(1) ORDER PROHIBITING PUBLICATION OF NAME OR IDENTIFYING PARTICULARS OF AGGRIEVED PERSON

(2) ORDER PREVENTING SEARCH OF THE TRIBUNAL FILE WITHOUT LEAVE OF THE CHAIRPERSON OR OF THE TRIBUNAL

IN THE HUMAN RIGHTS REVIEW TRIBUNAL **[2019] NZHRRT 27**

	Reference No. HRRT 019/2019
UNDER	**SECTION 50 OF THE HEALTH AND DISABILITY COMMISSIONER ACT 1994**
BETWEEN	**DIRECTOR OF PROCEEDINGS**
	PLAINTIFF
AND	**PAMELA NELL HURST**
	DEFENDANT

AT WELLINGTON

BEFORE:
Mr RPG Haines ONZM QC, Chairperson
Dr SJ Hickey MNZM, Member
Mr Mike Keefe JP QSM, Member

REPRESENTATION:
Ms J Herschell, Acting Director of Proceedings
Ms C Humphrey for defendant

DATE OF DECISION: 29 May 2019

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 22 May 2019.

[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:

[1] [This decision is to be cited as: *Director of Proceedings v Hurst* [2019] NZHRRT 27.]

[2.1] A Consent Memorandum dated 22 May 2019.

[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, a signed copy of which is filed with this memorandum, together with an anonymised copy.
> 2. The plaintiff requests that the Tribunal exercises its jurisdiction and issues:
>   (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 Right 4(1) by failing to provide services to the aggrieved person with reasonable care and skill; and
>   (b) A final order prohibiting publication of the name and identifying details of the aggrieved person in this matter.
> 3. In relation to the declaration being sought in paragraph 2(a) above, the parties respectfully refer to the agreed summary of facts. 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 anonymised agreed summary of facts be published by the Tribunal as an addendum to the decision.
> 4. 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).
> 5. In the statement of claim the plaintiff also sought the following relief:
>   (a) damages pursuant to s 57(1); and
>   (b) costs.
> 6. 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.
> 7. 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

[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.

[5.2] A final order is made prohibiting publication of the name and any other details which might lead to the identification of the aggrieved person. There is to be no search of the Tribunal file without leave of the Tribunal or of the Chairperson.

.....	.....	.....
Mr RPG Haines ONZM QC **Chairperson**	**Dr SJ Hickey MNZM** **Member**	**Mr Mike Keefe JP QSM** **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 29 May 2019.

BEFORE THE HUMAN RIGHTS REVIEW TRIBUNAL

HRRT /19

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 **PAMELA NELL HURST** of Tauranga, Registered Midwife

Defendant

AGREED SUMMARY OF FACTS

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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

Jane Herschell – Acting Director of Proceedings

AGREED SUMMARY OF FACTS

INTRODUCTION:

1. The plaintiff is the Director of Proceedings, exercising statutory functions under sections 15 and 49 of the Health and Disability Commissioner Act 1994 ("the Act").

2. The "aggrieved person" is Ms A.

3. At all material times the defendant was a self-employed registered midwife, providing maternity services to the aggrieved person as her lead maternity carer ("LMC"). The defendant became a registered midwife on 9 December 2011, and began practising in 2012.

4. 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 the aggrieved person.

5. On 30 March 2016, assisted by the Nationwide Health and Disability Advocacy Service, the aggrieved person's mother made a complaint to the Health and Disability Commissioner about services provided to the aggrieved person.

6. On 20 June 2017, the Health and Disability Commissioner (appointed under s 8 of the Act) finalised his opinion that the defendant had breached the aggrieved person's rights under the Health and Disability Commissioner (Code of Health and Disability Service Consumers' Rights) Regulations 1996 ("the Code") and in accordance with s 45(2)(f) of the Act, referred the defendant to the plaintiff.

BACKGROUND

7. At the material time, the aggrieved person was 20 years old and pregnant with her first child. The aggrieved person's estimated due date ("EDD") was 10 February 2016.

