Midwife, Ms B

General Practitioner, Dr C

A Report by the

Health and Disability Commissioner

(Case 01HDC03203)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Ms A	Consumer
Dr A	Consumer's husband
Ms B	Midwife / Provider
Dr C	General Practitioner / Lead Maternity Carer

Introduction

There are few events sadder than the stillbirth of a child. This report is about one such case. Ms A and Dr A were expecting their first child. After an apparently normal pregnancy, Ms A went into labour at the anticipated time. Tragically, 24 hours later, it was confirmed that her baby girl, baby A, had died before she was born.

At the outset I wish to acknowledge the loss suffered by Ms A and her husband, Dr A. I offer my sincere condolences.

This report is about the care that Ms A received both prior to baby A's death, and also in the days following. Ms A and Dr A are concerned that their midwife, Ms B, was not sufficiently responsive to Ms A's labour, and left Ms A without midwifery support for too long. Ms A and Dr A are also concerned at the level of care they received from their lead maternity carer, Dr C, especially in the post-partum period.

The purpose of this report is to examine the maternity services that were provided by Dr C and Ms B, and to report my opinion as to whether these services were provided in accordance with the Code of Health and Disability Services Consumers' Rights ("the Code").

Complaint

On 16 March 2001, I received a complaint from Ms A and Dr A. The issues I have investigated as a result of that complaint are as follows:

Ms B, midwife, did not provide adequate information and the appropriate standard of health care to Ms A. In particular, Ms B:

- *did not ensure that, during Ms A's pregnancy, Ms A was appropriately informed of the risks of labour and the range of medical interventions available to mitigate these;*
- *did not respect Ms A's choice of Dr C as her Lead Maternity Carer;*
- *informed Ms A that she should not contact Dr C during labour;*

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

- *did not take appropriate measures during Ms A's labour on 25 and 26 November 2000. In particular, Ms B:*
  - *did not visit her home and monitor her baby, until Ms A had been in labour for 15 hours*
  - *did not listen to the concerns that Ms A and Dr A had about the nature of her contractions*
  - *did not seek appropriate information from Ms A or Dr A about the progress of her labour*
  - *informed Dr A that Ms A could not go to hospital to have her baby checked without her*
  - *did not appropriately liaise with Dr C about the progress of Ms A's labour;*
- *incorrectly suggested to Ms A immediately after the delivery that her baby died as a result of the umbilical cord being around her baby's neck;*
- *did not ensure that Ms A was provided with appropriate postnatal mental health care;*
- *did not keep accurate records of her contact with Ms A and Dr A during her labour.*

Dr C did not provide adequate information and the appropriate standard of health care to Ms A. In particular, Dr C:

- *did not act as the primary carer during Ms A's pregnancy, despite being her Lead Maternity Carer and being informed on several occasions by Ms A that it was her preference for Dr C to be her primary carer;*
- *did not appropriately manage, as Lead Maternity Carer, Ms A's care during labour. In particular, Dr C did not ensure that:*
  - *Ms A was able to contact Dr C after-hours if necessary*
  - *Ms A's baby would be adequately monitored during her labour;*
- *did not ensure that Ms A was provided with adequate postnatal medical and mental health care;*
- *did not inform relevant staff at the medical centre where Dr C worked that Ms A's baby had died.*

An investigation was commenced on 13 September 2001.

Information reviewed

- Letter of complaint and supporting documentation
- Response to complaint from Ms B and Dr C, including clinical records
- Transcripts of interviews with Ms A, Dr A and Ms B
- Copy of file in relation to medical misadventure claim from ACC.
- Independent expert advice obtained from Ms Joyce Cowan, midwife.

Information gathered during investigation

Background
Ms A was 30 when she became pregnant to her husband, Dr A. Her maternity care was shared between Dr C, general practitioner, and Ms B, midwife.

Ms A's pregnancy was essentially normal, although she did experience a bout of gastritis at 37 weeks.

Ms A saw Dr C in relation to the pregnancy on 28 March 2000, at which time she was six weeks pregnant. Dr C provided all the antenatal care until Ms A was 20 weeks pregnant, and at 14 weeks they discussed the necessity to get a midwife as well. Ms A recalls discussing the issue of shared care, and being told that she needed a midwife even though Dr C was the lead maternity carer.

When she had her first meeting with her midwife, Ms B, Ms A recalls being told that from that point Ms B would take alternate antenatal visits with Dr C, in order that she develop a working relationship with Ms B prior to labour and delivery.

In her complaint, Ms A stated that she did not consider that she had been sufficiently informed as to the risks during labour, or the options available to mitigate these risks. She felt that she had been "subjected to a particular ideology [in favour of a natural process, rather than interventions] that was at no time justified to us".

Ms B's clinical notes do record, however, that there was some degree of discussion with Ms A and Dr A regarding different intervention options during the labour. Ms B informed me that on 16 November she discussed with Ms A different birth scenarios, and gave Ms A and Dr A a guided tour of the Delivery Suite at a Public Hospital. Ms B informed me that during that tour, she discussed with Ms A and Dr A a number of matters including pain relief, the use of the birthing rooms for intervention-free labours, the theatre rooms and the circumstances in which those rooms would be used (eg, forceps or Ventouse delivery), the involvement of paediatricians, Caesarean sections, the use of the CTG machines and the monitoring of the baby throughout labour.

Ms B also provided the couple with a MATPRO Maternity Guide and a pamphlet entitled "Epidurals for Labour and Delivery". The MATPRO booklet contains discussion of different labour scenarios such as induction of labour, Caesarean sections and transfer of care to the hospital staff.

On the morning of Saturday 25 November 2000 Ms A felt what she thought were minor contractions, which she described as "short, mild and infrequent cramps". Ms A stated that she last felt the baby move around midday that day; she specifically remembers this as she initially mistook the movement for a contraction.

