advised that it is awaiting completion of its annual documentation audits. The results of these, and the content of its technical skills training days (on communication and documentation), will be reviewed at the next Women's Health Service monthly quality and risk meeting. I recommend that the DHB advise me of the outcome of the review and any resultant changes by **1 July 2013**.

Follow-up actions

109.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Midwifery Council of New Zealand, and the Council will be advised of the names of Ms B and Ms C.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the New Zealand College of Midwives, and the College will be advised of the names of Ms B and Ms C.

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

Appendix A — Independent midwifery advice to the Commissioner

The following expert advice was obtained from registered midwife Thelma Thompson:

22 September 2011 — preliminary advice

"I have been asked to provide the Health and Disability Commissioner with preliminary advice on case number C11HDC00521 and that I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

I graduated with a Diploma of Nursing in 1984, a Diploma of Midwifery in 1989 and a Bachelor of Health Science in 1996. I have held my current position as Director of Midwifery Practice at Counties Manukau District Health Board since November 2002. Prior to that time I held a variety of clinical roles in both primary and secondary practice. I am the current Chair of the National DHB Midwifery Leaders Forum and was a member of the Midwifery Council of New Zealand from January 2004 to February 2010.

As Director of Midwifery Practice I am responsible for the professional oversight of the midwives at Counties Manukau DHB.

Part of my role as involves:

- providing professional direction and midwifery leadership within CMDHB;
- facilitating the provision of the highest quality midwifery care in accordance with designated standards of practice locally, nationally and internationally.

The Commissioner requested advice on:

- The approach taken by [the DHB's] midwifery staff to a couple that exhibited a degree of uncertainty and anxiety about their situation, particularly in regard to the support offered on their arrival at [the hospital] and between 12.45am and 2.10am [in] 2010.
- The standard of clinical documentation, particularly between 12.45am and 2.10am [in] 2010.
- The appropriateness of the disputed 'look from the door' review between lam and 1.30am [in] 2010.
- The timeliness of maternal and foetal assessment and monitoring after [Mr A] activated the call bell at (according to the midwife) 1.30am [in] 2010.
- The 21-minute delay between initial doubt being expressed over presence of a foetal heart beat and the obstetric registrar being paged.
- Does the inability of a midwife to perform an artificial rupture of membranes and apply a foetal scalp electrode on a patient 4–5cm dilated with a well applied and stretchy cervix, vertex presentation (station not recorded) raise any competency concerns?
- [Mrs A's] overall midwifery management, and any recommendations for further action that you consider necessary.

The following sources of supporting information that were sent have been reviewed prior to the advice being given:

- Complaint and correspondence from [Mr and Mrs A];
- Adverse Events Review Report from [the DHB];
- Clinical notes from [Mrs A's] admission to [the hospital];
- [Baby A's] post mortem report; and
- [The DHB's] Foetal Monitoring Policy at the time of [Baby A's] delivery.

Background and Summary
[Mrs A], gravida 2 parity 0; with an expected date of delivery of […] taken from her last menstrual period. [Mrs A] was admitted to [the hospital's] Delivery Suite at 2320 hours [date] during the 39 week gestation. Midwife (MW) [Ms B's] assessment was that [Mrs A] was in early labour (latent phase of labour) and suggested plan of management was for [Mrs A] to go home and await the establishment of labour. [Mr and Mrs A] chose to remain in hospital. Baby A's foetal heart rate (FHR) was 154–158 beats per min (bpm) upon admission assessment and 146–154 bpm at 2355hours, [Mrs A] was seen at 0045hours [date]. No physical assessment was done at this time.

[Mr A] activated the call bell at approximately 0200hours, due to [Mrs A's] pain; MW Ms E responded and commenced running a bath. MW [Ms B] returned to the Delivery Suite and this information was passed on to her by MW [Ms E].

At 02l0hours MW [Ms B] assessed Baby A's FHR and documented FHR at l02bpm. At 023lhours Associate Clinical Midwife Manager (ACMM) MW [Ms C] and MW [Ms B] were present. MW [Ms C] paged the Obstetric Registrar.