8. On 15 June 2015, at 5+5 weeks' gestation,[1] the aggrieved person booked the defendant as her LMC.

ANTENATAL CARE

9. The aggrieved person's pregnancy progressed as expected until 20 weeks' gestation. Throughout that time, the aggrieved person had regular antenatal appointments with the defendant.

10. On 23 September 2015, at 20 weeks' gestation, the aggrieved person underwent a routine ultrasound scan ("USS"). The scan showed normal fetal development apart from an umbilical abnormality. The USS report recorded:

> "…There is echogenic content identified within the right side of the umbilical cord proximal to the foetal insertion. This measures 14x10mm long. The cord surrounds the mass content, likely small bowel content.
> …
> There is a likely small omphalocele[2] identified vs umbilical hernia.[3] This appears to be an isolated finding.
> Foetal Medicine review recommended for karyotyping.[4] …"

[1] 5 weeks and 5 days.
[2] Rare abdominal wall defect where the intestines, liver, and occasionally other organs remain outside the abdomen in a sac because of failure of normal return of intestines and other contents back to abdominal cavity around ninth week of intrauterine development.
[3] When part of the intestine protrudes through the umbilical opening into the abdominal muscles.
[4] Test to identify and evaluate the size, shape and number of chromosomes in a sample of body cells.

11. The 2012 Ministry of Health *Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines)* ("Referral Guidelines") set the referral category for fetal abnormality as "consultation".[5]

12. The defendant referred the aggrieved person to the obstetric antenatal clinic at Tauranga Hospital (Tauranga ANC) and to the Maternal Fetal Medicine (MFM) service at Auckland City Hospital.

13. On 7 October 2015, at 22 weeks' gestation, the aggrieved person attended a routine antenatal appointment with the defendant.

14. On 8 October 2015, at 22+1 weeks' gestation, the aggrieved person was seen by MFM and underwent another USS which confirmed the abdominal wall abnormality. The USS report recorded:

> "… Abdominal wall: Herniation of abdominal contents adjacent (right side) of the cord insertion – most likely small bowel.
> 15x13 mm.
> …
> Umbilical hernia (possible exomphalos).
> …
> There is an abdominal wall defect, which is probably a hernia rather than exomphalos – although difficult to be certain. …"

15. The recorded birth plan was to keep the umbilical cord long when it was cut, to avoid any abdominal injury to the baby. A follow-up scan was planned for 32 – 34 weeks' gestation.

16. On 16 October 2015, at 23+2 weeks' gestation, the aggrieved person was seen at the Tauranga ANC by an obstetrician, who noted the MFM assessment, follow-up plan, and birth plan, and recorded that he did not consider there to be any other risk factors.

17. On 9 November, 25 November, and 9 December 2015, the aggrieved person attended routine antenatal appointments with the defendant.

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[5] The LMC must recommend to the woman that consultation with a specialist is warranted.

18. On 17 December 2015, at 32+1 weeks' gestation, the aggrieved person was seen by MFM, and underwent another USS. The USS showed a slight slowing of fetal growth, although the overall estimated fetal weight was still within normal range. The USS showed the abdominal wall defect to be unchanged, and it was considered to be more in keeping with that of an umbilical hernia. The USS also showed normal levels of liquor.

19. An obstetrician at MFM discussed the results with the aggrieved person and advised that the baby should be delivered at the hospital, but that the aggrieved person could have routine care during labour. The need to leave the umbilical cord long at delivery to avoid accidental injury to the bowel, was stressed. Serial growth scans were recommended. The obstetrician recorded a plan for the aggrieved person to have another growth scan in two weeks, and for a referral to the local obstetric service for input, with the defendant continuing routine care, and a paediatric review for the baby after delivery.

20. On 23 December 2015, at 33 weeks' gestation, the aggrieved person attended a routine antenatal appointment with the defendant. The defendant noted that the previous week's USS had shown slowed growth and that the plan was for a repeat USS in two weeks. The defendant provided the aggrieved person with a referral form for a repeat USS in "the next week or so".