There is a conflict in the accounts of Ms A and Ms B regarding when Ms A was told to call Ms B at the onset of labour. Ms A's recollection was that one of three preconditions had to be met – when her contractions were five minutes apart, there was a show or her waters

broke – and at that point she should call Ms B. Ms B states that no such pre-conditions existed; she informed me that she had told Ms A to contact her when they thought that "something was happening", when there were signs of labour. She informed me that it is helpful for her to know when a woman is going into labour because it helps her to plan her day, which can involve prioritising numerous commitments to other clients.

Initial phone call on 25 November
About 9.00pm on the evening of Saturday 25 November, Ms A called Ms B to let her know that labour had started, and that her contractions were five minutes apart. When Ms A called, Ms B was in the delivery suite, and so called Ms A back after about 20 minutes. Ms A informed her that the since about 6.30pm the contractions had been about five minutes apart, and just under a minute in length.

Ms A described the contractions as "intense", although Ms B has recorded them as being "short and mild". Ms A was coping with the contractions, and described herself as being "on something of a high". While there is dispute as to the exact description of the nature of the contractions, the contractions were five minutes apart and regular and there was nothing to indicate the need for any immediate assistance.

Ms A recalls Ms B telling her to call her if there was any change. Ms B, on the other hand, informed me that she told Ms A that she should call "any time". In reality, I do not think anything rests on this disputed wording. I consider that if either Ms A or Dr A had felt they needed to contact Ms B for any reason, they would have done so, and Ms B would not have intentionally indicated that further contact was to be made only when certain conditions were met.

Midnight phone call
The next contact was shortly after midnight that evening. Ms A was in the shower, and Dr A called Ms B, appraising her of the situation at home. At this stage, Dr A stated that Ms A's contractions were regular and over a minute in length. Dr A noted that at times his wife was doubled over with the pain and that when he called Ms B, his wife was in the shower trying to get some relief.

Ms B recorded information about Ms A's condition and that she was "coping". It appears that she formed this view based on her conversation with Dr A. In response to the provisional opinion, Dr A emphasised that he advised Ms B of Ms A's level of pain, the fact that she was sometimes doubled over, and that she was taking a shower to relieve the pain. Dr A suggested that "coping" was a subjective concept, but what was of more significance was the fact that he had described the extent of the discomfort and pain that Ms A was experiencing. However, Dr A also stated that although Ms A was in pain, they were aware labour was a painful process and did not want to "overstate the case". He considered that Ms A was able to stay at home at that point in time and was not losing control.

While I accept that the concept of "coping" could cover a wide range of situations, on the information available it appears that there was some common level of understanding that managing the labour at home was not physically beyond Ms A at that point.

Dr A states that he asked directly whether they could go to hospital to "get the baby checked out". He asked this not because they were specifically concerned about the welfare of either the baby or the mother, but so that they could get some idea of whether the labour was progressing. Dr A stated that the communicated intention was to get the baby checked and to return home. Ms A and Dr A stated that Ms B said that they could not go to hospital without her also being present. At interview Dr A said that he had made a "suggestion" that they go to hospital, and that once he had mentioned the possibility, there was no basis on which to insist that they go.

Ms B does not agree that she said that they could only go to hospital if she were present. She states that she was only asked when they should go to hospital, to which she replied when Ms A felt she needed to go. Ms B stated that Dr A asked whether they could "just go there" and she told them that they should first call her, so that she could notify the hospital of the admission. Ms B stated that this is common practice, and it is the expectation of the staff in the Delivery Suite at the Public Hospital, that the midwife will inform them when a woman is to be admitted. This is consistent with what she recorded in the clinical notes.

Ms B does not recall at any stage being told that Ms A and Dr A wanted to have the baby checked. At interview, Ms B said that she would have treated a specific request to have the baby checked as a "point of alert". She stated that her natural response to a question like that would be to ask, "Why is this person asking me this question?" Ms B also stated that a request to go to hospital is also something to which she would always respond, as it is often a good indication that the woman is becoming restless in her own home and thus that the labour is progressing.

There is sufficient information about this conversation to allow me to reasonably consider that what occurred was probably a fusion of the two accounts. I consider it likely that Ms B did not interpret Dr A as making a request to go to hospital and, based on the information she received from Dr A, considered Ms A able to continue to labour at home.

Ms B states that she asked Dr A to tell Ms A to call her back once she was out of the shower, as she always prefers to speak directly to the labouring woman. She informed me that it is important to be able to hear the woman, as in listening to her voice the midwife can obtain pointers as to how the woman is doing from the tone of her voice. It can also be helpful to listen over the telephone to the woman having a contraction, as this provides information about what is actually happening. Ms B's clinical notes record that she asked for Ms A to call her back.

Dr A states that no such request was made. At the time he made the phone call to Ms B he was feeling "vaguely sort of impotent and quite anxious". Having appraised Ms B of all the information, if he had been given the chance to have the information presented to her another way through Ms A, he would have "jumped at that".

At interview, Ms B was asked why, when she did not hear back from Ms A, she did not call Ms A herself. Ms B explained that there is always the possibility that the contractions could have eased off after the shower; when she did not hear back she assumed that was what had happened, and it would not have been appropriate to call back at that hour to check on

progress. Ms B also noted that Ms A could have called her back if she had been concerned about anything, as she had been told on a number of occasions that she could call any time.

While Dr A told me that he understood that they should call back only when the situation changed, I am satisfied that if Ms A had been specifically concerned about her welfare, or the baby's, she could have called Ms B at any stage during the night. Neither Ms A nor Dr A has suggested that they expected a negative reaction from Ms B if they telephoned her.

It is accepted that during the telephone conversations there was no specific discussion of the issue of foetal movement.

Subsequent events
Ms A called Ms B shortly after 7am the following morning, and according to her notes Ms A informed her that the contractions were less frequent and not as painful as previously. It was agreed that Ms B would have some breakfast and then come round to assess and examine Ms A.

Ms B arrived at about 8.45am. She stated that when she arrived she asked Ms A why she did not call back during the night, and Ms A replied that she had got some rest over the course of the night. Ms A denies that this question was asked or that she had had any rest during the night.

