IN THE HUMAN RIGHTS REVIEW TRIBUNAL **[2015] NZHRRT 10**

Reference No. HRRT 016/2015

UNDER	**SECTION 50 OF THE HEALTH AND DISABILITY COMMISSIONER ACT 1994**
BETWEEN	**DIRECTOR OF PROCEEDINGS**
	PLAINTIFF
AND	**JENNIFER CAMPBELL**
	DEFENDANT

AT AUCKLAND

BEFORE:
Mr RPG Haines QC, Chairperson
Dr SJ Hickey MNZM, Member
Mr RK Musuku, Member

REPRESENTATION:
Ms N Wills, Director of Proceedings
Ms C Humphrey for defendant

DATE OF DECISION: 9 April 2015

DECISION OF TRIBUNAL

[1] These proceedings under s 50 of the Health and Disability Commissioner Act 1994 were filed on 27 March 2015.

[2] The parties have resolved all matters in issue and the Tribunal is asked to make a consent declaration. On 27 March 2015 the parties also filed:

> **[2.1]** A Consent Memorandum dated 13 March 2015.
>
> **[2.2]** An Agreed Summary of Facts, a copy of which is annexed and marked “A”.

[3] The Consent Memorandum is in the following terms:

MAY IT PLEASE THE TRIBUNAL

1. The plaintiff and defendant have agreed upon a summary of facts on the basis of which the parties seek a declaration in paragraph 2(a) below. A signed copy of the agreed facts is filed with this memorandum. The parties are agreed that it is not necessary for the Tribunal to consider any other evidence for the purpose of making the declaration sought. The parties request that the agreed summary of facts be published by the Tribunal as an addendum to the decision.
2. The plaintiff requests that the Tribunal exercise its jurisdiction in respect of the following matters:
   (a) A declaration pursuant to section 54(1)(a) of the Health and Disability Commissioner Act 1994 ("the Act") that the defendant has breached the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 ("the Code") in respect of:
      (i) Right 4(1) by failing to provide services to the aggrieved person with reasonable care and skill;
      (ii) Right 4(2) by failing to provide services to the aggrieved person that complied with legal, professional, ethical, or other relevant standards.
3. The defendant consents to the Tribunal making the above declaration based on the facts set out in the agreed summary of facts.
4. In the statement of claim the plaintiff also sought the following relief:
   (a) damages pursuant to s 57(1); and
   (b) costs.
5. These other aspects of the relief claimed by the plaintiff have been resolved between the parties by negotiated agreement. There is no issue as to costs.
6. The defendant does not seek any order prohibiting publication of the defendant's name.

[4] Having perused the Agreed Summary of Facts the Tribunal is satisfied on the balance of probabilities that an action of the defendant was in breach of the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 and that a declaration should be made in the terms sought by the parties in paragraph 2 of the Consent Memorandum.

DECISION

[5] By consent the decision of the Tribunal is that:

[5.1] A declaration is made pursuant to s 54(1)(a) of the Health and Disability Commissioner Act 1994 that the defendant breached the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 in respect of:

[5.1.1] Right 4(1) by failing to provide services to the aggrieved person with reasonable care and skill;

[5.1.2] Right 4(2) by failing to provide services to the aggrieved person that complied with legal, professional, ethical or other relevant standards.

....	....	....
Mr RPG Haines QC **Chairperson**	**Dr SJ Hickey MNZM** **Member**	**Mr RK Musuku** **Member**

"A"

This is the Agreed Summary of Facts marked with the letter "A" referred to in the annexed decision of the Tribunal delivered on 9 April 2015.

