NOTE ALL NON-PUBLICATION ORDERS MADE BY THE TRIBUNAL HAVE BEEN RESCINDED AND NO LONGER APPLY

IN THE HUMAN RIGHTS REVIEW TRIBUNAL **[2017] NZHRRT 11**

Reference No. HRRT 020/2017

UNDER **SECTION 50 OF THE HEALTH AND DISABILITY COMMISSIONER ACT 1994**

BETWEEN **DIRECTOR OF PROCEEDINGS**

PLAINTIFF

AND **PRISCILLA PUNITA**

DEFENDANT

AT WELLINGTON

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

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

DATE OF DECISION: 3 April 2017

DECISION OF TRIBUNAL[1]

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[1] These proceedings under s 50 of the Health and Disability Commissioner Act 1994 were filed on 28 March 2017.

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[1] [This decision is to be cited as: *Director of Proceedings v Punita* [2017] NZHRRT 11. When first published on 3 April 2017 this decision was subject to final publication restrictions. Those restrictions were subsequently rescinded by the Tribunal in *Director of Proceedings v Punita (Rescission of Non-Publication Orders)* [2017] NZHRRT 21]

[2] Prior to the filing of the proceedings the parties resolved all matters in issue and the Tribunal is asked to make a consent declaration. The parties have filed:

[2.1] A Consent Memorandum dated 14 March 2017.

[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 this decision.
> 2. The plaintiff requests that the Tribunal exercises 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; and
>   (ii) Right 4(2) by failing to provide services to the aggrieved person that complied with legal, professional, ethical, or other relevant standards.
>   (b) A final order prohibiting publication of the name of the aggrieved person in this matter (Denise Simpson-Vogan), her partner at the time of these events (Russ Mead) and their baby (Axton Tutahi Mead, also known as Axton Tutahi Simpson-Vogan).
> 3. The defendant consents to the Tribunal making the above declaration based on the facts set out in the agreed summary of facts, and the non-publication order sought in paragraph 2(b).
> 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(a) of the Consent Memorandum.

DECISION[2]

[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 Right 4(1) by failing to provide services to the aggrieved person with reasonable care and skill and in respect of Right 4(2) by failing to provide services to the aggrieved person that complied with legal, professional, ethical, or other relevant standards.

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[2] The non-publication orders made in this decision at para [5.2] were rescinded on 14 June 2017 by *Director of Proceedings v Punita (Rescission of Non-publication Orders)* [2017] NZHRRT 21.

[5.2] A final order is made prohibiting publication of the name, address and any other details which might lead to the identification of the aggrieved person and of her partner at the time of these events and of their baby. There is to be no search of the Tribunal file without leave of the Tribunal or of the Chairperson.

.....	.....	.....
Mr RPG Haines QC	**Dr SJ Hickey MNZM**	**Mr RK Musuku**
Chairperson	**Member**	**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 3 April 2017.

BEFORE THE HUMAN RIGHTS REVIEW TRIBUNAL

UNDER Section 50 of the Health and Disability Commissioner Act 1994

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

Plaintiff

AND **PRISCILLA PUNITA** of Rotorua, Retired Midwife

Defendant

AGREED SUMMARY OF FACTS

HDC
Health and Disability Commissioner
Te Tāhau Hauora, Hauātanga

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

SUMMARY OF FACTS

INTRODUCTION

1. At all material times Ms Priscilla Punita (Ms Punita):

    a. was an independent midwife working in Rotorua;

    b. was a healthcare provider within the meaning of s 3 of the Act, and was providing health services, in the form of midwifery services as Lead Maternity Carer (LMC) to Ms Denise Simpson-Vogan (the aggrieved person); and

    c. had been practising as a midwife in a variety of clinical settings since graduating as a midwife in 1999.

MS SIMPSON-VOGAN, ANTENATAL VISITS AND MIDWIFERY CARE

Initial visit

2. Ms Punita became the LMC for Ms Simpson-Vogan on 25 July 2008. At that time, Ms Simpson-Vogan was in the ninth week of her second pregnancy. Ms Punita saw Ms Simpson-Vogan for a total of 10 antenatal visits.