On examining Ms A, Ms B was unable to locate a foetal heartbeat and accordingly arranged to meet Ms A and Dr A at the Public Hospital. After some further tests, it became apparent that the baby had died.

The time following Baby A's death was difficult for Ms A and Dr A. Sadly Ms A felt that she was unsupported by her carers, and that the counselling support that she did receive was inappropriate to meet her needs and wishes.

Ms B informed me that she visited daily after Ms A returned from hospital, for ten days, until Ms A and Dr A went on holiday. Ms B's notes over this period record a number of interactions with the couple during which issues of how they were coping, as well as their emotional reactions to events, were discussed.

Ms A pointed out that these visits were paid for by MATPRO as part of the midwifery services she was contracted to provide. I accept that this may be the case, but this does not alter the fact that the visits were made; nor does it alter the character of the interactions that took place during those visits.

As well as offering her own services by being able to be contacted at any time and by discussing coping and recovery issues – both physical and emotional – as they arose, Ms B also put Ms A and Dr A in touch with an experienced grief counsellor. Ms B informed me that the counsellor is "highly regarded in the obstetric community" for her knowledge and experience of working with bereaved parents. Ms B recorded that Ms A and Dr A found their first meeting with this counsellor to be a "very positive and helpful experience". Ms B

also noted that the counsellor stayed in contact for a number of weeks, and said that the counsellor informed her that the couple was "getting on well with their grief work".

Ms B also discussed with Ms A and Dr A the Stillbirth and Newborn Death Support (SANDS) group and provided them with a pamphlet. Ms B notes that the couple chose not to contact the organisation at that point.

Ms A feels that the support she was given was inadequate. She acknowledges that at the time she did not indicate that she required further or different assistance, but that it would have been unrealistic for her to do so, given that she was not in a position to respond rationally to her situation. In relation to the counselling she received, Ms A questions whether it was in fact grief counselling; she views it as on occasions having provided a degree of comfort, rather than counselling. I note that the counselling services Ms A received are not the subject of this investigation, although I acknowledge that Ms A found some of the counsellor's methods inappropriate.

Ms A recognises that Ms B made an effort to assist, but felt that the assistance that Ms B offered was also inappropriate and not helpful. Ms A also felt that Dr C felt "uncomfortable" with the situation and as a result did not have sufficient contact with the couple.

Independent advice to Commissioner

I obtained the following independent expert advice from Ms Joyce Cowan, a midwife:

"**Documents and records reviewed**

- Summary of relevant factual background drafted by the Commissioner's office
- A copy of the letter of complaint
- Response to the complaint from Ms [B]
- Copy of the relevant clinical records
- Midwives Handbook for Practice

Questions requiring expert advice

When Ms [B] was first notified of the commencement of labour on the evening of 25th November, was it appropriate to manage labour over the telephone at that point in time, rather than examine and assess Ms [A] in person?

Yes. The phone call was a notification of the onset of contractions and it was clear that Ms [A] was managing well and not concerned. The pregnancy had progressed well antenatally and had only just reached full term. The baby had been moving well at the last recorded antenatal visit and there were no identified risk factors. Ms [A] had visited her GP LMC two days previously and there had evidently been no concerns.

Ms [B] made it clear that Ms [A] could call her back at any time and expected to be called back sometime in the night. As first labours often take a few hours to establish it is not usual for a midwife to visit each woman expecting her first baby at the first phone contact. Management over the phone at this stage was entirely appropriate.

When Ms [B] was first notified of the commencement of labour on the evening of 25th November, should she have specifically asked about the presence of foetal movements?

The answer to this question is not so clear cut. In hindsight the question has increased significance. In reality, although it would be wise to ask about foetal movements at first communication during early labour, I cannot honestly say that every reasonable midwife would do so. During every antenatal visit Ms [B] had recorded the foetal activity and in practice midwives instruct women to report promptly any lessening of foetal movements below 10 episodes of movements per day. Having already established the importance of foetal movements antenatally, it is not unreasonable that Ms [B] did not specifically question Ms [A] about movements when she first made phone contact. Whilst it would have been good practice to question Ms [A] about foetal movements during the first phone contact I do not consider that it was outside the bounds of reasonable practice for Ms [B] not to do so at that point, particularly as there had been no prior concerns.

When Ms [B] was first notified of the commencement of labour on the evening of 25th November, was it appropriate to leave the onus with Ms [A] to call back as required, rather than taking proactive steps in relation to monitoring and checking the progress of the labour?

Yes. When Ms [A] called Ms [B] at 9.30pm on 25th November, the labour was in the very early first stage, not yet established. It is usually not necessary for the midwife to visit a woman that early in her labour but to encourage her to phone back as soon as she wants the midwife to provide further advice or visit her.

Overall, do you consider that Ms [B's] management at this point in time was in accordance with the practice of a reasonable and competent midwife?

Yes I do.

Do you have any other comments in relation to Ms [B's] management of this stage of labour?

No.

When Dr [A] called Ms [B] shortly after midnight on the morning of 26 November was it appropriate, based on the information available to Ms [B] at that time, to continue to manage the labour over the telephone rather than examine and assess Ms [A] in person?

The answer to this question really hinges on the matter of whether or not Ms [B] asked Dr [A] to get his wife to call her after she had finished her shower. Ms [B] maintains that she did in fact make this request. Dr [A] maintains that she did not. In my experience of midwifery practice it is usual to ask to speak to a woman over the phone before deciding on the need to visit or transfer to hospital because it is not always possible to make the appropriate decision by talking to a partner or other support person.

It was reasonable to ask to speak to Ms [A] in person before deciding whether a visit was necessary. In practice if a midwife speaks to the woman herself rather than the partner it is much easier to judge whether it is time to visit the woman at home or arrange a hospital admission. A support person's assessment of the progress of labour may be different from the impression gained by a midwife actually talking to the woman, especially when she has a contraction during the phone conversation. For example an experienced midwife recognises distinct breathing changes during contractions associated with progress through labour. Ms [B] was expecting to have a phone call from Ms [A] after she finished her shower and from this phone call she would have ascertained the need for a visit or transfer to hospital.