BEFORE THE HUMAN RIGHTS REVIEW TRIBUNAL

UNDER Section 50 of the Health and Disability Commissioner Act 1994

BETWEEN **THE DIRECTOR OF PROCEEDINGS**, designated under the Health and Disability Commissioner Act 1994

Plaintiff

AND **JENNIFER CAMPBELL**, Midwife, Hamilton

Defendant

AGREED SUMMARY OF FACTS

Level 11, 86 Victoria Street, Wellington 6011
PO Box 11934, Wellington 6142
Phone: 04 494 7900 Fax: 04 494 7901

Nicola Wills - Director of Proceedings

AGREED SUMMARY OF FACTS

INTRODUCTION:

1. The plaintiff is the Director of Proceedings, a statutory position created by section 15 of the Health and Disability Commissioner Act 1994 ("the Act"). The plaintiff is acting for and on behalf of Mrs Linda Barlow ("the aggrieved person").

2. At all material times the defendant was a self-employed registered Midwife.

3. At all material times the defendant was a healthcare provider within the meaning of s 3 of the Act, and was providing health services to Mrs Barlow.

4. On 22 December 2009 Mrs Barlow and her husband, Robert Barlow, complained to the Health and Disability Commissioner ("the Commissioner") about services provided to Mrs Barlow during the labour and delivery of their son, Adam Barlow, in October 2009. The Commissioner's file was closed pending a Coronial Inquest. Following the Coroner's decision on 7 May 2012, the Barlows renewed their complaint to the Commissioner on 22 June 2012 and the Commissioner commenced an investigation on 22 February 2013.

5. On 17 December 2013 the Commissioner (appointed under s 9 of the Act) finalised his opinion that the defendant had breached Mrs Barlow's rights under the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 ("the Code") and, in accordance with s 45(2)(f) of the Act, referred the defendant to the plaintiff.

6. In January 2015 pursuant to s 49 of the Act the plaintiff decided to issue proceedings against the defendant before the Human Rights Review Tribunal.

7. The defendant acknowledges she breached the Code as outlined in the Commissioner's report (Case 12HDC00876) available on http://www.hdc.org.nz/decisions--case-notes/commissioner's-decisions/2014/12hdc00876. The summary of facts outlined below reflects the findings in the Commissioner's report.

BACKGROUND

The aggrieved person

8. Mrs Linda Barlow was a second time mother, having given birth to her first son in 2006. Mrs Barlow had had high blood pressure during the labour and delivery of her first son.

9. Mrs Barlow and her husband, Mr Robert Barlow, planned a home birth for their first son, but the plan was abandoned when Mrs Barlow experienced difficulties during her labour. The baby was in the posterior position and became distressed; an emergency transfer to hospital was required, where the baby was born via a forceps delivery.

10. In 2009 Mrs Barlow had had a normal second pregnancy, with blood tests within the normal range, no abnormalities detected on her scans, normal urinalysis, and lots of fetal movements.

The defendant

11. Ms Campbell graduated as a midwife in December 2008 and had been practising as a self-employed midwife since that time.

12. In 2009 Ms Campbell was engaged in the First Year of Midwifery programme, which is a voluntary national programme for New Zealand registered midwifery graduates. In the programme, new practitioners are assigned an experienced mentor midwife, engage in further educational and professional development, and receive support.

13. Ms Campbell did not inform Mr and Mrs Barlow that she was a newly graduated midwife, or that she was participating in the First Year of Midwifery programme.

The clinic

14. The clinic is a primary birth centre and provides labour and birth facilities to Lead Maternity Carers ("LMC"s), and inpatient postnatal care to LMC clients. Independent LMCs utilise the clinic's facilities pursuant to an access agreement, as did Ms Campbell at the time of these events.

15. Mrs Barlow went on a scheduled tour of the clinic in late September 2009. She was told that, on admission, the LMC would usually monitor the fetal heart rate by CTG[1] for 20 minutes, and that if transfer to hospital was required, it would take five to ten minutes by ambulance.

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[1] Cardiotocography (as well as monitoring the fetal heart rate and rhythm, a cardiotocograph measures the strength and frequency of uterine contractions).