Obstetric Registrar [Dr D] arrived at approximately 0244hours. An emergency call was activated. [Dr D's] assessment showed that [Mrs A] was 6 cm dilated; a foetal scalp electrode (FSE) was applied with no foetal heart activity detected. An ultrasound confirmed no foetal heart activity. [Dr D's] management plan was to deliver [Baby A] by forceps due to reports of [Baby A's] FHR at 90 upon his arrival in the room. [Baby A] was delivered stillborn at 0250hours.

My response to the advice required is as follows:
The approach taken by [the DHB's] midwifery staff to a couple that exhibited a degree of uncertainty and anxiety about their situation, particularly in regard to the support offered on their arrival at [the hospital] and between 12:45am and 2:10am.

The initial assessment of [Mrs A] was of an acceptable standard. Assessment of [Mrs A] was that of latent phase of labour and discussion occurred with [Mr and Mrs A] in regards to the plan of going home. The couple were left to discuss this suggestion and make their decision. The couple decided to remain in hospital.

In relation to ongoing care during the latent phase of labour, practice is based upon individual assessment of the woman's need. Gould (2000) states 'The woman is the focus and therefore her perceptions are the governing factors when providing care in Labour' (pg 487; Pairman et al 2010). The ability to have the correct approach

towards [Mr and Mrs A] depends on the assessment and perception by the midwife of all aspects which impact on labour, including physiological, psychological and environmental.

There is no research to validate timing of assessments during the latent phase of labour. Expected practice of working in partnership includes making a plan with the woman as to further assessment times. 'The midwife needs to ensure that the woman knows how and when to make contact with her.' (pg 489; Pairman et al 2010)

'The second decision point of labour is when the woman wants intermittent support from the midwife' (Pg 35; NZCoM 2008) The choice that [Mr and Mrs A] made to remain in hospital reflected wanting intermittent support.

Assessment of the approach following the first assessment cannot be commented on. This is due to the limited information provided which does not include the complete interaction and communication between the midwives and [Mr and Mrs A]. The lack of documentation will be commented on in the next section.

The standard of clinical documentation, particularly between 12.45am and 2.10am on [the day of delivery].
The documentation was not of an acceptable standard. The departure from the standard is mild.

'Competency 2.16: provides accurate and timely written progress notes and relevant documented evidence of all decisions made and midwifery care offered and provided; (pg9; NZCOM 2008) and
'Standard Four: The midwife maintains purposeful, ongoing, updated records and makes them available to the woman and other relevant persons; Criteria: The midwife reviews and updates records at each professional contact with the woman; ensures information is legible, signed and dated' (pg 18 NZCoM 2008)

Not every relevant professional contact with the woman is documented within the clinical file. These include:

- Documentation by MW [Ms E] when she responded to the call bell from [Mrs A's] room at approximately 0200hours. Due to the lack of documentation the level of assessment of [Mrs A] cannot be commented on.
- Documentation by ACMM [Ms C] at the bottom of Examination and Progress Form sheet 2 and top back of sheet 2 is illegible, written in retrospect and appears not to be entered in chronological order of entry.
- There are two sheet 3's. On the back of the first sheet documentation by MW [Ms E] is stated written in retrospect however there are no times of when actions occurred included.
- On the second sheet 3, documentation by MW [Ms B] has the time of 0215hours which may or may not be written in retrospect. Again timeframes of when actions have occurred, even approximation are not included.

The appropriateness of the disputed 'look from the door' review between 1am and 1.30am on [the day of delivery].
I am unable to comment on the appropriateness of the 'look from the door' due to insufficient information. This would depend on the environment, visibility and the length of time. A walk past the door would not be sufficient, assessing for minimum of 5 minutes with good visibility and sound could assess a situation of a woman in latent phase without disturbing the woman if she were asleep.

The timeliness of maternal and foetal assessment and monitoring after [Mr A] activated the call bell at (according to the midwife) 1.30am on [the day of delivery].
There is a difference of opinion of the time frame of the call bell being activated between the staff and [Mr and Mrs A]. I cannot comment on the timeliness of this assessment as there is no documentation of this interaction. The Adverse Events Review report states that this occurred between 0130–0200hours but does not clarify the exact time. [Mr A] states it was at approximately 0200hours. The factors which would impact on the timeliness would include the assessment by MW [Ms E] of [Mrs A] and also the knowledge of when MW [Ms B] would be available to assess [Mrs A].

