Midwife, Ms B

A Report by the

Health and Disability Commissioner

(Case 12HDC00214)

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Executive summary

Background

1. Ms A's first pregnancy in 2004 had resulted in an emergency Caesarean section delivery because of her failure to progress in labour, and fetal distress.

2. On 25 Month1 2008, in the ninth week of her second pregnancy, Ms A had her first antenatal appointment with Ms B, an independent[1] midwife.

3. Ms B provided Ms A with information relating to vaginal delivery after Caesarean section, and advised her that her antenatal care would comprise both obstetrician and midwifery care.

4. Ms A saw an obstetrician, Dr C, at the public hospital (the hospital) on 19 Month5. Dr C advised Ms A that she should have continuous monitoring throughout her labour.

5. Ms B reviewed Ms A monthly until late Month5, and then increased the antenatal checks to fortnightly. Ms A's pregnancy progressed normally.

6. At 3.15am on 21 Month8, Ms A was admitted to the hospital in early labour. She was accompanied by her partner, Mr A, her mother, Mr A's mother, and a friend.

7. A hospital midwife admitted Ms A and attached a cardiotocograph (CTG) monitor.[2] The monitor indicated some fetal heartbeat irregularities — decelerations[3] with slow recovery.

8. Ms B arrived at the hospital at 3.35am and assessed Ms A, taking her baseline recordings of temperature and pulse rate. At that time, Ms B noted an irregularity on the CTG fetal heart trace. At 4am, Ms B disconnected the CTG monitor. She advised HDC that she did so because she considered that the fetal heart was showing "good variation",[4] Ms A's uterine contractions were irregular and mild, and Ms A was unhappy being restricted to the bed for monitoring.

9. Between 4.00am and 10.45am Ms B intermittently assessed the fetal heart rate (FHR), noting that it was between 130 beats per minute (bpm) and 150bpm. At 10.45am, Ms B noted that the FHR was between 121bpm and 128bpm.

10. At 11am, Ms B observed that the baby's head had descended to the perineum, but Ms A was exhausted. Ms B called for an obstetrician, Dr D, to assess Ms A. As delivery was imminent, Dr D stayed to assist Ms B with the delivery.

[1] Now referred to as a community based midwife.
[2] An electronic instrument used to monitor the fetal heart rate and rhythm and the strength and frequency of the uterine contractions.
[3] A decrease in the fetal heart rate below the baseline fetal heart rate.
[4] The normal fetal heart rate range is between 120 and 160 beats per minute. The small fluctuations in the fetal heart rate are called "variability".

11. At 11.40am, Dr D applied a ventouse suction cup[5] to the baby's head and delivered Baby A. Baby A was flat on delivery, with concerning Apgar scores.[6] The paediatric team was called, and Baby A was resuscitated and transferred to the hospital's Special Care Baby Unit.

12. Later that day Baby A was airlifted to the Neonatal Intensive Care Unit in a main centre but, despite full intensive management, he died at 26 hours of age.

Decision

13. Ms B did not fulfil the following responsibilities: adequate assessment of Ms A; continuous CTG monitoring; discussion with Ms A about the decision to cease monitoring; recording of her rationale for ceasing CTG monitoring; adequate monitoring of the fetal heart rate; and adequate communication with Ms A. Ms B failed to provide services to Ms A with reasonable care and skill and, accordingly, breached Right 4(1)[7] of the Code of Health and Disability Services Consumers' Rights (the Code).

14. By failing to document significant events, discussions and decisions, Ms B did not meet professional standards. Ms B's inadequate and misleading records were a breach of professional standards and, accordingly, she breached Right 4(2)[8] of the Code.

Complaint and investigation

15. The Commissioner received a complaint from Ms A and Mr A about the services Ms B provided to Ms A. The following issue was identified for investigation:

> *The adequacy of the treatment and care independent midwife Ms B provided to Ms A in relation to her pregnancy in 2008–09, in particular, during her labour and delivery on 21 Month8.*

16. An investigation was commenced on 5 March 2013.[9]

17. The parties directly involved in the investigation were:

Ms A	Consumer
Mr A	Complainant

[5] A ventouse is a vacuum device used to assist the delivery of a baby when the second stage of labour has not progressed adequately.
[6] The Apgar score is determined by evaluating the newborn baby on five criteria, heart rate, respiratory effort, muscle tone, reflex irritability and colour, and scoring each from zero to two. The sum of the five values gives the Apgar score, which ranges from zero to 10.
[7] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."
[8] Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."
[9] Ms A and Mr A advised HDC that they did not complain until 2012, when they became aware that Ms B was still practising as a midwife.

Baby A	
Ms B	Provider

18. Information was reviewed from:

Ms A
Mr A
Mrs F, Ms A's mother
Mrs G, Mr A's mother
Ms B
The District Health Board
Coroner
Mr A's relative
Ms M, midwife (expert advice provided to the coroner)
Dr K, consultant paediatrician (expert advice provided to the coroner)
Ms H, midwife
Dr J, pathologist
Dr L, consultant obstetrician and gynaecologist
Ms E, Ms A's friend

Also mentioned in this report:

Dr C	Obstetrician
Dr D	Obstetrician
Dr I	Paediatric registrar

19. Independent expert advice was obtained from a registered midwife, Ms Elizabeth Jull. Ms Jull's advice is attached as **Appendix A**.

Information gathered during investigation

Antenatal care

Booking visit

20. On 25 Month1 2008, Ms B, an independent midwife,[10] met Ms A for the first time when Ms A was in the ninth week of her second pregnancy. Ms A told Ms B that her first baby had been delivered in 2004 by emergency Caesarean section owing to failure to progress in labour and fetal distress. Ms A told Ms B that her labour had lasted 25 hours.

21. Ms B recorded the 25 Month1 visit, noting, "Midwifery care-plan discussed" and that Ms A's care would be shared between herself, as the Lead Maternity Carer (LMC), and an obstetrician. Ms B recorded that she would visit monthly and arrange serial scanning follow-up. Ms B gave Ms A the Ministry of Health pamphlet "Vaginal Birth after Caesarean" (VBAC) and the Sheila Kitzinger birth preparation DVD.

[10] Also referred to as a community based midwife.

Monitoring

22. Ms B recalls that she advised Ms A that, given her history, continuous fetal monitoring during labour was recommended, and that Ms A stated that she did not want to have continuous fetal monitoring during labour. Ms B did not document any discussions with Ms A on 25 Month1 about continuous fetal monitoring.

23. In response to the provisional opinion, Ms A advised HDC that no discussion took place on 25 Month1 regarding fetal monitoring. Ms A also advised HDC:

> "At no time **EVER** did I advise [Ms B] that I did not want to be monitored during the labour as it was due to my partner [Mr A] and myself, watching the monitor that we were able to ascertain that my first child was in distress."

Birth plan

24. On 25 Month1, Ms B recorded that she encouraged Ms A to formulate a birth plan and to visit the hospital to view the birth unit. The birth plan Ms A prepared is attached as **Appendix B**.

25. Ms A stated:

> "During the couple of times [Ms B] and I discussed birth plans I told her that I wanted my partner [Mr A] to be fully involved and not excluded and I would like to try for a natural birth, but I would not be upset if I needed to have another caesarean."

26. Ms A said that Ms B was always adamant that a Caesarean would not be needed, and that Ms A needed to change her thinking, as it was all in her head.

Subsequent antenatal care

27. On 27 Month2, Ms B saw Ms A and noted that Ms A was in the 13th week of her pregnancy and had been "unwell with morning sickness".[11] Ms B recorded that the fetal heartbeat was heard during the antenatal examination.

28. Ms B continued to visit Ms A each month, noting minor health issues such as ligament pain.

29. On 29 Month4, Ms B saw Ms A for her 22-week check, recording that she had had a "bout of UTI [urinary tract infection] treated with IV Augmentin". Ms B noted that she had advised Ms A to increase her fluid intake, and that Ms A was "not very keen" on this suggestion. In response to the provisional opinion, Ms A stated that at no stage did she refuse to increase her fluid intake.

30. On 19 Month5, Ms A was seen at the hospital antenatal clinic by an obstetrician, Dr C. Dr C wrote to Ms B to advise her of the consultation, stating:

[11] In response to the provisional opinion, Ms A advised HDC that she never suffered from morning sickness with any of her pregnancies.

> "We had a long discussion in the clinic today regarding VBAC (vaginal birth after caesarean) and [Ms A] has obviously read the leaflet you kindly gave her. We discussed not inducing labour, ensuring that she has good progress throughout labour and continuous monitoring. We also discussed the risk of scar rupture. She is keen to pursue this, and hence I have organised for her to have a further scan at 28 weeks to check on growth and liquor. I would be grateful if you could then organise a further scan at around 35–36 weeks and we will see her again in the antenatal clinic this time, just to ensure that this baby is not significantly larger than the last one."

31. There was no suggestion that Ms A told Dr C that she did not wish to have continuous fetal monitoring. Ms A told the Coroner that her understanding from the consultation was that her baby would be continually monitored during the labour.