3. Ms Simpson-Vogan had previously had a difficult childbirth experience at Dunedin Hospital in 2004, where her daughter was born following an emergency caesarean due to a failure to progress and fetal distress.

4. At the initial meeting on 25 July 2008, Ms Punita discussed a "midwifery care-plan" with Ms Simpson-Vogan.

5. Ms Simpson-Vogan advised Ms Punita at that meeting that she wished her partner Mr Russ Mead to be fully involved with the birth as she had had concerns in her past labour experience that the DHB staff had not

interacted with Mr Mead. Ms Simpson-Vogan also told Ms Punita that she would like to try for a vaginal birth after caesarean (VBAC). Ms Punita recorded this discussion in the clinical notes.

6. Also at that meeting on 25 July 2008, Ms Punita:

   a. provided Ms Simpson-Vogan with a copy of the Ministry of Health publication entitled *"Vaginal Birth after Caesarean"* (VBAC) and the Sheila Kitzinger birth preparation DVD; and

   b. encouraged Ms Simpson-Vogan to formulate a birth plan and visit Rotorua Hospital to view the Birth Unit.

7. These steps were documented in the clinical notes.

8. Ms Punita also recorded in the clinical notes:

   "Birth Plan encouraged.

   Hospital (Birth Unit) visit encouraged."

9. Ms Punita did not document any discussions about continuous electronic fetal monitoring during labour with Ms Simpson-Vogan at the 25 July 2008 meeting.

Subsequent antenatal visits and recommendation for continuous monitoring

10. Ms Simpson-Vogan attended an antenatal clinic at Rotorua Hospital on 19 November 2008, where she saw an obstetrician, Dr Ruth Swarbrick. Dr Swarbrick wrote to Ms Punita to advise her of the consultation on 19 November 2008, stating:

    "We had a long discussion in the clinic today regarding VBAC and [Ms Simpson-Vogan] 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."

11. At a further visit with Ms Simpson-Vogan on 17 December 2008, Ms Punita recorded *"pain levels questioned today in relation to birth and plan."* On 30 December 2008, Ms Simpson-Vogan told Ms Punita that she wanted a female obstetrician and Ms Punita advised Ms Simpson-Vogan how this could be arranged.

12. Ms Punita visited Ms Simpson-Vogan on 27 January 2009, when Ms Simpson-Vogan was in the 35th week of her pregnancy. Ms Punita again recorded that Ms Simpson-Vogan was *"encouraged to visit to B [birthing] unit and view monitors."* However Ms Simpson-Vogan did not visit the birthing unit prior to going into labour. Ms Punita also recorded that she discussed the *"VBAC policy"* with Ms Simpson-Vogan at that meeting and noted:

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

13. On 4 February 2009, Ms Simpson-Vogan attended the obstetric clinic and was seen by obstetrician Dr Madhuri Ballal. Dr Ballal advised Ms Punita by subsequent letter that Ms Simpson-Vogan's pregnancy was progressing well and:

> "Denise understands that we cannot induce her and she still would very much like VBAC."

Onset of labour and arrival at delivery suite on 21 February 2009

14. Ms Simpson-Vogan's waters broke at her home at 1200 hours on 21 February 2009. She decided to travel to Rotorua Hospital at 0300 hours

because Dr Swarbrick had told her that she needed to be fully monitored throughout her labour.

15. Ms Simpson-Vogan arrived at Rotorua Hospital delivery suite at 0315 hours, accompanied by her partner Mr Mead, a friend, Ms Simpson-Vogan's mother and Mr Mead's mother. The hospital midwife noted *"[a]ppears to be in labour, not distressed, says contractions 1 x 3-4...LMC notified of arrival."*

16. Upon arrival at the delivery suite, Ms Simpson-Vogan informed the hospital midwife that the obstetrician had told her the fetal heart rate (FHR) was to be monitored continuously.

17. The clinical notes record that the hospital midwife connected Ms Simpson-Vogan to the cardiotocograph (CTG) monitor[1] at 0330 hours.

18. The clinical notes record that at 0330 hours, the CTG showed the FHR at 120 beats per minute (bpm) variable.

19. At 0332 hours, the hospital midwife recorded:

> "FHR ↓100-108 started to recover slowly then decel 100 with quick recovery to baseline 120 bpm. Onto L/side FHR 120."