PARTICULARS RELATING TO MRS BARLOW

Antenatal care

16. On 30 September 2009, at 37 weeks' gestation, Mrs Barlow, aged 31 years, chose Ms Jennifer Campbell (then Jennifer Rowan) to be her LMC, after her first chosen LMC commenced long-term sick leave.

17. During Mrs Barlow's antenatal appointments with Ms Campbell, it was noted that the baby was in a posterior position,[2] which can result in a longer and more difficult labour.

18. On 5 October 2009 Mr and Mrs Barlow attended an appointment with Ms Campbell and advised Ms Campbell of the difficulties Mrs Barlow experienced with the birth of their first son, their anxiety associated with that, their concern that this pregnancy was mirroring the first pregnancy, and their concern that Mrs Barlow should therefore give birth at hospital.

19. Ms Campbell advised the Commissioner that she briefly touched on Mrs Barlow's previous delivery and briefly re-established the birth plan, but she did not do this in depth with them. She said that on reflection she should have sat with them and discussed both the previous pregnancy and delivery, and a birth plan for this labour.

20. At an appointment on 12 October 2009, Mr and Mrs Barlow again questioned the need for a hospital birth. Ms Campbell told Mrs Barlow

[2] A baby is said to be in the occiput posterior (OP) position (or posterior position for short) when it is head down but facing the abdomen. In this position, the back of the baby's skull (the occipital bone) is in the back (or posterior) of the woman's pelvis. Usually babies are born with their face towards the mother's back, which is called the anterior position. The anterior position is ideal, because it allows for the smallest diameter of the head to pass through the birth canal. If the baby is in the posterior position, a larger diameter will have to pass through the birth canal.

that posterior births can result in longer labours, but reassured her that second labours were usually a lot quicker, and therefore she did not recommend planning a hospital labour or birth. Ms Campbell reassured the Barlows that it was safe for Mrs Barlow to give birth at the clinic. Mrs Barlow agreed to continue with attempts at optimal fetal positioning, and that she was also going to try Pulsitilla to help turn the baby.

21. On 23 October 2009, when Mrs Barlow was three days beyond her due date, she attended the clinic for CTG monitoring. The CTG was normal. No other tests or observations were taken. Mrs Barlow was anxious that she was going to have another difficult labour, because she was going past her due date and the baby was posterior, as with her first son.

22. Mrs Barlow asked Ms Campbell again about labour and birth plans and the potential need for hospital intervention. Mrs Barlow also requested that a referral be made to the Women's Assessment Unit at the local hospital. Ms Campbell recorded on the referral: "Baby sitting POP since 37/40. Discussed optimal fetal positioning. Only 3 days past due date but Linda is very anxious [and] wanting this referral. Discussed with her that she probably wouldn't be seen until later next week. I will also do a CTG on Tues 27.10.09."

23. Mrs Barlow went into labour before an appointment at thehospital was scheduled.

Early labour and assessment at the clinic

24. At 12.30am on 25 October 2009, five days past her due date, Mrs Barlow's waters broke spontaneously at home and contractions started.

25. At 3.30am Mr and Mrs Barlow telephoned Ms Campbell and informed her that Mrs Barlow's contractions were strong, painful, occurring every two to four minutes and were lasting 60 seconds. Ms Campbell instructed the Barlows to meet her at the clinic.

26. At 4am Ms Campbell assessed Mrs Barlow at the clinic. Mrs Barlow was in pain, and was using Entonox[3] and a TENS machine[4] for pain relief. The fetal heart rate was recorded once at 4am by a short CTG monitoring as 110–118bpm and variable, with no decelerations. The contemporaneous notes made by Ms Campbell at 4am record:

> "Admitted to RREBC [the clinic] with history of SRM[5] at 0030, clear liquor, contractions directly following 2–4 mins apart lasting 60 secs. Very strong contractions on palpation. FHH[6] 110–118bpm. Has got a personal tens machine in use. Also using Entonox with contractions as she needs it. VE[7] with consent to assess. Cx[8] central, very thin, 2cm dilated, station –1. To have pain relief and go home to await labour."