21. On 7 January 2016, at 35+1 weeks' gestation, the aggrieved person attended a routine antenatal appointment with the defendant.

22. On 8 January 2016, at 35+2 weeks' gestation, the aggrieved person was again seen by an obstetrician at Tauranga ANC. The recorded plan was for the LMC to continue routine care, with the aggrieved person to be seen again in two weeks or sooner if indicated.

23. On 13 January 2016, at 36 weeks' gestation, the aggrieved person underwent a USS. The USS report recorded normal interval growth since the precious scan, and that the fetal hernia had not substantially changed since the USS taken at 20 weeks' gestation. The liquor volume was noted to be normal with the deepest pool measuring 4.1cms.

24. On 14 January and 20 January 2016, the aggrieved person attended a routine antenatal appointment with the defendant.

25. On 22 January 2016, at 37+2 weeks' gestation, the aggrieved person was seen by an obstetrician at Tauranga ANC who recommended a neonatal review post-delivery. Hospital delivery was also recommended, and a consultation with secondary care straight away if there were any concerns during labour.

26. On 27 January 2016, at 38 weeks' gestation, the aggrieved person attended a routine antenatal appointment with the defendant. The defendant recorded in her clinical notes that the aggrieved person had a day over the weekend when the baby had not moved as much as usual, and that the movements had changed, but that aggrieved person was still feeling the baby move each day.

EVENTS OF 3 – 4 FEBRUARY 2016

USS – diagnosis of oligohydramnios

27. On 3 February 2016, at 39 weeks' gestation, the aggrieved person underwent a USS at Medex Radiology, performed by a sonographer and a trainee sonographer. During the USS, the aggrieved person was experiencing some contractions.

28. The USS showed normal interval growth from the 36 week gestation scan with an estimated fetal weight of 3,113 grams.

29. The written USS report recorded: "Liquor oligohydramnios[6] (one single pool of 1.3cm)". The liquor was much reduced from the 36 week scan. The report noted there was no history of spontaneous rupture of membranes ("SROM") to account for the reduction in liquor. The USS report recorded that the abdominal anatomy and umbilical cord were unable to be reviewed due to the oligohydramnios. The USS report also recorded that the defendant was informed of the findings by telephone.

30. Medex Radiology's standard practice was to document verbal communication of ultrasound findings for results requiring prompt attention. Immediately following the USS, the trainee sonographer telephoned the defendant to report the USS findings and asked the defendant whether there was a history of SROM. The trainee sonographer recorded on her worksheet: "[defendant] verbal report ✓". The defendant has acknowledged it is unusual for a sonographer to call a provider about findings on a scan.

31. The report of the USS findings was sent to the defendant by facsimile at 5.42 pm the same day. The report was also sent to Tauranga Hospital, Tauranga ANC, and MFM. The defendant has stated that she did not receive a copy of the report. The defendant did not seek to access a copy of the report.

32. The Ministry of Health Referral Guidelines set the referral category for oligohydramnios as "consultation".

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[6] A deficient level of amniotic fluid. The Ministry of Health Referral Guidelines define oligohydramnios as no amniotic pool depth equal to or greater than 2cm, measured on a USS,

33. Following receipt of the trainee stenographer's telephone call, the defendant arranged to assess the aggrieved person at Tauranga Hospital due to the concern about the low liquor.

34. At 1.20 pm, the defendant met the aggrieved person and her partner at the hospital.

35. At 1.25 pm, the defendant began electronic fetal monitoring with the cardiotocograph ("CTG") monitor[7]. The aggrieved person was monitored with a CTG monitor for approximately 60 minutes.

36. At 1.30 pm, the defendant recorded that she undertook an initial assessment and the aggrieved person's observations[8] were normal, and that the aggrieved person advised she had been having mild contractions (one contraction every 10 minutes, lasting for 30 – 40 seconds) since 6.00 am that day. The aggrieved person's contractions settled during the CTG monitoring.

37. Following the CTG, the aggrieved person was reviewed by an obstetric registrar. The defendant also attended the consultation. The defendant recorded on a "maternity acute assessment" form that the reason for the referral to the obstetric registrar was: "Phonecall from Medex reporting ↓ liquor".