Ms Punita's arrival at delivery suite

20. At 0335 hours, the hospital midwife recorded in the clinical notes:

> "FHR remains variable ... no further decal. FHR 135. LMC in attendance."

21. Ms Punita subsequently recorded in the clinical notes, that at 0335 hours:

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[1] An electronic instrument used to monitor the fetal heart rate and rhythm and the strength and frequency of the uterine contractions.

> "Denise in bed with monitor attached for a trace. Lying left lateral. Reports uterine activity from 12mnight. Woke up with a discharge. Pad with mucusy discharge present. Temp 36.5°C. Pulse 80/mt. Late decal noted on trace with good recovery. Left lateral position."

22. Ms Punita completed her clinical notes for the labour and delivery retrospectively (post-delivery). The records do not indicate that they were made retrospectively, other than an entry on 21 February 2009 at 1150 hours. Ms Punita accepts that because the clinical notes were written in retrospect, the notes may not be entirely accurate and the recordings of time give only a general indication of when events may have occurred.

23. At some point after her arrival at the hospital, Mr Mead gave Ms Punita the birth plan written by Ms Simpson-Vogan and Mr Mead. The Birth Plan states, relevantly:

> For the birth of my baby (Axton Tutahi Mead) 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 Russ Mead to be my labour partner during the labour and afterwards, if I am unable to make discisions [sic] Russ will do so on my behalf and also any discisions [sic] 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.
>
> ....

24. Ms Punita did not discuss the written birth plan with Ms Simpson-Vogan or Mr Mead.

The CTG trace

25. The times recorded on the CTG trace differ from those recorded in the clinical notes. The CTG trace indicates the following:

    a. Commencement at 0321 hours

    b. A late deceleration at 0322 hours (90-115bpm) lasting 1-2 minutes before recovering (slowly) to baseline at 0325.

    c. Between 0325 and 0330 the CTG shows that the baseline fetal heart rate was 130-140bpm with normal variability (>5bpm) and the presence of accelerations.

    d. There were further fleeting dips in the heartrate at 0333 hours, 0338 hours, 0348 hours and 0354 hours. A late deceleration to 110 lasting 40s was evident at 0357 hours.

Discontinuation of monitoring

26. The CTG was discontinued at 0400 hours. Ms Punita disconnected the CTG knowing that this was contrary to the Lakes DHB policy for VBAC (which adopts the 2005 NZCOM Consensus Statement), contrary to Dr Swarbrick's advice to continuously monitor Ms Simpson-Vogan, and contrary to the RANZCOG Guidelines which indicate that late deceleration may be associated with significant fetal compromise and require further action. In particular, continuous electronic fetal monitoring (Guidelines 10 and 11).

27. Before disconnecting the CTG at 0400 hours Ms Punita misread the CTG, only identifying one deceleration and failing to identify the CTG trace as suspicious. Ms Punita advised Ms Simpson-Vogan and Mr Mead that she would carry out intermittent FHR monitoring while Ms

Simpson-Vogan was moving about. Ms Punita also advised Ms Simpson-Vogan she would carry out a vaginal examination to assess progress after 4 hours or earlier if necessary.

28. Ms Punita recorded in the clinical notes that at 0400 hours:

> "Monitor discontinued. Uterine activity irregular and mild. FH trace good variation.
> Russ and Denise have opted to stay.
> Agreed to a VE
> Longitudinal lie ROL uterine activity mild Cervix tip of finger – head high."
> Plan. VE repeated at 8 am. CTG – monitor baby if increase in uterine activity.
> Oral fluids – does not want to lie down.
> *Requests only female staff*

29. Before discontinuing the CTG monitoring, Ms Punita did not provide Ms Simpson-Vogan with any information to enable her to make an informed decision to continue or discontinue CTG monitoring. Ms Simpson-Vogan recalls that Ms Punita told her it was unnecessary to have the monitor on and that she then disconnected it. When Ms Simpson-Vogan reminded Ms Punita that the obstetrician had told her she was to be fully monitored, Ms Punita told her that was a formality and that obstetricians always said that.