27. Ms Campbell assessed Mrs Barlow as being in early labour and recommended that the Barlows return home. Ms Campbell accepts that her assessment of Mrs Barlow at 4am was incomplete and not thorough.

28. Mrs Barlow was experiencing significant pain and requested the use of the birthing pool to ease her pain, she also asked to remain at the clinic so that she could manage her pain by continuing to use Entonox. She expressed her clear desire to remain at the clinic and not return home.

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[3] A mixture of oxygen and nitrous oxide that is used as an inhalational analgesic.
[4] Transcutaneous Electrical Nerve Stimulation, commonly used for assisting with back pain or contraction pain during labour.
[5] Spontaneous rupture of membranes (waters breaking).
[6] Fetal heart heard.
[7] Vaginal examination.
[8] Cervix.

Ms Campbell sent the Barlows home, after leaving the room to discuss Mrs Barlow's request with the clinic staff.

Administration of pethidine

29. Ms Campbell recommended pethidine for pain relief, which was administered to Mrs Barlow at 5.15am.

30. The clinic's pethidine protocol requires that the drug be checked out from the controlled drug cupboard by a doctor, registered midwife or nurse together with another doctor, registered midwife or nurse or an enrolled nurse with a current generic IV certification. The protocol further states, "The controlled drug must be taken to the patient, together with the prescription sheet, and must be rechecked by two health professionals … to revalidate the medicine dose and patient identity." The protocol requires baseline maternal monitoring including blood pressure, pulse, respiratory rate, level of consciousness, pain assessment, and oxygen saturations. With regard to fetal monitoring, the protocol states:

> "Prior to administration of a narcotic to a pregnant woman, a baseline CTG monitoring must be reassuring.
>
> Post administration, a CTG monitoring should be done for a minimum of 30 minutes. If reassuring then discontinue until another dose is required. If non-reassuring notify Registrar immediately and continue CTG.
>
> Be aware that the fetal heart beat to beat variability and/or reactivity may be reduced when maternal pethidine is at its peak. If non-reassuring notify O&G Registrar immediately."

31. At 5.15am Ms Campbell gave Mrs Barlow 100mg of pethidine and 10mg of Maxolon. Ms Campbell did not assess Mrs Barlow's vital signs or the fetal heart rate prior to or after the administration of pethidine.

32. Ms Campbell accepts that she did not carry out a complete assessment before or after administering pethidine and that, in retrospect, she should not have sent the Barlows home, especially after pethidine administration.

Discharge home

33. At 6am the Barlows were sent home against their wishes. Ms Campbell did not examine Mrs Barlow or perform a vaginal examination prior to discharge. Mrs Barlow was in so much pain she could not walk, and had to be taken to her car in a wheelchair, where Ms Campbell assisted her onto the back seat of the car. Because of the pain, the only position Mrs Barlow could tolerate in the car was to be on all fours in the back seat.

At home

34. The Barlows arrived home at 6.30am, and Mrs Barlow was assisted to her bed. At that time Mrs Barlow was experiencing the same strong regular contractions, and was still in pain despite the pethidine.

35. At 9.30am Mr Barlow called Ms Campbell to come to their home, as they were scared, anxious, and exhausted. Ms Campbell arrived at their house at 10am and assessed Mrs Barlow. Mrs Barlow was found to be fully dilated, her contractions were strong with three to four contractions every ten minutes and lasting 60 seconds, and Mrs Barlow was pushing involuntarily at the height of her contractions. On vaginal examination, the cervix was fully dilated, at station 0, and clear liquor was draining. Ms Campbell instructed Mrs Barlow not to push.