32. At the end of Month5, Ms B increased the frequency of her visits to Ms A to two weekly.

33. On 12 Month6, Ms A was assessed at the hospital by the obstetric senior house officer (SHO), for worsening pain in her right flank, which radiated into her lower back and groin. The SHO noted that Ms A had also experienced these symptoms six weeks earlier. On that occasion, she was assessed in the Emergency Department, a renal scan was performed, which was normal, and Ms A was discharged with a prescription of Augmentin.

34. The SHO referred Ms A to the medical team for further assessment. Ms A had blood and urine tests and was provided with analgesia. Her case was discussed with the medical consultant, who considered that her care would be best managed by the obstetric team.

35. Ms A's blood and urine tests did not show any abnormality. Her pain settled with the prescribed analgesics. She was reviewed by the obstetric registrar on 13 Month6, before being discharged home with a prescription for oral antibiotics, and to the care of Ms B.

36. Ms B visited Ms A on 17 and 30 Month6. At these visits, Ms B recorded that Ms A reported good fetal movements, and Ms A's visit to the obstetrician was discussed. On 17 Month6, Ms B recorded, "Pain levels questioned today in relation to birth and plan" and, on 30 Month6, Ms A told Ms B that she wanted a female obstetrician and was advised how this could be arranged.

37. At the 27 Month7 check, when Ms A was in the 35th week of her pregnancy, Ms B recorded that she talked to Ms A about cutting back on the number of cigarettes she was smoking, and advised her to try to increase the amount of protein in her food.

38. Ms B recorded that Ms A's weight was 65kg, and noted that she was "encouraged to visit to B [birthing] unit and view monitors". Ms B also recorded that they discussed the VBAC policy, noting:

> "Progress made earlier at point of no progress during 1st birth and CS [Caesarean section]. Monitor baby — Continuous if meconium (baby poo) in bag of waters. Obst input."

39. On 27 Month7 Ms A had an obstetric ultrasound. The report stated: "[G]rowth is satisfactory for a gestation of 35 weeks 2 days."

40. Ms B advised the Coroner:

> "At 37 weeks and 38 weeks gestation, [Ms A] was encouraged to meet with me for a tour of the birth unit. At 38 weeks she cancelled the visit. I encouraged and gave [Ms A] and [Mr A] an opportunity to see how a fetal monitor worked. They declined. I made them an appointment to have one midwife visit in the birth unit area to help settle them into the birthing environment."

41. Ms B recorded in the Maternity and Midwifery Provider Organisation (MMPO) notes that Ms A telephoned to cancel her 31 Month7 visit, and missed her 10 Month8 appointment at Ms B's rooms.

42. Ms A stated:

> "At no time did [Ms B] offer the above appointments to tour the birth unit, and the only appointment that was cancelled was one I turned up for and [Ms B] said that she didn't have time to see me that day and rescheduled herself. An appointment was discussed at the birth unit, [Ms B] was to ring me with a time and this was to take place on the 21st of [Month8]. [Ms B] said that at this appointment she would do an internal exam that should start things moving along. This I objected too [sic] as I knew that I couldn't be induced and told [Ms B] so."

43. A relative of Mr A confirmed that she attended a visit with Ms A when Ms B was unable to see Ms A at the arranged time.

44. On 4 Month8, Ms A was seen at the obstetric clinic by obstetrician Dr D. Dr D advised Ms B that Ms A's pregnancy was progressing well. Dr D noted, "[Ms A] understands that we cannot induce her and she still would very much like VBAC."

45. When Ms A saw Ms B on 17 Month8, she reported some "niggles". Ms B recorded that the baby was in a good position, VBAC was discussed, and that she "offered Birth Unit visit. Not interested." Ms A's weight was again 65kg.

DHB policy

46. The DHB policy regarding fetal monitoring consisted of the New Zealand College of Midwives Consensus Statement on fetal monitoring (2005), which provides that "continuous fetal monitoring is recommended for high risk pregnancies when there is an increased risk to the baby".

47. In her evidence to the Coroner, Ms B stated that she was aware that the hospital had guidelines and protocols that provided that, in a case such as that of Ms A, the policy requires: "For V-BAC it is an active labour, continuous monitoring." Ms B stated in

her evidence that she went against both the policy and the advice given by the obstetrician.

Labour

Hospital midwife

48. At 12.00am on 21 Month8, Ms A's waters broke at home. At 3.00am, she decided to go to the hospital, as she understood from Dr C that she needed to be fully monitored throughout her labour.

49. In response to the provisional opinion, Ms A advised HDC that she did not tell Ms B that she had gone to hospital because Ms B had advised her not to go to hospital until her contractions were five minutes apart and she had a mucus show with blood in it. Ms A advised HDC that although she had tried to explain to Ms B that she needed to be fully monitored throughout her labour, she felt that Ms B did not listen to her.

50. At 3.15am Ms A, accompanied by her partner, Mr A, a friend, Ms E, Ms A's mother, Mrs F, and Mr A's mother, Mrs G, arrived at the hospital delivery suite. Ms A stated that when she arrived she told the hospital midwife that the obstetrician had told her she was to be fully monitored. Ms B was notified of Ms A's arrival.

51. The hospital midwife recorded that she connected Ms A to the CTG monitor at 3.30am. The hospital midwife noted that the CTG recorded the FHR at 120bpm. At 3.32am, the hospital midwife recorded:

> "FHR ↓200–108 started to recover slowly then decel[12] ↓100 with quick recovery to baseline 120bpm. Onto L/side FHR 120."

52. At 3.35am the hospital midwife recorded:

> "FHR remains variable [with] no further decel. FHR 135."

Ms B's arrival

53. In her evidence to the Coroner, Ms B stated that her notes were completed retrospectively but she had "not even made mention that [she] actually documented this in retrospect". The records do not indicate that they were made retrospectively, other than an entry on 21 Month8 at 11.50am. Accordingly, it is not possible to determine when the records were made.

54. Ms B recorded that she arrived at the delivery suite at 3.35am. She recalls that when she arrived at the hospital, Ms A was in good established labour, and that Mr A was present and encouraging Ms A during her contractions. Ms B said that Mr A gave Ms B their birth plan at that time — see **Appendix B**. In contrast, Ms A said that Ms B was given the birth plan after the CTG was disconnected at 4.00am.

55. Ms B recorded Ms A's baseline temperature and pulse rate, noting these observations to be within the normal range. Ms B noted that the CTG trace showed a late deceleration[13] of the fetal heart rate, with good recovery.

[12] Deceleration/decrease in heart rate.

Cessation of monitoring

56. The CTG shows that the baseline fetal heart rate was 130–140bpm with normal variability and the presence of accelerations. There was a late deceleration at the commencement of the CTG and another at 3.22am, when the heartbeat took three minutes to return to the baseline.[14]

57. At 4am, Ms B disconnected the CTG monitor. She recorded that Ms A's uterine activity at that time was irregular and mild, and the "FHR trace showed good variation".[15] However, it is indicated on the labour and birth summary form that labour was established at 4.00am.

58. Ms B advised the Coroner:

> "I disconnected the CTG at 0400hrs as [Ms A] and [Mr A] were unhappy at her being restricted to the bed for the monitoring.
>
> I was pleased with the trace and we discussed intermittent Fetal Heart Monitoring as long as all was well. I advised [Ms A] and [Mr A] that given they did not agree to continuous monitoring, I would like to carry out … intermittent fetal heart monitoring every 15 minutes, which could occur while [Ms A] was moving to which they agreed. They had not agreed to continuous monitoring. They also agreed to a vaginal examination to assess progress after 4 hours or earlier if necessary."

59. Ms A stated that at around 4am, Ms B told her and Mr A that it was unnecessary to have the monitor on and disconnected it. Ms A also stated that when she told Ms B that the obstetrician had told her that she was to be fully monitored, Ms B said that that was just a formality, and that obstetricians always say that. Ms A said:

> "[The obstetrician's] instructions were totally disregarded during my labour. [Ms B] had no intention of listening to their advise [sic] and was very off-handed as far as the obstetricians were concerned, stating numerous times that they were just a formality and guidelines, but she knew her job."

60. Ms B examined Ms A and recorded: "Longitudinal lie ROL uterine activity mild Cervix tip of finger — head high." Ms A recalls that Ms B told her and Mr A that they could go home and return later. Ms A stated: "We refused to do this." Ms A's mother, Mrs F, recalls that Ms B said that Ms A should not have come to the hospital so early, and that she should go home until labour was fully established. When Mrs F told Ms B that the obstetrician had advised full monitoring during the labour, Ms B said that she was the midwife and knew her job. This account is supported by Mrs G and Ms E, who were both present.

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[13] A transient decrease in heart rate, below the fetal baseline heart rate, occurring at or after the peak of a uterine contraction, which may indicate fetal hypoxia.
[14] The times on the CTG trace differ from those in the records.
[15] Constant variation from the baseline (variability) reflects a healthy fetal heart response.