The 21-minute delay between initial doubt being expressed over presence of a foetal heart beat and the obstetric registrar being paged.
This does not meet an expected standard. The departure from this standard is moderate, acknowledging that the cause of the outcome is irrelevant in determining as to whether there is a departure from the accepted standard.

If a foetal heart is suspected to be at 102 beats per minute, the first response is to call for help to gain assistance while remaining in the room if possible. At the point of recognition of foetal distress, it would be expected that an emergency call be done immediately to enable the appropriate action to be taken as soon as possible.

Health professionals are required to act according to what they assess. If an assessment is incorrect for example no foetal heart or a normal/recovered foetal heart rate, the health professional has acted according to what she/he assessed at the time.

Does the inability of a midwife to perform an artificial rupture of membranes and apply a foetal scalp electrode on a patient 4–5cm dilated with a well applied and stretchy cervix, vertex presentation (station not recorded) raise any competency concerns?
The ability to perform an ARM is an expected competency of a registered midwife. The ability to do this in all situations increases with experience and confidence. Competency cannot be assessed by one situation. Further information would be required to decide if there was any competency concern.

The ability to apply a FSE depends on the area of work. Applying a FSE would be a skill which would need to be learnt if not known previously for a midwife working in a secondary facility in a delivery suite.

[Mrs A's] overall midwifery management, and any recommendations for further action that you consider necessary.
This aspect has been mentioned previously in this report.

The ability to have the correct approach towards [Mr and Mrs A] depends on the assessment and perception by the midwife of all aspects which impact on labour, including physiological, psychological and environmental. There are many variables which impact on this and the communication which occurs between health professionals and the people they care for.

Was the communication clear between the midwives and [Mr and Mrs A] and did the midwife hear the concerns and anxieties of [Mr and Mrs A]. This is reflected in Pairman et al (2010) pg 487 'The ability to provide supportive midwifery care in labour is a multifaceted skill. The parameters of normal labour and birth are individual to each woman. To be able to recognise what is "normal" for each woman, a midwife needs to be available to her and alert to the ebbs and flows of that woman's experience.'

Another aspect of midwifery assessment is the use of the ultrasound scan by a registered midwife in this situation. This is not within the midwifery scope of practice. The midwife may have received recognised credentialed training.

References
Pairrnan et al 2010 midwifery preparation for practice 2e ELSEVIER Sydney Australia
New Zealand College of Midwives (NZCOM) 2008a Handbook for Practice. NZCOM Christchurch"

7 April 2012 — further preliminary advice
"… [deleted as repeat of earlier advice]

The following sources of supporting information that were sent have been reviewed prior to the advice being given:

- Complaint and correspondence from [Mr and Mrs A]
- Adverse Events Review Report from [the DHB]
- Clinical notes from [Mrs A's] admission to [the hospital]
- [Baby A's] post mortem report
- [The DHB's] Foetal Monitoring Policy
- [Ms B's] response
- [Ms E's] response
- [Ms C's] response

Background and Summary
[Mrs A], gravida 2 parity 0; with an expected date of delivery of […] taken from her last menstrual period. [Mrs A] was admitted to [the hospital's] Delivery Suite at 2320hours [date] during the 39 week gestation. Midwife (MW) [Ms B's] assessment was that [Mrs A] was in early labour (latent phase of labour) and suggested plan of

management was for [Mrs A] to go home and await the establishment of labour. [Mr and Mrs A] chose to remain in hospital. [Baby A's] foetal heart rate (FHR) was 154–158 beats per min (bpm) upon admission assessment and 146–154 bpm at 2355hours. [Mrs A] was seen at 0045hours [on the day of delivery]. No physical assessment was done at this time.

[Mr A] activated the call bell at approximately 0200hours, due to [Mrs A's] pain; MW [Ms E] responded and commenced running a bath. MW [Ms B] returned to the Delivery Suite and this information was passed on to her by MW [Ms E].

At 0210hours MW [Ms B] assessed [Baby A's] FHR and documented FHR at 102bpm. At 0231hours Associate Clinical Midwife Manager (ACMM) MW [Ms C] and MW [Ms B] were present. MW [Ms C] paged the Obstetric Registrar.