36. Ms Campbell called a priority one ambulance at 10.22am, and the ambulance arrived at the Barlows' house at 10.41am. Mrs Barlow was transported to the clinic. Ms Campbell accepts that she did not consult the Barlows about whether they wished to go to hospital at that point or back to the clinic, and that she should have consulted with Mr and Mrs Barlow about the place of birth. Ms Campbell accepts that, in hindsight, Mrs Barlow should have been transferred from home to hospital.

Labour at the clinic

37. Mrs Barlow arrived at the clinic at 11am and commenced active pushing. The contemporaneous clinical notes record that the fetal heart was heard at that time, but the heart rate was not documented. The contemporaneous notes record: "11.15am Change position onto left lateral. FHH. Fetal head still at spines."

38. At 11.45am Ms Campbell suggested that Mrs Barlow change position to her hands and knees. Ms Campbell did another vaginal examination and felt the anterior fontanelle at 2 o'clock, and could feel caput. The fetal heart rate was recorded as 136bpm.

39. The contemporaneous notes record: "11.45am Change position hands + knees. Ant. Fontanelle felt at 2'oclock on hands + knees. FHH 136 bpm."

40. At 12pm Ms Campbell suggested that Mrs Barlow try the birth stool for more gravity and force, as there had been no further descent. Mrs Barlow's contractions were still three to four every ten minutes, lasting 60 seconds. The contemporaneous notes record: "1200 Onto birth stool, no change on descent. Linda feeling very exhausted, contractions still 3–4:10. Feeling faint, drinking plenty. FHH." Ms Campbell agrees she did not take any maternal observations other than Mrs Barlow's temperature at 12.15pm.

41. Ms Campbell listened to the fetal heart on only four occasions between 11am and 12.30pm, and did not take any maternal observations other than Mrs Barlow's temperature at 12.15pm. Despite attempts to listen to the fetal heart rate using the CTG machine, the heartbeat was not heard and did not show up on the screen. Ms Campbell attempted unsuccessfully to insert an IV luer into Mrs Barlow before arranging hospital transfer. At 12.15 pm the contemporaneous notes read:

> "12.15 Back onto bed now. IV luer attempt. Susan [staff midwife] attempt IV luer on other side. T-36 [Celcius]"

42. At 12.30pm, because of her failure to progress, Mrs Barlow was transferred to the local hospital by ambulance.

Hospital

43. At 12.30pm Ms Campbell notified hospital delivery suite that Mrs Barlow was being transferred for "failure to progress" and an ambulance was called.

44. A retrospective note made by Ms Campbell on 26 October 2009, recording events at 1.15pm on 25 October, states: "On admission asked staff mw [Ms H] to auscultate fetal heart as I was unable to hear it at 12.45 before transfer …" Ms Campbell subsequently advised that this retrospective note was incorrect, and the time at which she was unable to hear the fetal heart rate before transfer should read 12.15pm. Ms Campbell did not record in the contemporaneous notes made at 12.15pm that she had been unable to hear the fetal heart.

Handover of care

45. There is nothing documented to indicate there had been a formal transfer or handover of Mrs Barlow's care to secondary services when Mrs Barlow arrived at hospital.

46. The Ministry of Health Guidelines for Consultation with Obstetric and Related Medical Services (the Referral Guidelines) that applied at the time stated that, for such a referral, the decision regarding on-going clinical roles and responsibilities "must involve a three way discussion between the specialist, the Lead Maternity Carer and the woman concerned. This should include discussion on any need for and timing of specialist review. The specialist will not automatically assume responsibility for on-going care. This will depend on the clinical situation and the wishes of the individual woman."

47. On reflection, Ms Campbell accepts it was her responsibility to ensure that care had handed over on arrival and that she failed to clarify this.