61. Ms B recorded that Ms A and Mr A had opted to remain in hospital, and documented her plan for Ms A's labour as:

> "Plan: VE [vaginal examination] repeated at 8am.
> CTG monitor baby if increase in uterine activity.
> Oral fluids, does not want to lie down.
> * Requests only female staff *."

62. At 5.15am Ms A went to the designated area outside the unit to smoke a cigarette. At 5.40am, Ms B recorded that she had assessed the baby's heart rate at 137–145bpm.

63. Ms B told the Coroner that she left the room for one hour 20 minutes in the period between 4am and 5.40am and, when she returned, she discussed with Ms A and Mr A that Ms A's waters had broken at home, and they did not say they had noticed blood loss or meconium. Ms B did not record this conversation in the clinical notes. Ms A stated that at 3.35am a pad with mucousy discharge was viewed by Ms B, and she recorded on two further occasions that there was a vaginal discharge of mucous and blood. In her evidence to the Coroner, Ms B agreed that she saw light green phlegmy discharge on the pad, and stated that meconium appears "greeny rather than slimy and wet as in mucous".

64. At 6am, Ms B recorded that Ms A was experiencing active labour pains. Ms B took a sample of Ms A's blood for the laboratory for cross-matching and, at 6.30am, assessed the baby's heart rate again, as 132–140bpm, which was within the normal range. Ms B also recorded Ms A's heart rate as 80bpm.

65. Ms B recorded that she subsequently checked the baby's heart rate every 15 minutes, and the rate varied between 130bpm and 158bpm.

66. At 8am, Ms B recorded Ms A's heart rate as 82bpm. The FHR at this time was 150–160bpm. Ms A managed her contractions in the knee-to-chest position, and had a warm shower at 9.15am. No vaginal examination is documented at this time, as had been planned.

67. At 10.30am Ms B recorded that Ms A was pushing. There is no record of the fetal heart rate at that time. At 10.45am Ms B assessed the FHR as "128–121bpm".

68. At 11am, Ms B was able to see a "peep" of the baby's head at the perineum, and at 11.15am consulted with Dr D, as she was concerned that Ms A was exhausted. Dr D assessed Ms A and observed the baby's head at the perineum. As delivery was imminent, Dr D stayed in the room.

69. Between 11.20am and 11.30am, Ms A was pushing actively and the FHR was noted to be between 115bpm and 128bpm.

70. At around 11.35am, registered midwife Ms H, another midwife, and a paediatric registrar, Dr I, answered a call-bell activation from Ms A's delivery room. Ms H stated that when she entered the room, Dr D and Ms B were preparing for an instrumental delivery of Ms A's baby. Ms H stated that when they entered the room,

Mr A told Dr D that he did not want anyone else in the room. Ms H recalls (and recorded retrospectively in the clinical records) that Dr D told Mr A that it was usual and advisable in the case of an instrumental delivery to have a second midwife and a paediatrician present, but Mr A asked the midwives and paediatrician to leave. Ms H recalls Ms A nodding her head in agreement with this request.

71. Ms H, the other midwife, and Dr I left the room. Dr I recorded that he would attend if needed and was available on pager.

72. Mr A told the Coroner that he did not want unnecessary people in the room, and was not told why the additional people were necessary.

Delivery

73. At 11.45am, Dr D easily applied a Kiwi Cup (ventouse suction cup) to Baby A's head and he was delivered at 11.50am, pale and not breathing, with a heart rate of 100bpm. Ms B observed meconium in the uterine fluid that came away with the baby, and placed an emergency call for the paediatrician and back-up obstetric staff.

74. Baby A was pale and floppy and making no attempt to breathe. His Apgar scores were assessed and noted as:

Apgar score	1 min	5 min	10 min	20 min
Heart rate	2	2	2	2
Respiratory	0	0	0	0
Muscle tone	0	0	0	0
Reflex irritability	0	0	0	0
Colour	1	1	2	2
Total	**3**	**3**	**4**	**4**

75. Ms H and another midwife responded to Ms B's emergency call. When Ms H arrived in the delivery room, she was asked to page Dr I.

76. When Dr I arrived, he took over Baby A's care. He suctioned Baby A, finding meconium in his pharynx and larynx. A further emergency call was made to the Special Care Baby Unit (SCBU), and perinatal and paediatric staff arrived to assist with a full resuscitation of Baby A, who was intubated[16] and placed on CPAP.[17]

[16] A tube placed into the trachea (windpipe) in order to maintain an open airway.
[17] Continuous Positive Airway Pressure, used to assist with breathing problems.

Transfer

77. Baby A was transferred to the hospital SCBU at 12.05am. Dr I recorded that Baby A was suffering severe peripartum hypoxia[18] caused by meconium aspiration. Chest X-rays were taken and blood for testing. Baby A was started on intravenous dextrose and antibiotics.

78. Baby A's parents were given an explanation about his condition, and arrangements were made to transfer Baby A to the Neonatal Intensive Care Unit in a main centre by helicopter. The retrieval team uplifted Baby A at 3.30pm.

79. Sadly, after full intensive management, Baby A died at 26 hours of age.

Coroner's inquest

Post-mortem report

80. A post-mortem examination was conducted by Dr J, who reported:

> "Microscopy of the brain confirmed extensive oedema, particularly of the white matter and there was widespread early hypoxia ischaemic neuronal injury. There was also evidence of white matter gliosis[19] that was likely to have been an antepartum event and probably related to the fetal malnutrition but — both reflected a suboptimal environment in utero, although this can be difficult to detect clinically at term.
>
> In summary this infant had features of fetal malnutrition that suggested a hypoxic environment in utero prior to onset of labour. Such infants are poorly equipped to deal with the stresses of labour."

Paediatric review

81. A consultant paediatrician, Dr K, was asked to advise the Coroner "how and why" Baby A died. Dr K stated:

> "This infant had evidence of profound antenatal hypoxia as evidenced by the failure to breathe after delivery and a very severely abnormal blood gas which was almost not compatible with life. Opportunities to avoid or prevent this fatal event did not present themselves after the infant's delivery. Opportunities to avoid or prevent such severe hypoxia could be provided with antenatal monitoring. Looking for slowing of the fetal heart rate and irregularities present on the CTG." [Emphasis in original.]

82. Dr K recommended that further advice about antenatal monitoring be obtained from an obstetrician, as this was outside his field of expertise.

Obstetric advice

83. A consultant obstetrician and gynaecologist, Dr L, advised the Coroner:

[18] Lack of oxygen in the period shortly before, during, and/or immediately after birth.
[19] A process leading to scars in the central nervous system.

> "The death would have been avoided if the CTG recording had been done throughout the labour that showed deterioration and features characteristic of progressive foetal asphyxia, such as decreased variability and decelerations that may not have been heard on the auscultation, which was thought to be normal."

Midwifery review

84. An expert midwife, Ms M, advised the Coroner:

> "Hypoxic foetuses may have a normal heart rate. If the foetus had been continuously monitored it would have been the pattern of the heart rate, rather than the actual rate, which would have alerted health professionals to the developing or presence of hypoxia.
>
> In my opinion, the foetus was not adequately monitored throughout labour. Ms A's known risk factors were: previous caesarean section for failure to progress and foetal distress, maternal smoking and suspicious CTG on admission to the birthing unit. It would be standard practice to continuously monitor a woman with a previous caesarean section throughout labour in case of scar rupture. The suspicious nature of the CTG on admission should have acted as a warning sign, indicating the need for increased surveillance. If continuous CTG monitoring had taken place then it is very likely that changes in the foetal heart rate pattern, as the hypoxia progressed during labour, would have alerted health professionals to the need for earlier intervention, with the probability that the death could have been avoided."

Ms B

85. Ms B advised HDC:

> "I do accept failure to follow the guidelines, in negotiating with the couple under my care, and as pointed out [by HDC's expert midwife, Elizabeth Jull] maintaining poor documentation throughout.
>
> I acknowledge, despite some differences in opinion as to the actual cause of death and the injury/compromise occurred — antenatal or labour? in failure to maintain best practice.
>
> I have attended all the required re-training, meeting the Midwifery Council requirements, and maintained my annual practice licence.
>
> I have now retired from the midwifery profession, and surrendered my APC [annual practising certificate] to the Midwifery Council, since November 2012.
>
> I have no intention to apply for any future APC."

Midwifery Council of New Zealand

86. The Midwifery Council of New Zealand (the Council) advised HDC that after being notified of the events that are the subject of this complaint, the Council ordered Ms B to undertake a competence review and, as a result of that review, in December 2009,

the Council issued Ms B with an order under section 38 of the Health Practitioners Competence Assurance Act 2003 concerning her competence.

87. On 28 February 2013, the Council confirmed that Ms B had surrendered her practising certificate on 21 December 2012, and was no longer practising as a midwife.