38. The registrar recorded that the aggrieved person had attended an ultrasound that day at Medex which had shown reduced liquor volume, with a single measurable pool only, and reduced fetal growth. There was

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or an amniotic fluid index < 7. Oligohydramnios is associated with maternal and fetal complications, including umbilical cord compression.

[7] A CTG monitor records the fetal heart rate and maternal contractions.

[8] Blood pressure, pulse, and temperature.

good fetal movement, and no history of SROM.[9] The obstetric registrar recorded that the aggrieved person had been seen at Tauranga ANC and MFM, and that the plan was to keep the umbilical cord long (at birth). The obstetric registrar further recorded that on examination, the aggrieved person appeared well, and the CTG was reassuring.

39. The obstetric registrar discussed the aggrieved person's presentation with a colleague and it was decided to book the aggrieved person into the hospital the next day to induce her labour.

40. The obstetric registrar did not document a plan for the aggrieved person, were she to go into labour before the planned induction.

41. The defendant did not consult the obstetrician about the plan for care in the event that the aggrieved person went into labour naturally before then.

Labour – first stage

42. During the evening of 3 February 2016, the aggrieved person's contractions started again. Established labour was recorded by the defendant to have commenced at 6.00 pm. At this time, the aggrieved person had a gush of fluid with a pink show.[10]

43. At 7.30 pm, the aggrieved person met the defendant at Tauranga Hospital.

44. At 7.40 pm, the defendant took the aggrieved person's baseline measurements: blood pressure ("BP") 122/72, pulse 96 beats per minute ("bpm"), Temperature 37°C.

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[9] Maternity acute assessment recorded: "USS today @ Medex ↓LV single pool only ↓growth Good FM Ø Hx SROM".

[10] A "show" is when the mucus plug blocking the entrance to the uterus comes away. A "pink show" is when that mucus plug is stained pink with blood.

45. The defendant under took a vaginal examination and recorded the aggrieved person was 8-9cm dilated and her cervix was fully effaced.[11] The defendant recorded that she felt the aggrieved person's membranes, meaning they were still intact.

46. The defendant did not consult with the obstetric team to clarify the plan for care when the aggrieved person went into spontaneous labour. It is routine practice to clarify the plan with an obstetrician when the clinical situation changes.

47. At 7.40 pm the defendant commenced CTG monitoring of the fetal heart rate ("FHR"). The defendant discontinued CTG monitoring at about 8.09 pm, reporting in the clinical notes that the CTG was "reassuring".

48. The CTG recorded that the baseline FHR was 120 – 130bpm and variability was between 5 – 15bpm. Accelerations were present. Occasional fleeting variable decelerations were also present.

49. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists *Intrapartum Fetal Surveillance Clinical Guideline* (Third Edition, 2014) ("RANZCOG Guidelines") state that a normal CTG is associated with a low probability of fetal compromise, and has the following features:

    - Baseline rate of 110 – 160bpm;
    - Baseline variability of 6 – 25bpm;
    - Accelerations of 15bpm for 15 seconds; and
    - No declarations.

[11] The cervix had thinned out in preparation for birth.

50. The RANZCOG Guidelines provide that all other CTGs are, by this definition, abnormal and require further evaluation taking into account the full clinical picture.

51. The aggrieved person's CTG was abnormal, as defined by the RANZCOG Guidelines.

52. The defendant failed to identify that the CTG was abnormal, and inappropriately recorded the CTG results as "reassuring".

53. At this time, the defendant recorded that the aggrieved person was wishing to use the birthing pool, and that the pool was filling. The defendant spoke to a staff midwife and asked her opinion on the aggrieved person using the birthing pool during labour.