48. Mrs Barlow was assessed at hospital by registrar Dr C at 1.20pm.

Abnormal fetal heart rate

49. At 1.20pm, the fetal heart was noted to be 140bpm with a variability of 5–8bpm which, although not reassuring, Dr C interpreted as being still within normal limits. Dr C found that Mrs Barlow was fully dilated and contracting every 3-4 minutes, the baby was in a posterior position, with his head just below the spines, and clear liquor was draining. There was a lot of "artefact" which made the trace difficult to interpret.[9]

50. Dr C instructed Ms Campbell to take Mrs Barlow's observations, insert an intravenous (IV) luer and commence IV resuscitation[10] for Mrs

[9] Disruption in the heart rate recording caused by mechanical problems.
[10] Intravenous fluid replacement.

Barlow, and to monitor the fetal heart rate and call her if there were any concerns. The hospital midwife was also present.

51. Ms Campbell accepts she failed to identify that the fetal heart rate was abnormal until she called Dr C back to assess Mrs Barlow at 2.25pm.

Emergency delivery

52. At 2.20pm Ms Campbell took Mrs Barlow's blood pressure and it was recorded as being 112/64.[11] Ms Campbell looked at the fetal trace and noted that it did not appear to show any variability. The hospital staff midwife noted that the CTG was non-reassuring and asked Ms Campbell to get the registrar urgently.

53. At 2.25pm Ms Campbell left the room to call Dr C. Dr C advised Ms Campbell that she would be down shortly. In the meantime, the staff midwife took Mrs Barlow's blood pressure again and found it to be very low (53/34). The emergency bell was activated, the emergency trolley was brought into the room, and Dr C was paged again. Dr C asked obstetric consultant, Dr K, to attend with her.

54. At 2.30pm Dr C and Dr K entered the room. Mrs Barlow was pale, tachypnoeic,[12] complaining of difficulty breathing, and had a distended abdomen and abnormal mottling of the skin. Dr K stated that an acute event resulting in maternal collapse was clinically obvious.

55. Dr C inserted a urinary catheter and noted blood in Mrs Barlow's urine. A vaginal examination revealed that the baby was still posterior. Dr K stated that the CTG was non-reassuring, with a baseline rate of 140bpm

[11] Normal (or ideal) blood pressure is below 120/80mmHg.
[12] Rapid breathing.

and absent variability. At 2.40pm it was decided to proceed with an emergency Caesarean section for possible uterine abruption.

56. Baby Adam Barlow was delivered at 3pm by emergency Caesarean section but could not be resuscitated and, sadly, died shortly after birth.

57. Mrs Barlow suffered a spontaneous uterine rupture, which led to a major intra-abdominal haemorrhage, which caused her to collapse. She required an emergency total abdominal hysterectomy under general anaesthetic, with simultaneous resuscitation and blood transfusions during the procedure. Mrs Barlow had a complicated postoperative recovery, with an initial inpatient stay of 37 days. Her injuries included bladder damage, cardiac arrest, hypoxic brain injury, skin grafting to her left arm, and sepsis. Mrs Barlow has required surgery several times since these events. Mrs Barlow suffered post-traumatic stress, depression, and anxiety, and has not been able to return to her previous level of employment.

58. Spontaneous uterine rupture in labour (not in the presence of a Caesarean section scar) is very uncommon in women in the developed world, and documented risk factors include prolonged second stage, obstructed labour, and malposition.

Documentation

59. All midwives entering employment with the clinic and all LMCs utilising the clinic pursuant to an access agreement are oriented to the clinic by a senior midwife, and that orientation can take up to several days. Ms Campbell signed her orientation checklist with all tasks marked as completed on 17 December 2008. During the Coroner's Inquest, Ms Campbell admitted that she did not read the policies that

she agreed to follow when she signed the access agreement with the clinic.

60. The clinic's Documentation policy, as it applied at the time of these events, notes that it is the LMC's responsibility for documentation in maternity notes, and that the clinical/maternity notes are the main source of communication among all health professionals. The policy states that notes should be written legibly and objectively, and should record findings and evaluations, and clients' care and responses to it. It also states that all changes in condition should be documented.

61. Ms Campbell accepts that her documentation was inadequate, particularly with regard to documentation of the fetal heart rate.