Relevant standards

88. The New Zealand College of Midwives *Midwives Handbook for Practise 2008* states:

> "Standard One
>
> The midwife works in partnership with the woman …
>
> Midwives respond to the social, psychological, physical, emotional, spiritual and cultural needs of women seeking midwifery care, whatever their circumstances, and facilitate opportunities for their expression …
>
> Midwives have responsibility to ensure that no action or omission on their part places the woman at risk.
>
> Midwives have a professional responsibility to refer to others when they have reached the limits of their expertise.
>
> Standard Two
>
> The midwife upholds each woman's right to free and informed choice and consent throughout the childbirth experience.
>
> Criteria
>
> The midwife:
>
> - Shares relevant information, including birth options, and is satisfied that the woman understands the implications of her choices.
>
> Standard Three
>
> The midwife collates and documents comprehensive assessments of the woman and/or baby's health and wellbeing.
>
> Standard Four
>
> The midwife maintains purposeful, on-going, updated records and makes them available to the woman and other relevant persons.
>
> Standard Five
>
> Midwifery care is planned with the woman."

Opinion: Breach — Ms B

89. Ms A's pregnancy and labour had a number of risk factors, which included that she had previously had a Caesarean section because her labour had failed to progress and the fetus was in distress. Ms A was also a smoker and, during her second pregnancy, had gained no weight since the 35th week of the pregnancy. Furthermore, the CTG trace, which was commenced shortly after 3am on 21 Month7, was not reassuring.

90. In this case, Ms B failed to communicate effectively and appropriately with Ms A and Mr A, failed to assess Ms A adequately, disregarded the recommendation of the obstetrician to perform continuous CTG monitoring, failed to discuss the removal of the CTG with Ms A, failed to adhere to expected DHB practice regarding monitoring of high risk pregnancies, and misinterpreted the CTG. Furthermore, her record-keeping was inadequate. Consequently, the care she provided to Ms A and her baby was seriously sub-optimal.

Consent to monitoring

91. Ms A had prepared a birth plan indicating that she preferred to be able to move around during labour and not give birth lying down. The birth plan did not state that she refused to be monitored during labour.

92. Ms A stated that she and Ms B discussed birth plans during the pregnancy, and Ms A had told Ms B that she wanted her partner to be fully involved and not excluded and would like to try for a natural birth, but would not be upset if she needed to have another Caesarean section. Ms A said that Ms B was always adamant that a Caesarean would not be necessary, and said that Ms A needed to change her thinking, and that it was all in her head. Ms A stated that when she told Ms B that the obstetrician told her that she was to be fully monitored, Ms B said that that was just a formality and that obstetricians always say that.

93. On 27 Month7 Ms B recorded in the midwifery notes, "Monitor baby — continuous if meconium (baby poo) in bag of waters."

94. Ms B told the Coroner that she "disconnected the CTG at 0400hrs as [Ms A] and [Mr A] were unhappy at her being restricted to the bed for the monitoring …". Ms B also stated that Ms A did not agree to continuous monitoring. However, this is not recorded.

95. Ms A stated that at around 4am on 21 Month7, Ms B told them it was unnecessary to have the monitor on and disconnected it, and that this was before Ms B had seen Ms A's birth plan. Ms A's mother, Mrs F, stated that she questioned this decision and pointed out that the obstetrician had said that Ms A was to be fully monitored, and that Ms B responded that she knew what she was doing.

96. Right 7(7) of the Code states that every consumer has the right to refuse services and to withdraw consent to services. Accordingly, Ms A had the right to refuse to undergo continuous monitoring during her labour. However, Ms A's records do not include any discussion regarding the cessation of monitoring. My expert, registered midwife Elizabeth Jull, advised:

> "If the woman refuses to have CTG monitoring with a high risk pregnancy, the midwife needs to carefully document the discussion in the woman's maternity notes, the woman's care plan and the hospital notes. It would be good practice to ask the woman to read and sign the refusal."

97. Baragwanath J stated in his decision in *Patient A v Nelson–Marlborough District Health Board*[20] that it is through the medical record that healthcare providers have the power to produce definitive proof of a particular matter (in that case, that a patient had been specifically informed of a particular risk by a doctor). This applies to all health professionals, who are obliged to keep appropriate patient records. Health professionals whose evidence is based solely on their subsequent recollections (in the absence of written records offering definitive proof) may find their evidence discounted.

98. Ms A's account is supported by the accounts of Mrs F, Mrs G and Ms E. Furthermore, there is no record in Ms A's notes of any discussion of the benefits and risks of continuous monitoring or refusal of consent. I therefore accept Ms A's account that she did not refuse to be continuously monitored during her labour, and that Ms B failed to discuss the removal of the monitor with her and Mr A.

Monitoring of fetal heart rate and interpretation of CTG

99. At 4am Ms B recorded: "[M]onitor discontinued uterine activity irregular and mild. FH trace good variation." In her evidence to the Coroner, Ms B stated:

> "I was pleased at the trace and we discussed intermittent fetal heart monitoring as long as all was well. I advised [Ms A] and [Mr A] that given they did not agree to continuous monitoring, I would like to carry out … intermittent fetal heart monitoring every 15 minutes, which could occur while [Ms A] was moving to which they agreed."

100. In contrast to this conclusion, expert midwife Ms M advised the Coroner:

> "[T]here was a late deceleration evident at commencement of the CTG, another which began at 0322hrs and the [fetal] heart took 3 minutes to return to the baseline. The presence of these decelerations and of two other less significant decelerations occurring before the CTG was discontinued classifies this CTG as 'suspicious' (NICE, 2007)."

101. Furthermore, it was Ms M's opinion that intermittent oscillation was not appropriate in this case as it would be standard practice to monitor the fetal heart continuously throughout active labour in a woman who had previously had a Caesarean section, in case of scar rupture.

102. At 5.40am the fetal heart rate was documented as being normal at 137–145bpm. The records indicate that the fetal heart was recorded again at 6.30am and then every 15 minutes until 10.15am. The ranges of fetal heart recording were essentially normal but

[20] *Patient A v Nelson–Marlborough District Health Board* (HC BLE CIV-2003-406-14, 15 March 2005).

rising to over 150bpm by 9.45am. Ms M advised the Coroner that "it is not possible however, to ascertain the fetal heart base line when using intermittent oscillation and detection of late decelerations may not be reliable (Jibodu & Arulkumaran, 2000)".

103. After 5.40am Ms A's contractions had increased. Despite the earlier plan to "monitor baby if increase in uterine activity" this did not take place. Ms M advised the Coroner that hypoxic fetuses may have a normal heart rate, and stated that, if the fetus had been continuously monitored, it would have been the pattern of the heart rate rather than the actual rate that would have alerted health professionals to the developing hypoxia or presence of hypoxia. Once Ms A was pushing, there was a period from 10.45am until 11.20am when the baby's heart rate was not assessed.

104. My expert midwifery advisor, Elizabeth Jull, advised me that the lack of regular and frequent monitoring of the fetal heart was a severe departure from accepted practice. I agree that Baby A was not adequately monitored throughout the labour and particularly during the second stage of labour. Ms B's failure to do so was a serious departure from expected standards.

Assessments

105. Ms B was required to collate and document comprehensive assessments of both Ms A's and her baby's health and well-being.

106. When Ms A was admitted to hospital, Ms B recorded her temperature and pulse. During the labour, Ms B took Ms A's pulse again at 6am and 8am.

107. Ms Jull advised me that Ms A was not adequately assessed. There were minimal baseline recordings performed when Ms A was admitted to hospital (temperature and pulse). While Ms B recorded Ms A's pulse on two other occasions, no other recordings were made at any time during her labour. Ms Jull advised: "[I]t is usual midwifery practice to complete detailed observations on arrival in labour. Blood pressure, pulse, temperature and respirations, also a detailed abdominal examination would normally be done."

Communication

108. Working in partnership with the woman is key to good midwifery practice.[21] In order to work in partnership with the woman, the midwife must ensure that communication is effective, and that she is responsive to the woman's concerns or anxieties.

109. Ms B did not communicate effectively with Ms A about continuous monitoring during the labour and, when an assisted birth was planned, she also failed to ensure that the parents understood why additional staff needed to be present.

110. In addition, when Ms A arrived at hospital in early labour, Ms B attempted to send her home despite the obstetrician having advised continuous fetal monitoring during the labour. When Mrs F told Ms B that the obstetrician had advised full monitoring during the labour, Ms B said that she was the midwife and knew her job.

[21] Competency One and Standard One contained in the *Midwives Handbook for Practice* (2008 ed.).

111. This Office has previously stated:[22]

> "[A] general issue raised by the case is the apparent failure of the midwives to listen carefully to what [Mrs A] was telling them … Providers should always treat consumers with respect and listen carefully to their concerns. This case is a reminder of why this is so important."

112. I accept Ms Jull's advice that communication was inadequate during Ms A's labour.

Record-keeping

113. Ms B was required to maintain purposeful, on-going and updated records. Ms Jull advised that the vaginal examination performed by Ms B is not clearly documented and that the documentation lacks detail (see below).