54. The staff midwife made a retrospective record of her conversation with the defendant, at 11.45 pm, and recorded:

> "Notes in retrospect due to emergency
> Asked advice by LMC:
> LMC reports woman wants to get in pool. I asked dilation. LMC states "I don't think there is much cervix left". She advised "the CTG is normal." I advised the LMC to keep [Ms A] out of the pool due to oligohydramnios (today on USS) and ?hernia / ?exomphalus. I explained that there may be other abnormalities not detected on USS, and that due to this, & ?SROM (oligohydramnios) at an unknown time, it would not be wise to let [Ms A] in the pool. I emphasized that if the LMC decided to let [Ms A] labour in the pool, that she needed to birth out of the water".

55. Despite the defendant seeking a second opinion about using the pool for the aggrieved person's labour, she chose not to follow that opinion.

56. Contrary to standard practice, the defendant did not make any record of her conversation with the staff midwife.

57. At approximately 8.10 pm, the aggrieved person entered the birthing pool. At this time, the CTG was discontinued. The defendant did not

recommence CTG monitoring during the remainder of the aggrieved person's labour or delivery.

58. The RANZCOG Guidelines provide: "Continuous CTG 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". The RANZCOG Guidelines list oligohydramnios as an antenatal risk factor.

59. In the presence of risk factors such as oligohydramnios and non-reassuring features on the CTG, the expected standard of practice is for continuous CTG monitoring.

60. The defendant was aware of this practice but failed to recognise that the aggrieved person was high risk.

61. Given the clinical situation, the defendant's decision to discontinue CTG monitoring and to allow the aggrieved person to labour and birth in the pool, was a significant departure from accepted midwifery standards.

62. The defendant has stated that she did not recognise the aggrieved person's low levels of liquor constituted oligohydramnios. However, there is no distinction between the management of a woman in labour with oligohydramnios or a woman with low levels of liquor.

63. A low level of liquor is not a normal finding and the aggrieved person's liquor levels had changed significantly from 36 weeks' gestation. Despite this clinical situation and the defendant's earlier concerns about the low levels of liquor, the defendant failed to follow the expected management of a woman in labour with low levels of liquor. As the LMC, the expected practice would be that the defendant review the USS report and/or clarify

the findings with the sonographer and/or an obstetrician if unsure of the severity of the low liquor.

64. At 8.30 pm, the defendant heard the FHR using a Sonicaid[12] and recorded that it was 130bpm. The defendant continued to use the Sonicaid to determine the FHR while the aggrieved person was in the birthing pool.

65. Also at 8.30 pm, the defendant recorded that the aggrieved person began to feel like pushing. The defendant asked the aggrieved person if she would like to get out of the birthing pool, and the aggrieved person advised she did not want to. The defendant recorded that the aggrieved person had a SROM and a pink show, in the birthing pool.

66. At 8.40 pm, the defendant recorded the FHR as approximately 120bpm.

Labour – second stage

67. The defendant recorded on the "Labour and Delivery Record" that the second stage of labour commenced at 9.00 pm. The defendant recorded in the clinical notes that the aggrieved person was pushing at the peak of each contraction, and the FHR was 130bpm.

68. At 9.20 pm the defendant recorded that the FHR as 120-130bpm.

69. At 9.40 pm the defendant recorded the FHR as 140bpm.

70. At 9.50 pm the defendant recorded the FHR as 120bpm.

71. The defendant retrospectively recorded the FHR as 100bpm at 9.55pm.

72. The normal range for FHR during labour is 110 – 160bpm.

[12] A handheld ultrasound transducer used to detect the FHR.

73. The RANZCOG Guidelines provide that in clinical situations where the FHR pattern is considered abnormal, immediate management should include:

- Identification of any reversible cause of the abnormality and initiation of the appropriate action;
- Initiation or maintenance of continuous CTG;
- Consideration of further fetal evaluation or delivery if a significant abnormality exists; and
- Escalation of care if necessary to a more experienced practitioner.

74. The Ministry of Health Referral Guidelines set the referral category for FHR abnormalities as "consultation".

75. Contrary to accepted midwifery practice, the defendant failed to advise the aggrieved person to leave the pool when the FHR was noted to be 100bpm, to enable closer monitoring of the FHR, or to advise the aggrieved person that consultation with an obstetric registrar was warranted.