Coroner's findings

62. The Coroner released his findings into the death of Adam Barlow on 7 May 2012. The Coroner concluded that Adam died as a result of intra-partum asphyxia, and that the hypoxic environment had arisen during a prolonged second stage of labour due to fetal malposition and uterine rupture. He found that four factors relating to Ms Campbell contributed to Adam's death:

    (a) the LMC failed to recognise that the progress of labour was not normal;

    (b) the LMC failed to convey urgency on transfer (either verbally or in documentation) to hospital staff;

    (c) the LMC and hospital staff failed to recognise the urgency of Linda Barlow's situation and expedite delivery; and

(d) the LMC and hospital staff failed to review and properly interpret the CTG trace.

63. This series of failures contributed to the hypoxic intrauterine environment by extending the second stage of labour.

64. The relevant standards are contained in the 2008 *Midwives Handbook for Practice* published by the New Zealand College of Midwives. The standards are accepted by Ms Campbell as being applicable at the time of the events that are the subject of this claim.

BREACH OF THE CODE

65. The defendant acknowledges that her conduct as outlined above constitutes a breach of the following Rights pursuant to the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996:

1. Right 4(1): the right to have services provided with reasonable care and skill; and

2. Right 4(2): the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

FURTHER LEARNING

66. To rectify her breaches, the defendant advises that she has completed further learning, and changed her practice (copies of an education and recertification planner, and professional references are appended to this agreed summary of facts). The defendant has also completed a competence review by the Midwifery Council.

____

Nicola Wills
Director of Proceedings

Date:

I, **JENNIFER CAMPBELL**, agree that the facts set out in this Summary of Facts are true and correct.

____

Jennifer Campbell

Date:

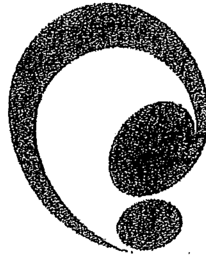
Midwifery Recertification Programme Summary and Planner

(Adapted from Midwifery Council Recertification Summary, March 2014)

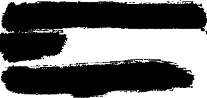
Your portfolio should include reflections about how research or learning has been incorporated into your practice.

CMH midwives present this recertification summary at their Performance Development Review for verification of meeting their APC Requirements

	1 April 2012 to 31 March 2013	1 April 2013 to 31 March 2014	1 April 2014 to 31 March 2015	1 April 2015 to 31 March 2016
Compulsory Education				
Combined Emergency Skills day (Annual – in 2014, due 12 months from when MR/NNR was completed in 2013)			Booked AUD 04/12/2014 Booked Skills 19/02/2015	
Midwifery Practice Day (Once every three years - due 3 years from last TSW Practice Day)		TSW-Sept 2013		Due 2016-2017
Breastfeeding Workshop (Half day, once every 3 years)				
Breastfeeding activity (Once every three years)			Applied breastfeeding workshop	
Midwifery Standards Review (Once every two years) *MSR Panels have discretion to change this requirement. New graduates are reviewed at the end of their first year*				Due June 2015
Practice across the Midwifery Scope Antenatal, Intrapartum, Postnatal				
Antenatal, Intrapartum, Postnatal	A I P	A I P	A I P	A I P
Elective Education				
In each 3 year period, 5 points per year, totalling a minimum of 15 points over 3 years	Courses attended & points:	Courses attended & points: 5 Compromised neonate 4 SUDI prevention 5 Maternal Mental Health	Courses attended & points: 5 Youth Health 5 Professional Issues 5 Contraception	Courses attended & points:
Professional Activities				
In each 3 year period, 5 points per year, totalling a minimum of 15 points over 3 years	Courses attended & points:	Courses attended & points 5 Perinatal Meetings	Courses attended & points 5 Perinatal Meetings 5 MDT 5 Revising guidelines	Courses attended & points



27 August 2012

Jennifer Campbell


Dear Jennifer

Thank you for calling me to advise that you about to return to work. I discussed your request regarding ongoing supervision with the Council at its recent meeting. I can advise you that the Council has agreed that supervision can cease. The conditions will be removed from your practising certificate and a new card will be forwarded to you as soon as possible. I will write to Helenmary and advise her of this in the near future. This means that your competence programme as required under the Order dated 15th July 2012 has now been completed.