If Ms [B] did in fact ask to speak to Ms [A] in person I consider that it was appropriate to continue to manage the labour over the phone. In that case it is clear that when Ms [B] finished speaking to Dr [A] over the phone shortly after midnight she was intending and expecting to continue the assessment within a short space of time by requesting that Ms [A] phone back after she had finished her shower. At that stage, had Ms [A] been too distressed to make a phone call herself it would have been reasonable practice to visit the couple at home in response to a further call from Dr [A].

If in fact Ms [B] did not ask to speak to Ms [A] in person when Dr [A] phoned at 0030hrs I do not consider that it was appropriate to continue to manage the labour over the phone rather than assess Ms [A] in person.

When Dr [A] called Ms [B] shortly after midnight on the morning of 26th November, should Ms [B] have specifically asked about the presence of foetal movements?

Again, my answer hinges on whether or not Ms [B] asked Dr [A] to have his wife call Ms [B] back. Ms [B] should have asked about foetal movements if she had spoken to Ms [A] who would have been able to answer the question directly. It could be argued that Dr [A] could have asked Ms [A] about foetal movements while she was in the shower and relayed the information back to the midwife by phone. However as Ms [B] was expecting Ms [A] to call in person shortly it was reasonable not to ask Dr [A] about movements during the phone conversation with him.

If Ms [B] did not ask to speak to Ms [A] in person when Dr [A] phoned at 0030hrs, Ms [B] should have specifically asked about the presence of foetal movements when she was making her assessment.

Assuming Ms [B] asked for Ms [A] to call her back when she was out of the shower, was it reasonable, when Ms [A] did not call back, to not telephone Ms [A] to check the progress of the labour, and instead wait for Ms [A] to make further contact?

Clearly, it would have been better for Ms [B] to call back after a short period of time, perhaps 30 minutes after Dr [A's] phone call. However, it was reasonable to assume that the shower had relieved the contractions enough to allow Ms [A] to rest. Sometimes in a first labour the latent phase can be erratic and last several hours and it was reasonable for the midwife to assume that contractions had slowed down after the shower. Given that it was the middle of the night and both the couple and the midwife would need to conserve energy for later when labour would be more active it was not unreasonable for Ms [B] to wait for the couple to phone back.

Ms [B] had understood that she had a good relationship with the couple antenatally, and therefore I imagine she would have thought that they would have felt able to phone her back if they were concerned.

The couple were considerate of Ms [B's] need for rest and did not want to phone unnecessarily in the night. However, from my impression of the situation, Ms [B] would have expected a phone call had she known that Ms [A's] contractions had not settled as she assumed. There is a conflict between what Ms [B] claims to have said about phoning back i.e. 'offered to call [Ms B] anytime if needed', and what Ms [A] claims was said to her husband i.e. 'she said to ring again when there was a change such as a show'.

When assessing labour over the phone it is common practice to suggest further communication when there have been changes such as a show, breaking of the waters or a change in the contractions. A midwife would also usually tell a woman to phone back if she is concerned at all. I acknowledge that it is very difficult to be objective when in pain or when supporting a partner in pain and also that the couple did not want to over-state the severity of the contractions.

In summary of my opinion in answer to this difficult question I consider that: -

It would have been better practice for Ms [B] to call the couple when she did not hear from them after approximately 30 minutes when it would have been expected that Ms [A] had finished her shower. However, not doing so was not unreasonable practice.

The fact that Ms [B] did not call back does not amount to a lack of skill or judgement, or abrogation of responsibility to her client. She understood that they would feel able to call her if concerned. The couple were free to phone back had they wanted Ms [B] to visit.

Overall, do you consider that Ms [B's] management at this point in time was in accordance with the practice of a reasonable and competent midwife?

Yes I do. However, I consider that although it was reasonable to manage the situation as she did given the circumstances, optimal practice would have been to make a physical assessment of Ms [A] in response to the phone call from Dr [A] at 0030hrs.

Do you have any other comments in relation to this stage of Ms [B's] management of the labour?

No.

Given the timing of the phone conversations with Ms [A] and Dr [A] was it appropriate for Ms [B] to have written her notes in the delivery suite after [Baby A's] birth, rather than contemporaneously?

Although it is optimal practice to document any midwifery communication or care contemporaneously it is not always possible or practical. I cannot claim that every competent midwife would get out of bed in the middle of the night to document a phone call. However it is usual to document that notes are written in retrospect if that is the case, and to state the reason.

Are there any other matters that you wish to comment on in relation to this matter?

Yes. I would like to comment on the accessibility of the LMC. Dr [A] and Ms [A] have said that they felt they had no access to their LMC Dr [C] during the night when Ms [A] was having contractions. Whilst I understand that the arrangement was that the midwife would provide the early labour care I do not think it would have been very difficult to contact Dr [C] as the hospital Delivery Suite would have had her phone number. Staff may have been reluctant to give the number to a caller over the phone but had Dr [A] requested contact with Dr [C] they would have been able to phone her and ask her to contact him. However, the most likely action had Dr [A] phoned the hospital is that the duty midwife would have suggested phoning back the midwife as a first option.

It is also usual for an LMC maternity provider to give phone contact details to a client when the maternity contract LMC form is signed at approximately 15 weeks.

In summary, I am very saddened to read of the death of [baby A] and my sympathy goes to her parents. I understand that they are extremely distressed by the loss of their baby and also the thought that something could have been done to save her.

It is impossible to say whether an assessment during the night would have made any difference. Prior to establishment of labour (generally considered to be when the cervix has effaced and started to progressively dilate) women may have painful contractions but do not always need a visit from their midwife. I certainly acknowledge that Ms [A] did experience severe pain throughout the night of 25th November and that she may have been quite distressed. However, Ms [A] was not in established labour when examined by Dr [C] in hospital at approximately 1000hrs on 26th November. At this stage the cervix was posterior and presumably closed because a prostin pessary was

inserted to hasten the process of effacement (softening and shortening), that precedes dilatation.