114. The findings of the CTG are not documented in Ms A's notes, which Ms Jull noted would have been good practice. Furthermore, no baseline fetal heart rate is recorded, and no comment is included about whether the tracing was reassuring. There is also no record of the frequency of Ms A's contractions, other than "uterine activity irregular and mild".

115. There is also no documentation to indicate that any discussion took place regarding the next steps, should care become complicated and need to be transferred to secondary care.

116. In addition, there is no evidence of an agreed care plan having been documented prior to the labour, and there is no acknowledgment that the notes were made retrospectively. There are inconsistencies in the recordings of the notes, for example, at 4am, Ms B disconnected the CTG monitor and recorded that Ms A's uterine activity at that time was irregular and mild, and the "FHR trace showed good variation". However, it is indicated on the labour and birth summary form that labour was established at 4.00am. Ms B has stated that conversations took place regarding monitoring, but there is no record of these. In addition, on 21 Month7 the retrospective hospital record refers to fresh meconium being present, whereas the baby birth details form refers to old meconium.

117. The notes must be an accurate record, and Ms Jull advised me that the inconsistencies in the records in this case are a serious departure from accepted practice.

Conclusions

118. In my view, the care Ms B provided to Ms A was unsatisfactory. Ms B failed to assess Ms A adequately; did not perform continuous CTG monitoring; did not discuss with Ms A her decision to cease monitoring; did not record her rationale for ceasing CTG monitoring; did not monitor the fetal heart rate adequately; and did not communicate adequately with Ms A.

119. Ms Jull advised that a number of these failures were severe departures from the accepted standard. Overall, I consider that Ms B's care of Ms A was seriously

[22] 07HDC04325, 13 December 2008.

suboptimal. I find that Ms B failed to provide services to Ms A with reasonable care and skill and, accordingly, Ms B breached Right 4(1) of the Code.

120. By failing to document significant events, discussions and decisions, Ms B did not meet professional standards. Ms B's inadequate and misleading records breached professional standards and, accordingly, I find that she breached Right 4(2) of the Code.

Recommendations

121. I recommend that Ms B apologise to Ms A. The apology is to be sent to this Office within one month of the date of this report, for forwarding to Ms A.

122. If Ms B resumes practice as a midwife, I recommend that she first:

- Organise a special midwifery standards review through the New Zealand College of Midwives, particularly focused on her documentation, and provide HDC with certified evidence that the special review has been completed.

- Undertake further education and training on documentation, care plans, monitoring during labour, and CTG interpretation, in conjunction with the New Zealand College of Midwives.

- Undertake further training on communication with clients, in conjunction with the New Zealand College of Midwives.

Follow-up actions

123.
- Ms B will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.
- 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, the New Zealand College of Midwives and the District Health Board, and they will be advised of Ms B's name.
- 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.

Addendum

124. The Director of Proceedings filed proceedings by consent against Ms B in the Human Rights Review Tribunal. The Tribunal issued a declaration that Ms B breached Right 4(1) of the Code by failing to provide services to Ms A with reasonable care and skill, and breached Right 4(2) of the Code by failing to provide services to Ms A that complied with legal, professional, ethical, or other relevant standards.

Appendix A — Independent midwifery advice to the Commissioner

The following expert advice was obtained from Ms Elizabeth Jull:

"I have been asked to provide an opinion to the Commissioner on case C12HDC00214 and have read and agree to follow the Commissioner's guidelines for independent advisors.

I registered as midwife in 1979 and have practised in the following areas of midwifery. Core Midwife, Lead Maternity Carer, accessing primary and secondary hospitals. I also care for women who choose to birth at home. At present I am working as a locum midwife and a casual core midwife in a primary maternity hospital.

I do not have any personal or professional conflict of interest.

Referral Instructions.

To provide comment on the following:

— A review of the case in light of the complaint.

— Your opinion on whether there were any aspects of [Ms B's] management (including documentation) of [Ms A's] pregnancy and labour that departed from expected standards and, if so the degree of departure.

— Whether there are any remedial actions or measures not yet undertaken by [Ms B] that should be considered.

Documents read.

— [Mr A's] and [Ms A's] complaint dated […]
— Undated complaint from [Ms A]
— [Baby A's] and [Ms A's] relevant clinical notes (from [the DHB])
— Coroners Findings
— Response from the NZCOM on behalf of [Ms B]
— Expert Advice from [Ms M] and [Dr L]

Care provided by [Ms B].

[Ms B] referred [Ms A] for a consultation to an Obstetrician regarding her pregnancy and labour care in a timely manner, i.e. at 25 weeks gestation.

[Ms A] had her options for care fully discussed at this appointment with the Obstetrician.

Letter dated [19 Month6] by [Dr C]:

> 'We had a long discussion today regarding VBAC (Vaginal birth after caesarean section) and she has obviously read the leaflet that you kindly gave her. We discussed not inducing labour, ensuring that she has good progress throughout labour and continuous fetal monitoring.'

[Ms A] was also seen again at the Obstetric clinic on [4 Month7] by [Dr D] (Obstetrician).

> '[Ms A] was seen in the clinic today. All seems to be well. The urine was clear and last week's ultrasound scan showed baby on the 50th percentile with normal liquor and resistive index. [Ms A] understands that we cannot induce her and she still would very much like VBAC. I have given her an appointment for review if she is still pregnant.'

[Ms A] was also assessed at the hospital on three occasions antenatally with abdominal pain and left flank pain. Despite several investigations regarding kidney function, no cause was found.

[Ms A] arrived at the hospital in labour on [21 Month8] at 0315hrs.

Communication

There appear to be problems with communication throughout the pregnancy and labour.

It would be usual practice for women to contact their LMC before going to hospital in labour, however sometimes women present at the hospital despite the LMC advising them to ring them first.

It is unclear as to whether [Ms B] advised [Ms A] to ring her when she went into labour (as I have not viewed the pregnancy care plan) but this is something that would usually be discussed in detail with the woman.

0315. [Ms A] and her family arrived at Delivery suite in labour. LMC notified by hospital midwife that [Ms A] had arrived in labour.

0335. [Ms B] was greeted on arrival at the hospital by the hospital midwife who had attached the CTG monitor to record the fetal heart rate and contractions.

> '[Ms A] was in good established labour, her partner attending and encouraging her. Both welcomed me and [Mr A] (partner) handed me their birth plan. The plan stated "[Ms A] wanted to be up and moving around during labour." I disconnected the CTG at 0400hrs as [Ms A] and [Mr A] were unhappy at her being restricted to the bed for monitoring.'

[Ms B's] report:

> '[Ms A] was advised by me that continuous fetal monitoring was recommended but expressed a wish for this not to happen.'

Paragraph 3 of [Ms B's] report to the coroner.

Statements by [Ms A] at the Coroner's inquest 19/8/2012.

Monitoring — 'at no time ever did I advise my LMC that I did not want to be monitored during the labour.'

[Ms A's] labour care plan did not document that she did not want to be monitored in labour.

If in fact [Ms A] was in 'good established labour' on arrival at the maternity unit it would be unusual for no fetal heart recordings to be done and documented for over an hour and a half 0400hrs–0540hrs. This statement does not match with the clinical records where [Ms B] has written, 'Monitor discontinued, uterine activity irregular and mild'. This would indicate that labour had not yet 'established'.

NZCOM Midwives Handbook for Practice. Standard Two.

The Midwife upholds each woman's right to free and informed choice and consent throughout the childbirth experience.

The Midwife shares relevant information, including birth options and is satisfied that the woman understands the implications of her choices.

[Ms B] did not meet this standard, there is no record of any discussions relating to informed choice, ie re continuous fetal monitoring in labour.

[Ms B] calls the Obstetrician to assist at the birth as [Ms A] is exhausted. [T]here is no CTG recording of the fetal heart rate (as recommended by the Obstetrician and recommended practice in caring for a woman having a vaginal birth after a caesarean section, VBAC). The baby is born unexpectedly compromised and needing urgent resuscitation. The Paediatrician was called to assist prior to the birth as is usual with an assisted birth (Kiwi Cup). There is no documentation regarding any discussion had with the family as to why the Paediatrician was called to assist at the birth.

[5 Month9]. [Dr K], Paediatrician, stated.

> 'I was informed by the midwife who was attending the delivery that the family's birth plan included minimal supervision by attending staff.'

[Ms A's] birth plan did in fact say:

> 'Only female Doctors/midwives/nurses to be in the delivery room and to do with the care for myself. If I am unable to make decisions [Mr A] will do so on my behalf and also any decisions concerning the care of our baby.'

Comment

Communication was inadequate during this time, [Ms A] was progressing well in her labour but there is no documentation to say that [Ms B] recommended continuous fetal monitoring.

Several family/support people documented in their letters of support that [Ms B] had made inappropriate comments to them during the labour.

Documentation

There are minimal baseline recordings performed on admission to hospital i.e. no blood pressure recordings at all during labour. It is usual midwifery practice to complete detailed observations on arrival in labour. Blood pressure, pulse, temperature and respirations, also a detailed abdominal examination would normally be done.