30. The plan Ms Punita recorded in the notes *"VE repeated at 8am. CTG – monitor baby if increase in uterine activity"* was not discussed with Ms Simpson-Vogan.

31. After the CTG monitor was disconnected, Ms Punita told Ms Simpson-Vogan that because labour was not fully established she should return home until labour was fully established. Ms Simpson-Vogan refused to go home, opting to stay at the hospital. Ms Punita recorded in the clinical notes: *"Russ and Denise have opted to stay…uterine activity mild"*.

32. In contrast to the clinical notes, Ms Punita recorded on the Labour and Birth Summary form that labour was established at 0400 hours.

33. Ms Punita left the room and had no contact with Ms Simpson-Vogan for one hour and 20 minutes sometime between 0400 hours and 0540 hours. The clinical notes do not record this period of no contact. Instead, the clinical notes indicate ongoing contact and review of Ms Simpson-Vogan and do not record a one hour 20 minute gap between notations during this time period. For example, Ms Punita recorded in the clinical notes that at 0445 hours Ms Simpson-Vogan was *"requesting to go out for a smoke"* and that at 0515 hours Ms Simpson-Vogan was *"out for a smoke."*

34. Ms Punita recorded in the clinical notes that at 0540 hours Ms Simpson-Vogan was back in the birthing unit *"Back into BU. Mobile. FHS 137-145/mt."*

35. In light of Ms Simpson-Vogan's risk factors (previous caesarean section for failure to progress and fetal distress, maternal smoking and suspicious CTG on admission to the birthing unit), continuous fetal monitoring from the point at which labour was established was recommended.

Active labour

36. Ms Punita recorded in the clinical notes that Ms Simpson-Vogan was experiencing "active labour pains" at 0600 hours. Contractions were 1 in 4 for 40s. She did not reinstate CTG monitoring of Ms Simpson-Vogan as per her earlier plan, nor did she discuss monitoring with Ms Simpson-Vogan or Mr Mead.

37. After 0600 hours (and up until the time Ms Simpson-Vogan felt like pushing at around 1000 hours), Ms Punita carried out intermittent auscultation with a hand-held Doppler. At 0630 hours Ms Punita recorded that contractions were 1 in 3 for 40s. Ms Punita recorded that she had monitored the fetal heart rate at 0630 hours, 0745 hours, 0800 hours, 0815 hours, 0830 hours, 0900 hours and 1000 hours.

38. Neither Ms Simpson-Vogan nor her support persons present at the birth recall Ms Punita monitoring the fetal heart rate as often as was subsequently recorded by Ms Punita.

Delivery of baby Axton

39. Ms Punita recorded that Ms Simpson-Vogan was *"pushy"* at 1015 hours with the FHR *"158 – 166/mt"*, *"pushing"* at 1030 hours and *"squatting up"* with FHR *"128 – 121"* at 1045 hours.

40. Ms Punita recorded that at 1100 hours she was able to see a *"peep"* of the baby's head at the perineum.

41. At around 1115 hours she consulted with Dr Ballal, as she was concerned that Ms Simpson-Vogan was exhausted. Ms Punita recorded that Ms Simpson-Vogan was *"pushing actively"* at 1120 hours with the FHR noted at *"128-115"*.

42. Dr Ballal assessed Ms Simpson-Vogan and observed the baby's head at the perineum. As delivery was imminent, Dr Ballal stayed in the room.

43. Ms Punita recorded that between 1120 hours and 1130 hours, Ms Simpson-Vogan was *"pushing – actively"* with the FHR noted as *"128 – 115"*.

44. At around 1135 hours, registered midwife Kathleen Smerdon, another midwife, and a paediatric registrar, Dr Ben Wheeler, answered a call-bell activation from Ms Simpson-Vogan's delivery room.

45. When Ms Smerdon entered the room, Dr Ballal and Ms Punita were preparing for an instrumental delivery of Ms Simpson-Vogan's baby.

46. Ms Punita recorded that between 1140 hours and 1150 hours *"head descending – on perineum"* and the FHR as *"127 – 115/mnt"*.