Obstetric Registrar [Dr D] arrived at approximately 0244hours. [Dr D's] assessment showed that [Mrs A] was 6 cm dilated; a foetal scalp electrode (FSE) was applied with no foetal heart activity detected. An ultrasound confirmed no foetal heart activity. [Dr D's] management plan was to deliver [Baby A] by forceps due to reports of [Baby A's] FHR at 90 upon his arrival in the room. An emergency call was activated for the Neonatal Team. [Baby A] was delivered stillborn at 02:50hours.

My response to the advice required is as follows:

Standard and appropriateness of midwifery care provided by:

- *[Ms B]*
- *[Ms E]*
- *[Ms C]*

All of the New Zealand College of Midwives (NZCoM) Standards (2008) are applicable to this case, either during interaction with [Mr and Mrs A] or following the case. Under each section I have selected the standards which are most applicable to the advice requested and commented on the appropriateness of the midwifery care.

Appropriateness of the monitoring of [Mrs A] between her admission and when [Mr A] rang the call bell.

The NZCoM Standards (2008) applicable are:

Standard

1. The midwife works in partnership with the woman
2. The midwife upholds each woman's right to free and informed choice and consent throughout the childbirth experience
5. Midwifery care is planned with the woman.

The monitoring of [Mrs A] was of an acceptable standard. The clinical notes and [Ms B's] response reflect evidence of the above standards.

The initial assessment was that [Mrs A] was in the latent phase of labour. There is no research to validate timing of assessments during the latent phase of labour. Usual

practice ranges between 1–4 hours based on the individual assessment of the woman's need.

At any time labour can change from the latent phase to established labour. No one can predict when this will occur. The diagnoses of established labour occurs after labour has commenced and rely on assessments by the midwife and the woman and family requesting assistance as they become aware of progression.

Were [Ms B's] actions reasonable when she first had concerns once she suspected an unsatisfactory foetal heart rate? Was [Ms B's] call for assistance from [Ms C] within an appropriate time-frame?

The NZCoM Standards (2008) applicable are:

6. Midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk.
    - Demonstrates competency to act effectively in any maternity emergency situation

[Ms B's] practice does not meet the expected standard for both of these questions. The departure from this standard is moderate, acknowledging that the cause of the outcome is irrelevant in determining as to whether there is a departure from the accepted standard.

When the foetal heart was suspected to be 102 beats per minute [Ms B] initially tried different positions to assess the fetal heart rate, which is acceptable. The time to do this would usually be three to five minutes. It appears to have taken [Ms B] up to 15–20 minutes before seeking assistance. When [Ms B] was not able to assess a fetal heart within the normal range the first action expected would be to call for help. A midwifery assist bell or emergency bell would usually receive a quicker response than leaving the room and finding the Associate Charge Midwife Manager (ACMM). While help is coming the midwife in the room would be expected to continue with the assessment. The usual next action is to assess vaginally and artificially rupture the membranes and attach a fetal scalp electrode if the cervix is dilated adequately.

Health professionals are required to act according to what they assess. If an assessment is incorrect for example no foetal heart or a normal/recovered foetal heart rate, the health profession has acted according to what she/he assessed at the time.

Were [Ms C's] actions reasonable when she was called in to assist [Ms B]? Was [Ms C's] call for assistance for [Dr D] the appropriate course of action at that time, and was it within an appropriate time-frame?

The NZCoM Standards (2008) applicable are:

1. Midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk.
    - Demonstrates competency to act effectively in any maternity emergency situation

The sequences of [Ms C's] actions are portrayed differently in the notes compared with the responses and also the timing is not accurately written. A fair assessment of practice against the standard cannot be made.

The expected practice would be that once [Ms C] confirmed fetal distress or an absence of a fetal heart rate, the first action would be to call for assistance. This would usually be an emergency call which would notify all staff at once. [Ms C] chose to page the Obstetric Registrar and this may have been quicker in this situation/environment. Calling for assistance would be a priority over other actions such as bringing the ultrasound for the Obstetric Registrar to confirm fetal heart activity. If other staff are available in the unit, they could assist to bring necessary equipment.

The standard of clinical documentation by:

[Ms B]
[Ms E]
[Ms C]

The NZCoM Standards (2008) applicable are:

5. The midwife collates and documents comprehensive assessments of the woman and/or baby's health and wellbeing.
6. The midwife maintains purposeful, on-going, updated records and makes them available to the woman and other relevant persons.