The vaginal examination performed by [Ms B] was also not clearly documented and lacked detail.

It is also good practice to document the findings of the CTG in the patient notes.

This was not done, ie no baseline fetal heart rate was recorded, no comment was made about whether the tracing was reassuring by [Ms B]. There was also no record of how frequent the contractions were, 'uterine activity irregular and mild.'

Statement by [Ms B] to the Coroner 23/2/2010.

> 'I was pleased at the trace and we discussed intermittent fetal heart monitoring as long as all was well. I advised [Ms A] and [Mr A] that given they did not agree to continuous monitoring, I would like to carry out a intermittent fetal heart monitoring every 15 mins, which could occur while [Ms A] was moving to which they agree. They had not agreed to continuous monitoring.'

[Ms A] presents her labour care plan on arrival at the hospital, which documents that she wants to be 'up and moving around during labour and not to give birth lying down'.

There is no documentation by [Ms B] that this care plan for labour has been discussed.

There are some irregularities in the documentation and the communication during labour.

Patient notes, 0400hrs.

> 'Monitor discontinued. Uterine activity irregular and mild. FH tracing good variation'.

There was obviously some discussion regarding going home at this stage as [Ms B] documented: '[Mr A] and [Ms A] have decided to stay'. On the labour and birth summary form for the hospital notes, at 0400hrs it indicates that labour has established.

Established labour is when the contractions are regular and strong. This does not match with the labour notes, above. [Ms B] also documents in the hospital notes at 0400hrs. Plan: CTG monitor baby if increase in uterine activity. The CTG was not used again.

[Ms B] stated:

> '[Ms A] was advised by me that continuous fetal monitoring was recommended but expressed a wish for this not to happen.'

There is no record of any discussion between [Ms B] and [Ms A] regarding future monitoring.

There appears to be a dispute about the fetal monitoring.

[Ms A] stated:

> 'At no time EVER did I advise [Ms B] that I did not want to be monitored during the labour as it was due to my partner and myself watching the monitor that we were able to ascertain that my first child was in distress.'

There is no documentation in the hospital notes of the conversation as above.

I agree with [Ms M], ACC's Expert Advisor, who stated:

> 'When working in partnership with women the onus is on the midwife to create a functional partnership (competency 1 NZCOM 2008). If an area of disagreement or refusal by the woman to allow a recommended practice arises, then it is good practice for the midwife to discuss the risks in detail and ensure that the woman is fully informed and consents to the management plan. The outcome of the discussion and the midwifery actions should then be documented in the records (Standard 2 NZCOM 2008). The MMPO ante natal care plan and ante natal records kept for [Ms A] have no record of [Ms B] and [Ms A] ever having a discussion about fetal heart monitoring in labour.'

Notes by Hospital Midwife, written in retrospect at 1225pm on [21 Month8]:

> 'Called to room as [Dr D] and LMC [Ms B] preparing for instrumental birth at approx 1135hrs. Paediatrician paged at some time by Midwife [Ms H].
>
> Partner in discussion with [Dr D], does not want anyone else in room — advised by [Dr D] that 2nd midwife and Paediatrician usually present and advisable for instrumental birth. Asked myself to leave — does not wish anyone else present — [Ms A] nodded in agreement with partner. Out of room.
>
> [Dr I] Paed Reg (Paediatric Registrar) attended birthing unit as requested by page. As per parents wishes told to [Dr D] and LMC [Ms B] that they did not want anyone else in the room including a Paediatrician for the baby. [Dr I] left BU (Birthing Unit) and said would attend @ anytime if needed and to page him.'

11.50. Emergency call bell, midwives attended and an emergency call was made to [Dr I].

In a letter (not dated), [Ms A] stated:

> 'We were not informed of any risks involved with the use of the kiwi cup.'
>
> '[Baby A] was placed on my chest by [Dr D].'
>
> '[Mr A] noticed that [Baby A] wasn't breathing and removed him to the resuscitation table and screamed for help.'
>
> 'When [Ms B] and [Dr D] tried to explain things they were using terms that [Mr A] and I didn't understand.'

Hospital notes, [21 Month8], 1610hrs, [Ms B] documents:

> '[Mr A], [Ms A's] partner talked with LMC before leaving, he apologised for questioning professionals who came into room.'

It appears that [Ms B] had not informed [Ms A] and her partner of the importance of having a Paediatrician present at an assisted birth (Kiwi Cup). There is no documentation to support this.

[21 Month8], [Ms B] documents in the hospital notes in retrospect:

> 'Emergency and staff call bell activated by LMC, baby cord pulse felt — no breathing, covered in **fresh** meconium.'

The baby birth details page of the hospital notes differ from the labour notes above.

Baby Birth Details form, summary (documented by [Ms B]): 'Kiwi Cup, Male, old meconium, very poor apgars'.

The documentation is inconsistent.

I do not have copies of the MMPO (Maternity and Midwifery Provider Organisation) notes, but it is evident from [Ms M's] expert advisor notes from 17/6/2010 that the documentation of discussions re fetal monitoring in labour were not recorded antenatally on the care plan.

The labour notes document that help was called appropriately (Obstetrician for the birth) and Paediatrician for help with resuscitation of the baby.

It is evident that [Ms B] was not aware that the baby was under stress during labour.

Labour notes: 11.15am entry by [Ms B].

> 'Informed OB Consult maternal exhaustion.'

[Ms B] did not monitor the fetal heart adequately as mentioned by [Ms M], who noted; 'In my opinion the fetus was not adequately monitored throughout labour'.

Remedial Actions undertaken by [Ms B].

2009: Competence Review and assessment, by the Midwifery Council of NZ.

A completed review and assessment of a midwife's competence conducted under sections 34–44 of the Health Practitioners Competence Assurance Act 2003 (The Act). As a result of this review [Ms B] was ordered to undertake a competence programme with the following components (including passing all assessments).

The following courses have been completed.

- NZCOM (New Zealand College of Midwives) Documentation course, 'Dotting the I's and Crossing the T's'. (1 Day course.)
- Midwifery Council representative visited [Ms B's] work premises.
- Audit of practice by the Midwifery Council.
- Electronic Fetal Surveillance course.
- Two day Technical Skills Workshop (Covering many obstetric emergencies.)
- Full day course on infant resuscitation.
- On Line NZ Maternity and Midwifery Systems package from Otago Polytechnic.
- Supervision by a Midwife appointed by the Midwifery Council. (Supervisor to report to Council.)
- Facilitated a meeting at [the] DHB to address issues of communication and to develop a plan for ongoing communication.

[Ms B] was to provide to the Midwifery Council a plan that shows how she will reorganise her practice so that she has regular time off call, has an identified back up person, facilitates women meeting the back up person, ceases to provide on-call cover for the DHB, and will maintain her caseload within professional guidelines of 6–8 women per month.

Of note is the following recommendation by the Midwifery Council of NZ.

Letter to [Ms B], 11th May 2012:

> 'The council has decided that a condition be imposed on [Ms B's] practising certificate which will prohibit her from prescribing until she has successfully completed the pharmacology and prescribing course.'

Letter to [Ms B], 11th May 2012:

> 'The Midwifery Council has considered the favourable reports from the midwifery supervisor and has agreed to remove the condition that [Ms B] is supervised. This condition has been removed from [Ms B's] practising certificate.'

I have checked the Midwifery Council Website today (5/9/2012) and it indicates that [Ms B] has no restrictions imposed on her practising certificate. From this I assume that [Ms B] has completed all requirements set by the Midwifery Council. There is no written record in the file to confirm that the pharmacology and prescribing course has been completed. There is also no written confirmation from [Ms B] that she has supplied her plan to the Midwifery Council to reorganise her practice, as noted above. [Ms B] appears to have completed all remedial actions imposed by the NZ Midwifery Council. [Ms B] will be required (as are all Midwives) to have a Midwifery Standards Review every two years. All Midwives are reviewed by a consumer and a Midwife.

I strongly recommend that [Ms B] consider working within a group Midwifery practice (if this is not at present happening). This would facilitate support and peer mentorship.

Standard 7, NZCOM, 2008. Identifies processes for ensuring midwife back-up access and support to other colleagues as necessary.

Opinion.

There were many areas of inadequate communication and documentation in the labour care.

The lack of documentation regarding discussions surrounding fetal monitoring is a severe deviation from accepted practice. There was no evidence of documentation prior to the labour of an agreed care plan.

The failure to document the decisions relating to informed consent is a severe deviation from accepted practice. There were inconsistencies in the recording of the notes. The notes must be an accurate record. This discrepancy is a serious departure from accepted practice.

The lack of regular and frequent monitoring of the fetal heart in the second stage of labour is a severe deviation from accepted practice.

There is no documentation to indicate that any discussion took place regarding what would happen if care became complicated and needed to be transferred to specialist obstetric/secondary care.

Elizabeth Jull
Expert Midwifery Advisor
New Zealand College of Midwives.

Additional advice

"I have been asked to provide further advice re the above case.