47. Dr Ben Wheeler, entered the Birthing Unit at 1145 hours. Mr Mead told Dr Ballal and Ms Punita that they did not want any unnecessary people in the room, and Ms Simpson-Vogan nodded her head in agreement. At 1147 hours Dr Wheeler left the Birthing Unit and said he would return at any time if he was needed and he could be paged. This interaction was recorded in the clinical notes by Ms Smerdon.

48. At 1145 hours, Dr Ballal easily applied a Kiwi Cup (ventouse suction cup) to baby Axton's head and he was delivered at 1150 hours, pale and not breathing, with a heart rate of 100bpm.

49. Ms Punita 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.

50. Axton was pale and floppy and making no attempt to breathe. He had poor Apgar scores of "3" at 1 minute, "3" at 5 minutes and "4" at 10 minutes.

51. Ms Smerdon and another midwife responded to Ms Punita's emergency call. When Ms Smerdon arrived in the delivery room, she was asked to page Dr Wheeler.

52. When Dr Wheeler arrived, he took over Axton's care. He suctioned Axton, 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 Axton, who was intubated and placed on Continuous Positive Airway Pressure.

53. Notes stated to be written in retrospect by Ms Smerdon at 1150 hours state:

> "Emergency call bell midwives Smerdon & Watson attended. I was instructed to page Paeds. Emergency page to Dr Wheeler made. Emergency call bell continued & attended to by Dr F. Nagel, SCBU & perinatal staff followed by Dr B Wheeler. Full resuscitation. Baby transferred to SCBU once stable with portable neopuff & father in attendance. End of retrospect."

54. Notes stated to be written in retrospect by Ms Punita at 1150 hours state:

> "Emergency and staff call bell activated by LMC – Baby cord pulse felt – no breathing, covered in fresh meconium."

55. Notes stated to be written in retrospect by Registered Midwife E Watson state at 1225 hours:

> "Called to room as Dr Ballal and LMC Priscilla Punita preparing for instrumental birth at approx 1135 hours. Paediatrician paged at same time by midwife K. Smerdon.
>
> Partner in discussion with Mrs Ballal – does not want anyone else in room – advised by Mrs Ballal that 2nd midwife and paediatrician usually present and advisable for instrumental birth. Asked myself to leave – does not wish anyone else present – Denise nodded in agreement with partner. Out of room."

Transfer to SCBU and Waikato Hospital

56. Axton was transferred to Rotorua Hospital SCBU at 1205 hours. Dr Wheeler recorded that Axton was suffering severe peripartum hypoxia

caused by meconium aspiration. Chest X-rays were taken and blood was taken for testing. Axton's initial blood gas on arrival in the SCBU showed a pH of 6.69 and a base deficit of -24 consistent with severe antenatal asphyxia. Axton was started on intravenous dextrose and antibiotics.

57. Axton's condition was explained to his parents and arrangements were made to transfer Axton to Waikato Hospital Neonatal Intensive Care Unit (NICU) by helicopter. The Waikato Hospital retrieval team uplifted Axton at 1530 hours.

58. Sadly, after full intensive management, Axton died at Waikato Hospital at 1430 hours on 22 February 2009 at 26 hours of age with his parents present.

Coroner's inquest

Post-mortem report

59. A post-mortem examination was conducted in Wellington by Dr Jane Zuccollo, who reported:

> 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.

60. The Coroner found in his certificate of findings dated 19 October 2010:

> I find that AXTON TUTAHI MEAD also known as AXTON TUTAHI SIMPSON-VOGAN was born at Rotorua Hospital on the 21st February 2009 and died at Waikato Hospital on the 22nd February 2009 as a result of perinatal asphyxia in a background of subgaleal haemorrhage and

foetal malnutrition. The foetal malnutrition occurred in a hypoxic environment in utero prior to the onset of labour.