The midwifery care provided by Ms [B] appears to have been of a reasonable standard, based on the knowledge that she had at the time. Various factors affected communication between Ms [B] and Dr [A]. There are conflicting reports from both parties. However, the fact remains that Ms [B] was accessible by phone at any time. There were no identified risk factors in the pregnancy and [baby A's] death was tragic and unexplained."

ACC investigation

A detailed investigation into Ms B's midwifery care was also conducted by ACC, in considering a claim for medical error in respect of Baby A's death. As part of my investigation I have reviewed ACC's file. Much of the material on the file is directly relevant to the issues I have to consider in forming my opinion on this matter.

What is most apparent from the ACC file is that there is a clear divergence of opinion between the independent midwife who provided advice on the one hand, and the obstetrician advisor and the Medical Misadventure Panel on the other.

Initially, a preliminary finding of medical error was made in reliance on the advice of an obstetrician who considered that the 15-hour delay in physical assessment, and the lack of emphasis on the importance of foetal movement over the course of the pregnancy, in combination amounted to negligence on the part of Ms B.

This finding was challenged by Ms B, and she relied on an opinion provided by an expert midwife. That report concluded that "the decision to await further communication from Ms A was a reasonable practice at that time of night and given there was no indication of urgency or request to visit from Ms A or her partner".

The Medical Misadventure Panel concluded that the midwife had failed to provide care in accordance with the College of Midwives' standards, and thus medical error had occurred.

Ms B then sought a review of the case, but ultimately the review did not address the substantive clinical issues, as the medical error finding was quashed on unrelated legal grounds.

Relevance to this investigation
In the particular circumstances of this case, I do not think it would be appropriate for me to rely on the expert opinion provided during the course of the ACC process as the review did not provide a satisfactory determination of the issues.

Accordingly, in the circumstances, I consider the most appropriate way for me to proceed is to approach the issue independently of the ACC process, based on the advice I have received from my own independent expert advisor.

Post mortem report

The pathologist was not able to determine the cause of death, only that Baby A had been stressed for hours or possibly days prior to her death in utero.

Code of Health and Disability Services Consumers' Rights

The following Right in the Code of Health and Disability Services Consumers' Rights is applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

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

Other relevant standards

Also relevant to this complaint are the standards set out in the New Zealand College of Midwives Handbook for Practice. The handbook states:

> "**Decision Points for Midwifery Care**
>
> These decision points identify the critical times when there ought to be an assessment during pregnancy and childbirth.
>
> The number of decision points does not necessarily reflect the number of consultations nor the depth of knowledge required to make a full midwifery assessment. It is assumed consultations are based on individual need and care given accordingly. …"

It is the Second Decision Point outlined in these standards that is the most relevant to the assessment of the present situation. The Handbook describes this Second Decision Point as follows:

"The Second Decision Point in Labour – When the woman wants intermittent support from Midwife

This timing provides a further opportunity for assessment of the woman in labour.

INFORMATION SHARED

- Check how the woman is feeling about the labour and whether she wants on-going support from her Midwife.

From examination

- Assess woman's well-being, including her emotional and behavioural responses;
- Check blood pressure and pulse;
- Discuss need for vaginal examination;
- Assess contractions, lie, presentation and descent of baby;
- Assess baby's well-being, including heart rate;
- If membranes have ruptured, check liquor.

HEALTH INFORMATION PROVIDED

- Encourage the woman to eat and drink if she wishes;
- Follow birth plan in consultation with woman;
- Encourage her to take up whatever position she feels comfortable in;
- Check that support is available."

Opinion: No breach – Ms B

When I commenced this investigation, a number of matters were notified to Ms B as forming the terms of reference for my investigation. However, as the investigation progressed, it became clear that the fundamental issues are whether Ms B managed Ms A's labour appropriately and whether the postnatal care was appropriate. While Ms A and Dr A have indicated their frustration and disappointment at other aspects of the care that Ms B provided, it is apparent that the above matters are the critical areas of concern, which I will deal with first.

In response to my provisional opinion, Ms A and Dr A emphasised that my opinion failed to explain the role of the midwife in the labour process. While I can understand their point of view, it is important for my role in this matter to be clear. It is not for me to stipulate the clinical responsibilities of health professionals, or to establish guidelines as to the nature and scope of their practice. That is a role for the registration bodies and the professional colleges. My role is instead to assess the services provided in the context of all the circumstances of the individual case and form an opinion – often guided by a peer expert – on whether the services complied with the Code of Rights.

For background purposes, I have included a statement taken from the College of Midwives Handbook as to the role of the Midwife. I emphasise that this is for background only, and at the specific request of the complainants. The actions of Ms B in the present case cannot be judged solely by reference to such a general statement.

The scope of practice of the midwife defined by the New Zealand College of Midwives

The College *Handbook for Practice* defines the scope of practice of the midwife in the following way:

> "The Midwife must be able to give the necessary supervision, care and advice to women prior to, and during pregnancy, labour and the post-partum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant.
>
> This care includes preventative measures, detecting complications in mother and child, accessing medical assistance when necessary and carrying out emergency measures …."

Management of labour

The time between when Ms B was first notified of Ms A's labour, and when she arrived in person to conduct a physical examination, was a period of around 12 hours. During that period, there were three phone discussions between either Ms A or Dr A and Ms B.

In essence, the issues I need to address are whether Ms B responded appropriately to the information available to her over that period by managing the labour over the telephone, or whether she was insufficiently responsive, and should have made a more proactive assessment of maternal and foetal well-being.

An important starting point in considering this issue is the College *Handbook for Practice*, which outlines a number of standards for midwifery practice, and details a number of "decision points" at which the midwife is required to make critical assessments and determine the subsequent course of action.

Unfortunately, on their own, these standards do not provide a clear answer to the critical issues in this case. (It is apparent that the First Decision Point, which requires the midwife to ascertain certain information as to the nature of the contractions and the general state of

the woman, had already been reached.) The fundamental issue in this case is whether the Second Decision Point referred to in the handbook, which requires a physical assessment of the mother and an assessment of foetal well-being, had in fact been reached at the times that Ms A or Dr A spoke to Ms B on the telephone.