Midwifery Council of New Zealand's 'Competency 2.16: provides accurate and timely written progress notes and relevant documented evidence of all decisions made and midwifery care offered and provided;' (pg9; NZCOM 2008)

During an emergency complete documentation by the staff carrying out the actions is not often possible to be written at the time events are occurring. It is acceptable practice for someone to keep time of different events during the emergency and for notes to be written retrospectively as soon as possible, acknowledging in the notes that they are retrospective and including the time of events occurred in the body of the notes.

[Ms B]
The documentation was not of an acceptable standard. The departure from the standard is mild.

On the second sheet 3, documentation by MW [Ms B] has the time of 0215hours which may or may not be written in retrospect. Again timeframes of when actions have occurred, even approximation are not included.

[Ms E]
The documentation was of an acceptable standard. This advice has changed following reviewing [Ms E's] statement and the Clinical notes.

[Ms C]
The documentation was not of an acceptable standard. The departure from the standard is moderate.

Documentation by [Ms C] at the bottom of Examination and Progress Form sheet 2 and top back of sheet 2 is illegible, appears not to be entered in chronological order of entry and while it is written in retrospect it is unclear what actions occurred at what time. The amount of documentation is minimal in comparison to her actions and involvement with [Mrs A].

Which professional standards and guidelines are applicable in relation to this complaint?

Included in the body of the report.

References

New Zealand College of Midwives (NZCOM) 2008a Handbook for Practice. NZCOM Christchurch"

9 October 2012 — further advice
"… [deleted as repeat of earlier advice]

The following sources of supporting information that were sent have been reviewed prior to the advice being given:

Complaint and correspondence from [Mr and Mrs A] and family members, including response to [the DHB] report
Adverse Events Review Report from [the DHB]
Clinical notes from [Mrs A's] admission to [the hospital]
[Baby A's] post mortem report
[The DHB's] Foetal Monitoring Policy
[Ms B's] response, received 20 January 2012
[Ms E's] response, dated 9 January 2012
[Ms C's] response, received 20 January 2012-10-02

In addition:
Notification of investigation letters, dated 23 April 2012
Response to notification of investigation from [Ms B], received 28 May 2012
Response to notification of investigation from [Ms C], received 28 May 2012
Response to notification of investigation from [the DHB], received 28 May 2012
Interview summaries from [Ms C] and [Ms B]
Amended interview summary for [Ms C]
Letter from [Ms B] regarding interview summary
Information from [Ms F], received 7 July 2012
File notes from phone calls with [Mr and Mrs A] (9 July and 21 August 2012).

Information from [the DHB] including page report and 777 report.

Background and Summary

[Mrs A], gravida 2 parity 0; with an expected date of delivery of [date] taken from her last menstrual period. [Mrs A] was admitted to [the hospital's] Delivery Suite at 2320hours [date] during the 39 week gestation. Midwife (MW) [Ms B's] assessment was that [Mrs A] was in early labour (latent phase of labour) and suggested plan of management was for [Mrs A] to go home and await the establishment of labour. [Mr and Mrs A] chose to remain in hospital. [Baby A's] foetal heart rate (FHR) was 154–158 beats per min (bpm) upon admission assessment and 146–154 bpm at 2355hours. [Mrs A] was seen at 0045hours [on the day of delivery]. No physical assessment was done at this time.

[Mr A] activated the call bell at approximately 0200hours, due to [Mrs A's] pain; MW [Ms E] responded and commenced running a bath. MW [Ms B] returned to the Delivery Suite and this information was passed on to her by MW [Ms E].

At 0210hours MW [Ms B] assessed [Baby A's] FHR and documented FHR at 102bpm. MW [Ms B] tried different positions to locate the FHR, re-palpated [Mrs A] to re-assess [Baby A's] position. Obtained a cardiotocograph (CTG) machine and assessed that the cardiac transducer was not working. [Ms B] left the room to obtain another which was stored only a few doors down. Spoke to the Associate Clinical Midwife Manager (ACMM), MW [Ms C], to inform her of the situation and asked her to come. The ACMM also assessed with a sonicaid and then with a CTG.

An ultrasound scan (USS) was brought to the room at some point and used.