Referral Instructions
In your earlier advice you indicated the need to record a mother's refusal to receive CTG monitoring.

1. Please advise the circumstances in which CTG monitoring (including continuous CTG monitoring) is recommended and/or required.
2. If a patient refuses to receive CTG monitoring with a high risk pregnancy, [what] is the role of the midwife?
3. Please advise what level of monitoring was recommended or required in the present case and why?
4. Any other comments or information you believe is relevant would be appreciated.

1) Circumstances in which CTG monitoring (including continuous CTG monitoring) is recommended and/or required.
The following guidelines/statements and policies are provided to give some comparison of information available from different sources.

Continuous electronic fetal monitoring (CEFM) is recommended in labours 'at risk'. The following guideline (from RANZCOG) lists the risks antenatally and in labour. The highlighted factor being the key one in this case.

Royal Australian and New Zealand College of Obstetricians and Gynaecologists. (RANZCOG) Clinical Guidelines: Intrapartum fetal surveillance-second edition 2006.

Ante natal risk factors.

Prior Uterine scar/Caesarean Section.
Abnormal Doppler
Abnormal CTG
Suspected IUGR (intrauterine growth restriction.)
Oligohydraminos.
Prolonged pregnancy.
Multiple pregnancy.
Breech Presentation.
Significant APH (Ante partum haemorrhage.)
Prolonged ROM (Rupture of membranes more than 24 hours.)
Known fetal abnormality.
Pre eclampsia
Diabetes
Other significant medical conditions.
Intrapartum Risk Factors.
Induction of labour.
Augmentation of labour.
Epidural analgesia
Abnormal vaginal bleeding
Maternal pyrexia above 38°C
Meconium stained liquor
Oligohydramnios at ARM
Active first stage more than 12 hours. Regular contractions/4cms+
Active second stage more than 1 hour (pushing for 1 hour.)
Abnormal auscultation.
Abnormal CTG.

NZCOM Consensus Statement on Fetal Monitoring in Labour. 2005.

> 'Continuous fetal monitoring is recommended for high risk pregnancies where there is an increased risk to the baby.
>
> Commencement of continuous Electronic Fetal Monitoring (EFM) needs to be considered if any fetal heart rate abnormalities are detected in labour.'

NZ Guidelines Group MOH Nov 2004.

> 'The possible benefits and risks of EFM should be discussed with women with previous caesarean section. Regardless of the chosen monitoring method, the fetal heart rate should be recorded. Abnormalities in the fetal heart rate may precede uterine rupture and specialist consultation should be sought immediately.'

[Another DHB] ([Another] District Health Board.) Policy, Cardiotocograph (CTG) Recording. Original date 16/8/1999. Revised 24/5/2010.

> 'To ensure that all women who are assessed as having potential ante natal risk factors or develop intrapartum risk factors receive appropriate fetal monitoring. This applies to all women who are within the secondary care facility. Risk factors are those defined by the RANZCOG guidelines (Appendix 1) as listed above, or after consultation with the on call consultant.
>
> Women identified with having risk factors or who develop risk factors should have continuous CTG monitoring subject to informed consent in accordance with the Code of Health and Disability Services Consumers' Rights Regulation 1996.'

[Another DHB] Policy. Management of women with previous caesarean section. Original issue date 28/5/97. Revised 6/11/09.

> 'Continuous electronic fetal monitoring (CEFM) is recommended.
>
> The woman should be encouraged to be upright and to move around freely if she chooses intermittent auscultation.
>
> The wireless CTG is useful if continuous CTG is required to enable the woman to mobilise or labour/deliver in the water.'

[Another DHB] have also produced a DVD 'Birthing after Caesarean Section', which can be viewed on 'You Tube' … VBAC [Another DHB].

This DVD is designed for consumers to view and inform themselves regarding options for a vaginal birth after a caesarean section. EFM is discussed on this DVD.

NICE guidelines. National Institute for Clinical Excellence.
Intrapartum care of healthy women and their babies during Childbirth.
Clinical guideline 55, 2007. www.nice.org.uk

Indications and risk factors for continuous electronic fetal monitoring (EFM):

- Significant meconium stained liquor and consider continuous EFM for lightly stained meconium stained liquor.
- FHR less than 110 or greater than 160bpm, decelerations after a contraction.
- Maternal pyrexia 38 degrees once or 37.5 degrees twice 2 hours apart.
- Fresh bleeding in labour.
- Oxytocin in labour.
- Woman's request.

Other Risk factors present.

- **Previous caesarean section.**
- Pre eclampsia
- Pregnancy more than 42 weeks gestation.
- Premature rupture of the membranes more than 24 hours.
- Induced labour.
- Diabetes.
- Ante partum haemorrhage.
- Other maternal medical diseases.

In all of the quoted sources above the key factors of previous caesarean section and pushing for more than one hour in second stage of labour are listed as reasons for CTG monitoring. There is agreement between the sources on the appropriate procedure to be followed, although some sources are more prescriptive than others.

2) If a patient refuses to receive CTG monitoring with a high risk pregnancy, what is the role of the midwife.

The NZCOM defines the role of the midwife in the following competencies (Handbook, Standards of Practice 2008).

> 'The balance of power within the partnership fluctuates but it is always understood that the woman has control over her own experience.
>
> The Midwife provides up to date information and supports the woman/wahine with informed decision making.'

If the woman refuses to have CTG monitoring with a high risk pregnancy, the midwife needs to carefully document the discussion in the woman's maternity notes, the woman's care plan and the hospital notes. It would be good practice to ask the woman to read and sign the refusal. It would also be advisable for the Midwife to document what written information was given to the woman and identify where that documentation was sourced from. Given the multiple sources of information it is important that the material is specifically mentioned, and the date it was published.

It also is noted that the following is stated in the Code of Ethics, NZCOM Handbook for Practice 2008:

> 'Midwives accept the right of each woman to control her pregnancy and birthing experience.
>
> Midwives accept that the woman is responsible for decisions that affect herself her baby and her family/whanau throughout her childbirth experience.'

[Ms A] wrote out a care plan that indicated she wanted to be 'up and moving around during labour and not give birth lying down.' It would be appropriate for the Midwife to inform the woman that she would need to monitor the fetal heart rate regularly by intermittent auscultation if she is moving around and that if there were concerns with the fetal heart rate she would need to consult with a specialist obstetrician regarding further care. If there are concerns with the fetal heart rate the recommendation would be to commence continuous electronic fetal monitoring.

Statements within Standard Two, the Code of Ethics and Competency Two contained in (Handbook, Standards of Practice 2008), all support the notion of informed consent, with any conflicts of intended action between midwife and woman clearly documented and discussed fully. Ideally these discussions should be held before the birthing rather than as situations arise. The Midwife has a clear responsibility to ensure that no action or omission on their part places the woman at risk and to ask for help from other medical professionals if she has a concern re the care of a woman or her baby.

Whilst Standard Two, NZCOM Midwives Handbook for Practice, 2008 (updated version), has numerous statements regarding respecting the woman's right to make choices, there is an equally important statement relating to clearly state when her professional judgement is in conflict with the decision or plans of the woman. Standard two also states that the midwife discusses with the woman and colleagues as necessary, in an effort to find mutually satisfying solutions and documents decisions and her midwifery actions.

There is no documentation in the Hospital Maternity notes, the patient maternity notes (MMPO) or [Ms A's] care plan to say that she declines to have continuous electronic fetal monitoring in labour.

3) Please advise what level of monitoring was recommended or required in the present case and why.

[Ms A] was referred to be seen by a specialist obstetrician by her Lead Maternity Carer [Ms B], in line with the Maternity Referral Guidelines, 2007; Previous caesarean section.

[Ms A] was seen by [Dr C] (Locum Obstetrican/Gynaecologist). Date [19 Month5].

In the letter [Dr C] wrote to [Ms B] (copy to [Ms A]), [Dr C] documents:

> 'We had a long discussion in the clinic today regarding VBAC (vaginal birth after caesarean section) and she has obviously read the leaflet that you kindly gave her. We discussed not inducing labour, ensuring that she has good progress throughout labour and **continuous fetal monitoring** [bold inserted by writer]. We also discussed the risk of scar rupture. She is keen to pursue this.'

Guideline 10. RANZCOG. Fetal Surveillance Clinical Guidelines.

> 'Continuous Electronic Fetal Monitoring (EFM) should be recommended when risk factors for fetal compromise have been detected antenatally, are detected at the onset of labour or develop during labour.'

Ante natal risk factor, previous caesarean section.

[Ms M] RM, in report to the Coroner 17/6/2010 noted that:

> 'It is not possible to ascertain the fetal heart baseline when using intermittent auscultation and detection of late decelerations may not be reliable.
>
> Hypoxic fetuses may have a normal heart rate (Jibodu & Arulkumaran 2000). If the fetus had been continuously monitored it would have been the pattern of the heart rate, rather than the actual rate, which would have alerted health professionals to the developing or presence of hypoxia.'