In order to assess Ms B's management, I therefore need to assess one essential question, which I have asked of my advisor; was it appropriate for Ms B to continue to manage the labour over the telephone, or was a physical examination of Ms A and the baby required? Related to this is the issue of whether Ms B in fact had sufficient information to be able to appropriately make this decision.

I think it is clear, based on all the information available to me over the course of this investigation, that it would have been preferable for Ms B to visit and physically assess Ms A after the midnight phone call. There is no evidence to establish – or even indicate in any meaningful way – what difference this might have made. My advisor noted that such an assessment would have been "optimal practice". But a provider does not breach the Code simply because they have not complied with optimal practice. Instead, Right 4(1) of the Code demands that practitioners exercise "reasonable care and skill"; this is a materially different standard from "optimal care and skill". The issue for me to determine therefore is whether Ms B acted in accordance with the degree of care to be expected of a *reasonable* midwife.

Initial phone call – 9.00pm, 25 November
It was at this time that Ms A rang Ms B to advise her that contractions appeared to have started, they were about five minutes apart, and had been since about 6.30pm that evening. Ms B decided at that stage that she did not need to visit Ms A to examine her in person. While there is some conflict surrounding the exact nature of the contractions, it is apparent that Ms B's assessment was that Ms A was coping and there was no indication of the need for a visit or other assistance from Ms B.

My expert advisor considered Ms B's decision "entirely appropriate" in the circumstances. She advised that first labours often take some hours to establish, and added that it is not usual for a midwife to visit a woman having her first labour, at the first phone contact. My advisor also noted that there had been no indications of increased risk, as the pregnancy had progressed well and was only just full-term. Furthermore, the previous antenatal visit had recorded that the baby was moving well, and Ms A had seen Dr C only two days previously and there had been no apparent concerns.

It is accepted that when first notified of the impending labour, Ms B did not ask Ms A whether she had recently felt the baby move. As my advisor notes, with the benefit of hindsight the issue of foetal movement assumes an increased significance.

My advisor considered that as a matter of best practice it would have been ideal to ask about foetal movement at that time, but the failure to do so was not unreasonable. The importance of foetal movement had been made clear during the antenatal care, and there was no specific cause for concern in that regard. My advisor noted that she "cannot honestly say that every reasonable midwife" would ask the question.

I therefore consider that Ms B's management following the initial phone call was appropriate in the circumstances of the case. While it would have been preferable to ask whether Ms A had recently felt the baby move, Ms B's overall management at this point was reasonable and in accordance with professional standards.

Second phone call – midnight, 26 November
It was shortly after midnight that Dr A called Ms B, while Ms A was in the shower trying to relieve the pain of her contractions. Following her conversation with Dr A, Ms B again decided to continue to monitor the labour over the telephone, rather than visiting and assessing Ms A in person.

Two issues arise out of this phone call. First, Dr A maintains that he stated that they wished to go to hospital at that time. Secondly, there is a dispute as to whether Ms B, at the end of the conversation with Dr A, asked for Ms A to call back once she was out of the shower.

Transfer to hospital
As noted earlier in my report I do not consider it likely that Ms B would have refused a direct request by Dr A that they go to hospital at that point. Nor can I see any reason for Ms B to insist that she be present when Ms A arrived at the hospital. However, I also consider that Dr A was clearly seeking some sort of guidance as to their next step, and was contemplating transferring to hospital at that point.

It seems likely to me that this particular aspect of the dispute arises out of a misunderstanding. Certainly the evidence falls well short of enabling me to conclude that there was any sort of intention on the part of the midwife to delay Ms A's transfer to hospital at that point.

Request to call back
The question whether Ms B asked Ms A to call her back is more problematic. In the circumstances of this case this question has become central to the issue of whether Ms B's management at the time was reasonable.

My expert advised me thus: if Ms B were reasonably to decide to continue to manage the labour over the telephone at that time, such a decision should not have been made without first speaking to Ms A. It is important that the midwife gain as accurate an impression as possible by direct communication with the woman herself. Speaking to Ms A directly would have enabled Ms B to ask about her condition and how she was coping, as well as asking about foetal movement. Accordingly, if Ms B did ask for Ms A to call her back, her management was appropriate. Even though Ms B did not hear back from Ms A, my advisor considered that, given that it was Ms A's first labour, it would have been reasonable for Ms B to assume that things had settled down, and knowing that Ms A had been asked to call back, to catch some sleep in anticipation of a phone call in the near future.

On the other hand, if Ms B had not asked for Ms A to call her back, then my advisor considered it would not have been appropriate to continue to manage the labour over the telephone, without the benefit of direct contact with the labouring woman. Furthermore,

Ms B would not have provided herself with the opportunity to ask Ms A about foetal movement.

During the course of the investigation, I interviewed both Dr A and Ms B. The issue of whether Ms B asked for Ms A to call her back was raised with both of them, and each was equally definite and credible in their respective recollection of events. Both parties provided persuasive reasons supporting their version of events; Ms B says that it is an important part of midwifery practice to speak to the woman in person as it enables the midwife to make a better assessment based on the woman's response to contractions and the pattern of her breathing, while Dr A says that he was clearly looking for reassurance and would have seized the opportunity to have Ms A call back for further discussion if this had been offered.

I am unable to conclude with any degree of confidence what took place during that phone call. I am faced with two conflicting accounts from credible individuals, and I find I have no basis to prefer one account over the other. While I am entitled to make a finding of fact in cases where there is conflicting evidence, I do not consider that I am in a position to do so in the present case.

Conclusion

I do not consider that the conversation at 8.45am, as to whether Ms B asked Ms A why she did not call back, assists me with resolving the conflicting evidence before me.

In order to find that a provider under investigation breached the Code, I must be satisfied on the balance of probabilities – ie, more probable than not – that the facts supporting the allegation are made out. Here, that is not the case. I consider the conflicting accounts to be equally balanced. The evidential threshold has not been met and accordingly, where unresolved conflicts in evidence remain, I am obliged to find the allegation unproven.