The ACMM instructed MW [Ms B] to do a vaginal examination (VE), artificial rupture of membranes (ARM) and fetal scalp electrode (FSE) application while she went to call the Obstetric Registrar and others. A call to locate the Obstetric Registrar originating from [the hospital] was logged with the call system at 0231hours.

Obstetric Registrar [Dr D] arrived. His assessment showed that [Mrs A] was 6cm dilated; a FSE was applied with no foetal heart activity detected. [Dr D's] management plan was to deliver [Baby A] by forceps due to reports of [Baby A's] FHR at 90 upon his arrival in the room. The Obstetric Registrar requested the ACMM to put out an emergency call for the neonatal team which was logged with the call system at 0246hours, and to inform the Obstetric Consultant. [Baby A] was delivered at 0250hours following a local anaesthetic application then the first attempt with the forceps which was discontinued with [Mrs A] still experiencing pain. Another dose of local anaesthetic was administered and the second pull with forceps.

Following the review of the additional information, my response to the advice required is as follows:

Standard and appropriateness of midwifery care provided by:
[Ms B]
The documentation was not of an acceptable standard. The departure from the standard is mild.

[Ms C]
The documentation was not of an acceptable standard. The departure from the standard is mild.

a. Please describe the CTG trace in detail (including the timing it shows). Please note that we have been unable to verify the accuracy of the times shown.

The CTG trace cannot be interpreted as either a fetal heart or maternal pulse. The markings on the CTG trace show attempts of using the CTG at certain times. Even though the timing has not been verified the time taken between attempts of these times will be accurate. I have aligned the times of when the CTG was turned on, which may relate to actions of staff. The photocopy of the trace has no identification label of [Mrs A] on it.

- 02:15hours markings show a potential heart rate between 60–105 beats per minute (bpm). This could potentially correlate with the first attempt with the CTG machine to find a fetal heart by [Ms B].
- 02:22hours (7 minutes later) No markings are present. This shows the machine was turned on. This could potentially correlate with the first attempt with the CTG machine to find a fetal heart by [Ms C].
- 02:28hours (6 minutes later) Markings show a potential heart rate between 80–160 beats per minute (bpm). No one can recall writing on the CTG 'ACM called to room Reg called'. The timing of this documentation cannot be validated.
- 02:35hours (7 minutes later) A thin line and markings commence following the ARM and FSE application by the Obstetric Registrar. This coincides with recollection of the timing of his arriving into the room by the midwifery staff. The documentation on the CTG trace 'can't get fetal heart' reflects potentially even though markings were being printed, there was no confirmation that this was a fetal heart.
- 0253hours (18 minutes later) The thin line markings discontinue.

b. Were [Ms B's] actions reasonable from when she first suspected an unsatisfactory fetal heart?

c. Was [Ms B's] request for assistance from [Ms C] made appropriately and within an appropriate time frame?

d. Were [Ms C's] actions reasonable from when her assistance was requested by [Ms B]?

The above questions cannot be answered with complete certainty. I cannot assess if [Ms B's] and [Ms C's] actions were reasonable with the additional information provided.

The actions that [Ms B] and [Ms C] describe themselves to have completed were reasonable responses. The discrepancy in the timeframe, in my opinion, leaves approximately 10 minutes difference between [Ms B's] recollection and [Ms C's] recollection unanswered for.

My advice in the 6 April report was as follows:

'When the foetal heart was suspected to be 102 beats per minute [Ms B] initially tried different positions to assess the fetal heart rate, which is acceptable. The time to do this would usually be three to five minutes. It appears to have taken [Ms B] up to 20 minutes before seeking assistance. When [Ms B] was not able to assess a fetal heart within the normal range the first action expected would be to call for help. A midwifery assist bell or emergency bell would usually receive a quicker response than leaving the room and finding the Associate Charge Midwife Manager (ACMM). While help is coming the midwife in the room would be expected to carry on the assessment. The usual next action is to assess vaginally and artificially rupture the membranes and attach a fetal scalp electrode if the cervix is dilated adequately.' (pg 3, 4)

The change of advice is due to the further information from [Ms B] giving greater detail of her actions and that she spoke with [Ms C] while collecting the second cardiac transducer. [Ms C's] recollection of [Ms B] coming to her office with the cardiac transducer to inform her of the situation also confirms this; however [Ms C's] timing is different. [Ms C's] timing does not correlate with [Ms B], or the CTG recorded time and/or the locater call to the Registrar at 0231hours. It now appears that the time taken for [Ms B] to notify [Ms C] was significantly less then 20 minutes.