61. In his reserved findings, the Coroner relied on the expert evidence of Dr Sylvia Rosevear, a Consultant Obstetrician and Gynaecologist, and Lesley Ansell, an expert Midwifery Advisor from the New Zealand College of Midwives, to make the following findings:

    a. Ms Punita made the decision to disconnect the CTG monitor at 0400 hours.

    b. The decision to disconnect the CTG monitor was a crucial one in the context of Axton's birth, was not the right decision and was against hospital policy, obstetrician advice and clearly wrong based on an interpretation of a suspicious CTG.

    c. The evidence of Lesley Ansell, an expert Midwifery Advisor from the New Zealand College of Midwives was accepted:

> *"In my opinion, the foetus was not adequately monitored throughout labour. Ms Simpson-Vogan'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 active 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. …*
>
> *There was a late deceleration evident at the commencement of the CTG, another which began at 0322 hours and the foetal heart took 3 minutes to return to the baseline rate. The presence of these decelerations occurring before the CTG was discontinued classifies this CTG as 'suspicious' (NICE, 2007). When CTG monitoring takes place, the foetus initially responds to any form of hypoxia with decelerations and*

foetal heart rate pattern, then with changes in the baseline rate and variability (Schifrin & Ater, 2006). The suspicious nature of the CTG acts as a warning sign, therefore continuous monitoring of the foetal heart throughout labour would have been the most appropriate course of action."

d. Intermittent auscultation (monitoring) in this case was not appropriate as it would be standard practice to continuously monitor the fetal heart in a woman with previous caesarean section throughout active labour in case of scar rupture. Auscultation provides a heart rate at the time of auscultation but not the pattern of the heart rate which would have alerted health professionals to the developing or presence of hypoxia.

e. Continuous CTG monitoring throughout labour could have prevented the death of Axton.

RELEVANT STANDARDS

62. The Midwives Handbook for Practice (2008) states at Standard Two:

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
- facilitates the decision-making process without coercion

...

- respects the decisions made by the woman, even when these decisions are contrary to her own belief

...

- clearly states when her professional judgement is in conflict with the decision or plans of the woman
- discusses with the woman, and colleagues as necessary, in an effort to find mutually satisfying solutions

...

- documents decisions and her midwifery actions

63. Competency One of the Competencies contained in the Midwives Handbook provides:

> Competency One:
>
> 'The midwife works in partnership with the woman/wahine throughout the maternity experience'...
>
> **Explanation**
>
> The word midwife has an inherent meaning of being "with woman". The midwife acts as a professional companion to promote each woman's right to empowerment to make informed choices about her pregnancy, birth experience and early childhood. The midwifery relationship enhances the health and well-being of the woman/wahine, the baby/tamaiti, and their family/whanau. The onus is on the midwife to create a functional partnership. The balance of 'power' within the partnership fluctuates but it is always understood that the woman has control over her own experience.

64. Further, Performance Criteria for Competency One include that, amongst other things, the midwife:

> 1.1 centres the woman/wahine as the focus of care;

65. The New Zealand College of Midwives Consensus Statement "Foetal monitoring in labour" (2005) states that:

> **"The New Zealand College of Midwives (Inc) considers that one to one midwifery care and intermittent auscultation of the foetal heart is the most appropriate method of assessing foetal wellbeing in an**

uncomplicated labour. The New Zealand College of Midwives does not support the routine use of continuous foetal monitoring on admission or in labour for women who have uncomplicated pregnancies.

...

Recommendations:

Midwives caring for women in labour provide continuous close support and monitoring. The assessment of foetal wellbeing is one component of this intrapartum care and consideration must be given to the woman's preferences and priorities in light of potential risk factors to both mother and baby. The following recommendations are made:

- Women must be able to make informed decisions regarding their care with access to evidence-based information.
- Prior to any form of foetal monitoring, the maternal pulse should be palpated simultaneously with FHR auscultation in order to differentiate between maternal and foetal heart rates.
- For a woman who is healthy and has had an uncomplicated pregnancy, intermittent auscultation with a Pinard stethoscope or hand held Doppler, is the recommended method of monitoring foetal wellbeing in labour.
- Continuous electronic foetal monitoring is recommended for high-risk pregnancies where there is an increased risk to the baby.
- Continuous electronic foetal monitoring should be used where oxytocin is being used for induction or augmentation of labour.
- Commencement of continuous foetal monitoring needs to be considered if any foetal heart rate abnormalities are detected in labour.

66. The Lakes District Health Board (Lakes DHB) policy on fetal monitoring consists of the NZCOM Consensus Statement (2005).

67. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists Clinical Guidelines on "Intrapartum Fetal Surveillance" (2nd ed. 2004-2006) (the RANZCOG Guidelines) state at Guideline 1:

1 Communication and information

Women are encouraged to involve themselves in making informed decisions together with their obstetrician, general practitioner or midwife about intrapartum fetal surveillance, based on accurate information and consideration of their particular risk factors, if any.

...

Women should have the same level of general care and support, regardless of their decision about intrapartum fetal surveillance.

Guideline 1

During their pregnancy, women should be offered information on intrapartum fetal surveillance

...

Case reviews have indicated that adverse perinatal outcomes are more likely to occur where there is lack of clear communication between clinicians caring for the individual woman and failure to use clear and consistent terminology...

...

Guideline 4

Fetal surveillance in labour, whether by intermittent auscultation or by electronic fetal monitoring, should be recommended to all women, in accordance with these guidelines.

...

IA [Intermittent Auscultation] should be undertaken at least every 15 – 30 minutes in the first stage of labour. In the second stage of labour, when fetal oxygenation is prone to change more rapidly, IA should be at least every 5 minutes in the absence of active pushing and toward the end and for at lease 30 seconds after each contraction during active pushing in the second stage of labour.

Guideline 10

Continuous EFM (electronic fetal monitoring) should be recommended when either risk factors for fetal compromise have been detected antenatally, are detected at the onset of labour or develop during labour.

Good practice note

Where continuous EFM is required for the substantial part of labour, and if the EFM to date is considered to be normal, monitoring may be interrupted for short periods of up to 15 minutes to allow personal care (e.g. shower, toilet). Such interruptions should be infrequent and not occur immediately after any intervention that might be expected to alter the FHR (e.g. amniotomy, epidural insertion or top-up etc).

...

Guideline 11

In clinical situations where the FHR pattern is considered abnormal, immediate management includes:

- Identification of any reversible cause of the abnormality and initiation of appropriate action (e.g. correction of material hypotension, cessation of oxytocin and/or tocolysis for excessive uterine activity) and
- Initiation or maintenance of continuous EFM.
- Consideration of further fetal evaluation or delivery if a significant abnormality persists.

Good Practice Note

...

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

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

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

- Prolonged bradycardia (<100 bpm for >5 minutes).
- Absent baseline variability.

- Sinusoidal pattern.
- Complicated variable decelerations with reduced baseline variability.
- Late decelerations with reduced variability.

BREACH – RIGHT 4(1) AND 4(2) OF THE CODE OF HEALTH AND DISABILITY SERVICES CONSUMERS' RIGHTS (the Code)

68. Ms Punita accepts the Coroner's findings, based on expert evidence, and that the findings accord with her understanding of the relevant standards of the midwifery profession. Ms Punita accepts that in failing to continuously monitor the fetal heart rate she failed to comply with the RANZCOG Guidelines, Lakes DHB policy and the advice given by the obstetrician, Dr Ruth Swarbrick.

69. In addition Ms Punita accepts that she failed to communicate effectively and appropriately with Ms Simpson-Vogan, by:

    a. Failing to adequately discuss Ms Simpson-Vogan's written birth plan with her;

    b. Failing to adequately discuss the decision to discontinue CTG monitoring;

    c. Failing to provide Ms Simpson-Vogan with adequate information to allow her to make an informed choice regarding the discontinuation of the CTG monitoring;

    d. Failing to adequately respond to Ms Simpson-Vogan when she questioned Ms Punita about why she was not being continuously monitored as per the recommendation of Dr Swarbrick; and

e. Failing to adequately explain to Ms Simpson-Vogan why additional medical staff are required for assisted births.

70. Ms Punita accepts that her actions as outlined above amount to a breach of the Code, namely:

> Right 4(1) *Every consumer has the right to have services provided with reasonable care and skill.*
>
> Right 4(2) *Every consumer has the right to have services provided that comply with legal, professional, ethical and other relevant standards.*

Dated at Wellington this of March 2017

_____

Nicola Wills
Director of Proceedings

I, Priscilla Punita agree that the facts set out in this Summary of Facts are true and correct.

_____

Priscilla Punita

_____

Date