It is entirely speculative as to what may have happened had Ms B spoken to Ms A. It is impossible to say whether Ms B would have then decided that she needed to visit in person. Even if Ms B had visited, it is again speculative as to whether this would have had any effect on the outcome. However, there are a number of matters that are worth commenting on in relation to this issue.

While Ms B did not speak to Ms A at midnight, she formed a picture of Ms A's condition and levels of coping. Dr A's evidence was that Ms A was managing at home at that time, although she was in considerable pain. Ms B has informed me that that was also largely her assessment, based on her conversation with Dr A.

At this point there were no indicators to suggest that this was a high-risk labour. The pregnancy had progressed normally and there is no information from Ms A or Dr A that there was any apparent cause for concern regarding the welfare of either mother or baby, or that indicated the need for an immediate visit by Ms B.

I accept that Ms B was expecting a call from Ms A and that Dr A and Ms A could call Ms B at any time. My expert advised it was reasonable for Ms B not to call Ms A back as Ms B considered that the contractions had slowed and had allowed Ms A to get some rest.

I have found that Ms B's management of the initial phone call at 9pm was reasonable.

In these circumstances I accept my expert advice that Ms B's management of Ms A's labour was reasonable and did not breach Right 4(1) of the Code.

The remaining issue relates to foetal movement. If Ms B had talked to Ms A that night, she would have had the opportunity to question whether the baby was moving. It seems that in the circumstances of this case that is the only flag that might have alerted the midwife to the possibility that the baby was not healthy, and prompted a midnight visit to assess mother and baby.

But again it is entirely speculative, and indeed outside the terms of this investigation, to consider whether, or to what extent, this may have affected the outcome. The only conclusion I am able to draw in the circumstances of this case is that appropriate practice required Ms B to give herself the opportunity to assess Ms A in person and to ask about foetal movement. As I have explained above, I have been unable to determine whether she did so.

In response to my provisional opinion, Ms A and Dr A queried whether the issue of foetal movement was in fact relevant to the assessment of the midwife's actions in this case. Having carefully reviewed the file with this issue in mind, I am satisfied that the issue is relevant. My expert advisor was clearly of the view that the issue of foetal movement was significant. This is supported by the experts instructed by ACC, who also saw foetal movement as an element of assessing foetal well-being during labour. It would have been inappropriate to have analysed the actions of the midwife without making reference to the issue of communication regarding foetal movement during the labour.

Postnatal care

It is clear that Ms B did recognise the hurdle facing Ms A in coping with her grief following Baby A's death, and took steps to ensure that both Ms A and Dr A felt supported.

I accept that looking back at the situation, Ms A feels that the support she received was inadequate and that the counselling was ineffective and on occasion counterproductive. In response to the provisional opinion Ms A emphasised that at the time she did not even consider that the assistance of the counsellor was "counselling", and that there was no counselling relationship between her and the counsellor.

However, the objective view of the situation, based on the information available to me, suggests that Ms B made genuine and reasonable efforts to ensure that the couple had available to them the required support networks and assistance. Ms B visited daily after Ms A returned from hospital, for ten days, until Ms A and Dr A went on holiday. It is my view

that Ms B's notes over this period demonstrate a substantial degree of concern about the issues facing Ms A and Dr A and whether supports were in place.

Ms B also put the couple in touch with a counsellor who she understood to be very good in the area of grief counselling. While ultimately the counselling that was provided may not have been what the couple needed, is not a matter for which Ms B can be held responsible.

Furthermore, it is apparent from the clinical notes that Ms B discussed with the couple how they were coping and whether they had sufficient and effective support, as well as the possibility of contacting the SANDS support group. It also seems that at the time, Ms A and Dr A responded to the efforts being made by Ms B, and Ms A acknowledges that she did not ask for further help. While that may be understandable given the trauma she had recently experienced, from Ms B's point of view she considered the couple to be well supported, getting good assistance from a grief counsellor, communicating openly with her, and apparently coping as well as could be expected in the circumstances, knowing that support groups were available if they wished.

There does not appear to have been anything to suggest to Ms B that her efforts were misdirected or unappreciated.

The information available indicates that she made genuine and reasonable attempts to ensure that Ms A and Dr A had the requisite support in the postnatal period. In these circumstances, I consider that Ms B did not breach the Code.

Clinical notes

Ms B acknowledges that her clinical notes recording her conversations with Ms A and Dr A over the course of the labour were not written immediately following the conversations taking place. Ms B informed me that the notes were written on the morning of 26 November in the delivery suite at the Public Hospital.

My expert advisor informed me that although it is optimal practice to write clinical notes contemporaneously, not every midwife would get out of bed in the middle of the night to document a phone call. My advisor did also note, however, that if the notes are written after the event, this should be recorded, along with the reason why.

In the present case I accept that while it was not optimal practice for Ms B to have written her notes after the event, it was nevertheless reasonable that she did not do so, given the timing of the phone calls. I have weighed the fact that the notes are not contemporaneous in forming my opinion.

I also note that there is nothing in the clinical notes to indicate that they were not made contemporaneously; good practice demands that this be made clear. While I do not consider that this amounts to a breach of the Code, I bring this matter to Ms B's attention, and recommend that she improve her practice in this regard.

Opinion: No breach – Dr C

Lack of involvement as LMC

A number of the notified allegations related to concern on the part of Ms A and Dr A that despite Dr C being Ms A's lead maternity carer, her involvement throughout the pregnancy and the labour was subordinate to that of the midwife.

Ms A acknowledged that she was aware that a large part of the antenatal care would be provided by a midwife.

Dr C provided all the antenatal care up to 20 weeks, and thereafter saw Ms A on a number of occasions. I do not consider that there is any basis to the suggestion that Dr C in any way abdicated her responsibilities as the lead maternity carer.

In relation to Dr C's role in managing the labour, Dr C was not notified that Ms A had started labouring until shortly before her admission to hospital on the morning of 26 November. By that stage there was nothing that Dr C could do to assist Ms A.