[Ms B] undertook to confirm her assessment of the FHR with a CTG and request help. The action of attempting to assess the FHR with a CTG is expected practice. [Ms B] notified [Ms C] during the time of obtaining the CTG machine cardiac transducer to be able to complete her assessment. The next step is to assess with FSE while help is being requested. [Ms C] requested [Ms B] to do this while she called for help.

With the additional information I could still not decipher at what time events occurred between 0210hours and 0231hours due to the varying recollections presented. This included the exact timing [Ms B] notified [Ms C]; what occurred when they were both in the room prior to the 0231hours locator call to the Obstetric Registrar; and who and at what time the USS was retrieved and used.

[Ms C's] recollection of timing of events and what her actions were are inconsistent with other sources of information. Please see response to question 'e.'

This specifically relates to [Ms C's] recollection of the timing of events which is different to [Ms B's] recollection and the time recorded on the CTG and the time of the locator call to the registrar. Another aspect which is different is [Ms C's]

recollection of the retrieving and usage of the USS which is different to [Ms B's] documentation in the notes and the recollection of the family.

e. Your view on the length of time taken from an unsatisfactory fetal heart rate being noted, to calling the Registrar (noted as 21 minutes from the clinical records). It would be helpful if you could provide alternatives based on the accounts of [Ms B], [Ms C] and the family.

In my view a length of time of 21 minutes from the initial recognition of an unsatisfactory FHR being noted, to calling a Registrar does not meet an expected and usual practice.

[…] The following are the main discrepancies:

The timing of when MW [Ms B] informed [Ms C].

- MW [Ms B] recalls it was 5–10 minutes following her first assessment of an un-reassuring FHR at 0210hours.
- [Ms C] recalls it was at 0230hours.
- Family recalls it was after [Ms B] had assessed with sonicaid and CTG.
- CTG machine first commenced and showed cardiac markings at 0215hours and 0222hours. Either of these times could have been when both MW [Ms B] and [Ms C] returned to the room together.
- NB. The CTG timings have not been confirmed.

The retrieval of the USS and usage.

- MW [Ms B] recalls being asked to get the USS and documented that [Ms C] used it.
- [Ms C] recalls getting it herself between 0235hours and 0244hours and not using it.
- The registrar documented that USS was in the room when he arrived and USS performed.
- Family recall [Ms C] obtaining and using the USS.

The timing of the [Ms C's] call to the Obstetric Registrar

- [Ms B] recalls this was while she was doing a VE and attempted ARM.
- [Ms C] recalls that she had been in the room about 5 minutes prior to this.
- Pager system records show this call occurred at 0231hours.

The timing of the arrival of the Obstetric Registrar.

- The Obstetric Registrar documents arrival at approximately 0244hours.
- MW [Ms B] and [Ms C] recall shortly after the Registrar was located, within 5 minutes.
- The CTG trace reflects a thin line from 0235hours which is most likely from the FSE that the Obstetric Registrar applied. In contrast with this, it is documented that there was no FHR at this point.

f. Do you have any recommendations for any of the providers involved in this complaint?

[Ms B] and [Ms C] have both reflected on this situation and reflected on their practice. They have both completed education on documentation and changed their practice accordingly.

Health professionals are required to act according to what they assess. If an assessment is incorrect for example no foetal heart or a normal/recovered foetal heart rate, the health professional has acted according to what she/he assessed at the time. A recommendation is to consider that by escalating an unreassuring FHR via either a midwifery assist bell or emergency bell would be quicker in this situation than walking to notify the ACMM on shift. Upon reflection this action may also have notified medical staff in the ward."

4 December 2012 — further advice

"*When [Ms C] was alerted to concerns, who was responsible for the care of this woman and baby?*

Both midwives were responsible for the care of this woman according to information they had and the assessment they performed. The NZCoM Standards (2008) 6 'Midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk.'