The Council wants you to be supported as you return to practise and to ensure that the rights systems and structures are in place for you. The Council has therefore decided that it will write to Thelma Thompson, Director of Midwifery at CMDHB to ensure that you have the required support. I will forward a copy of my letter to Thelma in due course.

If you have any questions please do not hesitate to contact me.

Yours sincerely,

Susan Calvert
Midwifery Advisor, Midwifery Council
Suecalvert@midwiferycouncil.org.nz

MIDWIFERY COUNCIL OF NEW ZEALAND
Level 2, 69-71 Boulcott Street, Wellington 6011, PO Box 24448, Manners Street, Wellington 6142
Phone: +64 4 499 5040, Fax: +64 4 499 5045, Email: info@midwiferycouncil.health.nz, Website: www.midwiferycouncil.health.nz

19 March 2015

The Chairperson
Health Practitioners Disciplinary Tribunal
PO Box 10509
The Terrace
Wellington 6143

Dear Sir

Re: Midwife Jennifer Campbell 15- 13835

The Council has been requested by Ms Campbell's lawyer Carla Humphrey to confirm that Ms Campbell has completed the competence programme which was set under s38 of the Health Practitioners Competence Assurance Act 2004.

Here is a timeline which details the Council's processes with respect to the notification that it received in January 2010.

Birth of Adam Barlow	**October 2009**
HDC notification to the Council of the Barlow complaint	January 2010
Midwifery Council processes: Competence review undertaken S38 order competence programme, including practice under supervision Completion of competence programme Cessation of supervision	 March 2010 July 2010 September 2011 August 2012

The S 38Order Concerning Competence comprised the following components:

- Attends a NZCOM Dotting the I's, Crossing the T's workshop by 30 September 2010
- Completes an electronic fetal monitoring course by 28 February 2011
- Attends an obstetric emergency refresher course that covers uterine inversion, uterine rupture, and resuscitation of the pregnant woman by 31 December 2010. Course to be approved by Midwifery Council, Midwifery Advisor
- Attends and completes an adult CPR update that includes resuscitation of the pregnant woman by 31 March 2011
- Completes the postgraduate course Clinical Topic Promoting Normal Birth through Otago Polytechnic by 31 December 2010
- Completes the AUT Pharmacology and Prescribing course (2010) for midwives by 30 June 2011
- MSR pre April /2011

Evidence of completion of courses and reflections is to be sent to the Council.

I can confirm that all education components of the competence programme were satisfactorily completed by September 2011. However, Ms Campbell remained under supervision until August 2012, not because the Council had any ongoing concerns about her competence but because supervision continued to provide a professional safety net for her as she remained under intense media scrutiny leading up to and following the release of the coroner's finding in May 2012.

The Council was also aware that Ms Campbell had ceased community-based practice around the time of the coronial inquest 2011 and had commenced practice as an employed midwife at Counties Manukau DHB in May 2011. The Council had discussions with the Director of Midwifery at Counties Manukau to ensure that the DHB had in place the right structures and systems to support Ms Campbell in her place of work.

Finally the Council would add that since Ms Campbell completed her competence programme three and a half years ago and her period of supervision two and half years ago, no issues or concerns have been raised with respect to her competence.

I hope this is sufficient to explain the Council's processes and Ms Campbell's satisfactory completion of her s38 Competence Programme. If I can be of more assistance, please contact me.

Yours sincerely

Sharron Cole
CEO/Registrar

Cc: Carla Humphrey