There is therefore no basis for a finding that Dr C breached the Code in relation to the antenatal care that she provided.

No further action: Dr C

Postnatal care

Another aspect of Ms A's concerns was that Dr C was insufficiently proactive in ensuring that Ms A received adequate postnatal mental health care.

It is clear that in the postnatal period, Dr C was minimally involved. However, Dr C informed me that she was kept appraised of the situation by the midwife. Ms B's clinical notes confirm this. Dr C also recalls speaking to Ms A on the telephone. Ms A does not recall this conversation. Ms B's clinical notes do record at least one telephone conversation that Ms A and Dr A had with Dr C. Dr C also informed me that she called on a number of occasions in early January but did not receive a reply.

Dr C was also aware that Ms A and Dr A were receiving grief counselling. Dr C stated that her "intention was not to be distant or uncaring but to give this couple some choice as to my involvement at this stage". Dr C thought that the support of the couple's family and friends was paramount at this stage, but that they knew that she could be contacted at any time. In this context I note that Ms B provided Ms A and Dr A with Dr C's mobile phone number.

Dr C does acknowledge that she did not do a formal mental health assessment at the six-week postnatal check. She apologises for this, and explains that her attention was at this

time focused on the concern then being expressed by Ms A as to the lack of monitoring during the labour, and on trying to set up a meeting among the parties to discuss the issue.

I accept that Dr C felt that she was kept appropriately appraised of the situation. I can also accept that she did not wish to appear intrusive at what was a difficult and emotional time for the family, especially as she was aware that the couple was receiving support both from Ms B as well as the grief counsellor.

It is unfortunate that Dr C did not perform a formal assessment of mental health at the six-week check. However, it had become clear at that stage that Ms A was expressing serious concerns about the management of her pregnancy and labour, and thus while it was perhaps careless to omit the check, Ms A's concerns were clearly focused elsewhere and it is understandable that Dr C's became so as well. Accordingly, while a formal assessment of Ms A's mental health at that time might well have been helpful, I do not consider in the circumstances that I need to address this issue further, especially when Dr C has acknowledged the omission and offered her apologies for it.

Accordingly, while there is some concern regarding the lack of a mental health assessment at the six-week check, in all the circumstances of this case, where such an omission has been acknowledged and apologies offered, I do not consider it necessary for me to take further action in relation to this issue.

Other issues – No further action required

Lack of information during pregnancy and labour
Part of Ms A's complaint was that Ms B, over the course of her pregnancy, did not provide her with sufficient information in relation to the risks of labour, or the medical interventions available to mitigate these.

I do not think that the evidence supports this allegation. Ms B informed me that over the course of the pregnancy she discussed different labour scenarios with Ms A and Dr A, provided them with written information on the subject, and gave them a guided tour of the delivery suite, during which further scenarios were discussed. Accordingly, I do not think that this is a material issue that needs to be addressed in any further detail in this report.

Information provided by Ms B
Ms A also expressed concern at the fact that Ms B allegedly stated that the reason for Baby A's death was that the cord was around her neck. Ms B informed me that she offered this information to Ms A and Dr A simply as a possible cause of the death; she did not make a definitive statement. Ms B stated that as a post mortem had been requested, it was clear that that would be the best source of information as to the cause of death, and that she had no intention to mislead Ms A or Dr A.

I do not think it is necessary for me to address this issue further. It is apparent that Ms B was simply attempting to provide Ms A and Dr A with possible answers to their questions about Baby A's death. There is no suggestion that Ms B, in conveying this information, was intending to deceive or mislead.

In response to my provisional opinion, Ms A reiterated her concern that this information was conveyed to them; Ms A expressed concern that regardless of whether there was any intent to deceive, the information should not have been communicated in circumstances where it was likely to mislead.

I am not persuaded by these comments that further action is required in relation to this issue. While it seems likely that Ms B's comment was in fact incorrect, it was nonetheless clearly made in good faith.

Dr C's involvement in the labour
Another element of the complaint was that Dr C did not provide appropriate care during Ms A's labour, and did not ensure that she was able to be contacted. Again, I do not consider that this aspect of the complaint requires further consideration. Dr C was not aware that Ms A was in labour until the following morning, and there is no suggestion that either Ms A or Dr A tried to contact her but were unable to do so. I do not consider that this issue requires further consideration.

Informing staff at Medical Centre
It is unfortunate that the staff member at the medical practice who Ms A contacted did not recall that Ms A's baby had died. Dr C informed me that she had told staff of Baby A's death, and apologises that this was not recalled by the individual staff member.

Issues surrounding meeting with clinicians
Other issues were also raised surrounding the meeting that took place following Baby A's death, and the way in which the meeting was arranged and conducted. This is not a matter to be appropriately considered as part of this report, as it did not form part of the maternity services provided by Ms B and Dr C.

Recommendations

This case has raised some difficult issues relating to the practice of midwifery and postnatal care. While I have not found that the providers involved breached the Code, I recommend that Dr C and Ms B review their practice in relation to the following issues:

- First, the provision of postnatal support to bereaved parents. Ms A and Dr A felt that they were under-supported and without knowledge of or access to the services they needed. While I do not consider that either of the providers involved can be held responsible for this, I nevertheless recommend that they consider how they might better

support and assist grieving parents in the future, bearing in mind the concerns raised by the complainants in this case.

- Secondly, my expert advisor acknowledges that Ms B did not comply with "optimal practice" in leaving Ms A to labour for over 12 hours without a physical examination. While I have found that this did not breach the Code, I nevertheless recommend that Ms B have regard to the comments of my expert advisor in her future practice.

- Finally, my expert advised me that while in some circumstances it is understandable for midwives to write non-contemporaneous clinical notes, this should be clearly identifiable in the clinical record. I recommend that Ms B review her record keeping in light of the comments of my advisor.

Actions

- A copy of this report will be sent to the Medical Council of New Zealand and the Nursing Council of New Zealand.

- A copy of this report, with identifying details removed, will be sent to the New Zealand College of Midwives and to the Royal New Zealand College of General Practitioners, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.