In an employed situation, a staff midwife would take clinical leadership and direction from a designated senior midwife, unless the staff midwife had concerns that the action or lack of action that was occurring was unsafe.

If [Ms C] had arrived at 2.22am (and the call to the Registrar was at 2.31am), would this time-frame (of about 9–10 minutes) represent appropriate care?

In my opinion, with the information I have received, I do not agree that 9 minutes represents appropriate care from being informed of a possible fetal bradycardia to requesting medical assistance. I could not find any research or literature review available which stated what an appropriate time would be from concern and/or recognition of an abnormal fetal heart to escalation to a medical professional.

I asked a variety of health professionals (total number of 10), ranging from a graduate midwife, senior midwives, lead maternity carer and obstetric consultants at Counties Manukau District Health Board the question 'In the Assessment Labour and Birthing unit at Middlemore Hospital, how long from concern/recognition of a fetal bradycardia would you expect an emergency call to be put out to the Obstetric team?' The responses were generally around 2–3 minutes with a maximum of 5 minutes allowing for different situations. No other information was given to them in seeking their response.

I note that your preliminary advice states that [Ms C's] departure from expected standards was moderate, but this is changed to be mild in your further advice. Could you please explain the reason for this?

In reference to the standard of documentation, this changed after more information was sent through. I considered what reasonable practice in an equivalent situation would be and decided that the expected standard had not been met and that the deviation from the standard was mild.

Reference
New Zealand College of Midwives (NZCOM) 2008a Handbook for Practice. NZCOM Christchurch

Does a suspected fetal heart of 102bpm constitute fetal distress?

A fetal heart rate of 102bpm in isolation does not constitute fetal distress. A bradycardia is described as <110bpm (RANZCOG 2006, pg 25). A prolonged bradycardia of <100bpm for > 5 minutes is very likely to be associated with fetal compromise requiring immediate management.

The following is from RANZCOG (2006, pg 9) 'Good Practice Note' on Management of fetal heart rate patterns considered suggestive of fetal compromise.

'The following features are unlikely to be associated with significant fetal compromise when occurring in isolation:

• Baseline rate 100–109.
• Absence of accelerations.
• Early decelerations.
• Variable decelerations without complicating features.

The following features may be associated with significant fetal compromise and require further action, such as described in Guideline 10:

• Fetal tachycardia.
• Reduced baseline variability.
• Complicated variable decelerations.
• Late decelerations.
• Prolonged decelerations.

The following features are very likely to be associated with significant fetal compromise and require immediate management, which may include urgent delivery:

• Prolonged bradycardia (<100 bpm for >5 minutes).
• Absent baseline variability.
• Sinusoidal pattern.
• Complicated variable decelerations with reduced baseline variability.
• Late decelerations with reduced variability. See Appendix E for definitions.'

At 2.10am, who should have been called, according to normal/expected practice?
When [Ms B] was not able to assess a fetal heart within the normal range, she was concerned that the machine was not working correctly and went to obtain another piece of equipment. At this point [Ms B] spoke to [Ms C] informing her of the situation.

If there had been no concern about the equipment the expected practice would be to call for help by using a midwifery assist/emergency bell. While response to the call bell is coming the midwife in the room would be expected to carry on the assessment. The usual next action is to assess vaginally and artificially rupture the membranes and attach a fetal scalp electrode if the cervix is dilated adequately.

If concern remains regarding fetal wellbeing then an emergency call to the Medical team.

Health professionals are required to act according to what they assess. If an assessment is incorrect for example no foetal heart or a normal/recovered foetal heart rate, the health professional has acted according to what she/he assessed at the time.

References
Retrieved from http://www.ranzcog.edu.au/publication/womens-health-publications/intrapartum-fetal-surveillance-clinical-guidelines.html
The Royal Australian and New Zealand College of Obstetricians and Gynaecologists; Intrapartum Fetal Surveillance: Clinical Guidelines — Second Edition (2006).”

16 January 2013 — further advice

“*Please say what departure from expected standards it would be if [Ms C] has arrived in the room at 2.22am, and called the Registrar at 2.31am.*

If a Clinical Charge Midwife is called into a room by another midwife with a concern of a fetal heart. The Clinical Charge Midwife is then not able to find a normal fetal heart from her assessment and takes 9 minutes to request medical assistance; the departure from the expected standard is moderate.”