The preferred level of monitoring recommended for [Ms A] was continuous when in established labour. There is an increased risk of scar rupture in a previous caesarean section birth and abnormalities of the fetal heart rate can indicate a problem.

Any other comments or information you believe is relevant would be appreciated.

Re-information given to [Ms A].

Both [Ms B] and [Dr C] mention that VBAC information (pamphlet) was given to [Ms A] to read, the specific pamphlet is not identified.

There is a pamphlet produced by the Ministry of Health, 'Vaginal Birth After Caesarean Section', containing information for pregnant women who have had a previous caesarean section birth (published July 2004). This pamphlet is commonly given to women to read, there is no mention of Electronic Fetal Monitoring in it. It states:

> 'Vaginal Birth after caesarean section (VBAC) is a safe option for the majority of women. Women considering their birthing options following caesarean section should have access to research-based information regarding the outcomes of VBAC.'

NZCOM Consensus statement VBAC, updated 2002.

Documentation from MMPO (midwifery notes) of [27 Month7], by [Ms B]:

> 'Encouraged to visit the B Unit (Birthing Unit) and to view monitor. VBAC Policy. Progress made earlier. At point of no progress during first birth and CS. Monitor baby — continuous if meconium (baby poo) in bag of waters. Obst input.'

This entry indicates that [Ms B] planned to monitor baby continuously in labour, if there was meconium present. From the documentation it is not clear if [Ms A] viewed [the DHB's] Policy/NZCOM statement on Fetal Monitoring in Labour.

[Ms A] cancelled the following ante natal visit on [31 Month7] and missed her appointment on [10 Month8] at [Ms B's] rooms.

[17 Month8] at 38.2 weeks, [Ms B] documents in the maternity notes.

> 'VBAC discussed, offered Birth Unit visit, not interested.'

Documentation by [Ms B] in the MMPO notes [27 Month7] indicates that she was keen to show [Ms A] around the birthing unit/delivery suite and explain what care would be provided, so that [Ms A] could become familiar with the unit as her last baby was not born there. The documentation also indicates that [Ms B] discussed VBAC care again. This is good practice and indicates an interest in informing [Ms A].

Also of note is the fact that the 'policy' given by [the DHB] to the Health and Disability Commissioner regarding fetal monitoring in labour is in fact the consensus statement from the New Zealand College of Midwives. This is a statement not a policy.

In summary, the grounds for fetal monitoring vary according to the information available, mainly in detail of what are specific risks.

[Another DHB] (for example) has a policy which uses the RANZCOG algorithm to identify the risk factors.

[The DHB] does not have a policy for CTG monitoring and instead uses the NZCOM consensus statement.

Further research-based information regarding the outcomes of Vaginal Birth after caesarean section pregnancies could be accessed and made available to women.

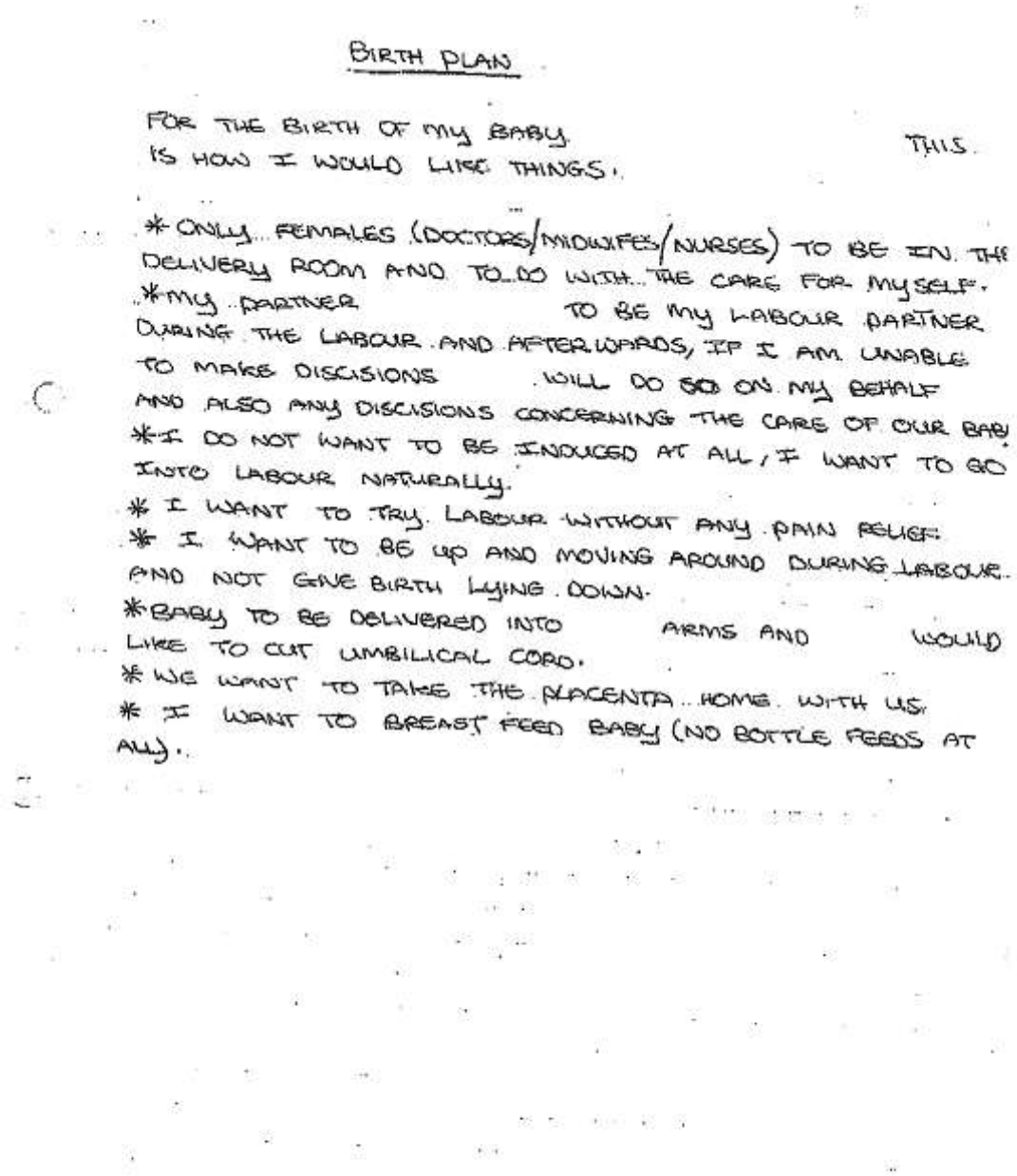
References.

NZCOM Consensus Statements.
Consensus statement Fetal Monitoring in labour (2005).
Consensus statement: Vaginal Birth After Caesarean Section. Updated 2002.
Consensus Statement: Informed Consent and Decision Making. Updated 2000
Care of women with a previous Caesarean section. NZ Guidelines Group

www.nzgg.org.nz November 2004.
Cardiotocograph CTG Recording, Policy [Another DHB] Revised 24/5/2010.
Management of Women with previous caesarean section. Policy [Another DHB] Original issue 28/5/97. Revised 6/11/09.
RANZCOG Clinical Guidelines Intrapartum fetal surveillance algorithm. Second edition 2006.
NICE guidelines. National Institute for Clinical Excellence.
Intrapartum care of healthy women and their babies during childbirth. Clinical guideline 55, 2007. www.nice.org.uk
NZCOM Handbook for practice. Updated version 2008.
Vaginal Birth After Caesarean Section, Information for pregnant women who have had a previous caesarean birth. MOH 2004.
Discussion re CTG policy [Another DHB] with [….] acting Director of Midwifery at [Another DHB].

Elizabeth Jull
Expert Midwifery Advisor
New Zealand College of Midwives"

Appendix B — Birth plan



BIRTH PLAN

FOR THE BIRTH OF MY BABY. THIS IS HOW I WOULD LIKE THINGS.

* ONLY... FEMALES (DOCTORS/MIDWIFES/NURSES) TO BE IN THE DELIVERY ROOM AND TO DO WITH... THE CARE FOR MYSELF.
* MY PARTNER TO BE MY LABOUR PARTNER DURING THE LABOUR AND AFTERWARDS, IF I AM UNABLE TO MAKE DISCISIONS WILL DO SO ON MY BEHALF AND ALSO ANY DISCISIONS CONCERNING THE CARE OF OUR BABY
* I DO NOT WANT TO BE INDUCED AT ALL, I WANT TO GO INTO LABOUR NATURALLY.
* I WANT TO TRY LABOUR WITHOUT ANY PAIN RELIEF.
* I WANT TO BE UP AND MOVING AROUND DURING LABOUR AND NOT GIVE BIRTH LYING DOWN.
* BABY TO BE DELIVERED INTO ARMS AND WOULD LIKE TO CUT UMBILICAL CORD.
* WE WANT TO TAKE THE PLACENTA HOME WITH US.
* I WANT TO BREAST FEED BABY (NO BOTTLE FEEDS AT ALL).