76. The RANZCOG Guidelines and the New Zealand College of Midwives Consensus Statement, 'Assessment of fetal wellbeing during pregnancy' (2012) further provide that the fetal and maternal heartbeats should be differentiated, regardless of the mode of monitoring used, to ensure an accurate record of fetal wellbeing is obtained. In the presence of a FHR of 100bpm, the defendant did not check the aggrieved person's pulse to ensure that she was hearing the FHR rather than the maternal pulse.

77. At 10.00 pm, the defendant recorded that peeks of vertex[13] were visible on pushing.

78. At 10.10 pm, the defendant recorded that the aggrieved person was "pushing really well vertex advancing".

79. The defendant retrospectively recorded the FHR at 10.15 pm as 100bpm.

80. Contrary to accepted midwifery practice, the defendant did not record the auscultated FHR after each contraction or every five minutes during the active second stage of labour.

81. The defendant did not advise the aggrieved person to leave the birthing pool when delivery was imminent.

Delivery

82. At about 10.17 pm, the defendant delivered the aggrieved person's baby ("Baby N") underwater and unwrapped the cord from around his neck. The defendant handed Baby N to the aggrieved person for skin-to-skin and noted Baby N was pale, floppy, lacking in tone, and not breathing, although she could feel a pulse in the umbilical cord. At this point the defendant was not alarmed about Baby N's condition. The defendant attempted to stimulate Baby N by drying and rubbing him.

83. At approximately 10.19 pm, the defendant pressed the midwifery assist call bell and the staff midwife responded and entered the delivery room.

84. When the staff midwife entered the delivery room, she pressed the emergency call bell, opened the delivery instruments and moved them to within reach of the defendant, and plugged in the oxygen and tested it.

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[13] The baby's head.

85. During the delivery, the defendant's delivery instruments were not open, or within reach in preparation for the birth. It is standard practice for a midwife to have the equipment needed for birth and resuscitation checked and prepared before the birth, in case it is needed (for example the resuscitation table set up with heat lamp on and oxygen plugged in).

86. At about 10.20 pm, a number of staff midwives responded to the emergency call bell and entered the delivery room. Baby N's umbilical cord was cut at approximately three minutes of age and Baby N was transferred to the resuscitation table.

87. Contrary to accepted midwifery practice, the defendant failed to press the emergency call bell immediately when Baby N was born pale and floppy and making no respiratory effort, to obtain immediate neonatal assistance, and failed to clamp and cut the umbilical cord immediately to enable prompt neonatal resuscitation.

Post-delivery - Baby N

88. After being transferred to the resuscitation table Baby N was given intermittent positive pressure ventilation via a Neopuff. Baby N's clinical notes record that his heart rate was 120bpm, but that he had no tone, was blue, and was not breathing spontaneously.

89. Paediatric medical assistance was called for and the staff midwives assisted with Baby N's resuscitation until a paediatric Senior House Officer arrived at approximately 10.22 pm, when Baby N was 4 – 5 minutes of age, and took over resuscitation. A paediatric Registrar arrived shortly after, as Baby N's heart rate dropped, and Baby N was intubated.

90. Baby N's Apgar scores[14] were 0 at 1 minute, 2 at 5 minutes, and 4 at 10 minutes.

91. Baby N took his first spontaneous breath at 30 minutes of age.

92. The defendant transferred the aggrieved person's care to hospital staff at about 2am and went home.

93. At about 10.05 am on 4 February 2016, the Waikato Neonatal Retrieval Team arrived at the hospital.

94. At about 2.30 pm, Baby N was transferred to Waikato Hospital by helicopter.

95. Sadly, Baby N passed away at 12.46 pm on 5 February 2016. Baby N was diagnosed with hypoxic ischaemic encephalopathy.[15]

FURTHER LEARNING

96. As a result of this complaint, the Midwifery Council of New Zealand ("the Council") undertook a competency review of the defendant in May 2017. The Council ordered the defendant to undertake a competence programme, including 12 months' supervision. The defendant began the competence programme in July 2017.

97. As a result of the complaint, and in compliance with the prescribed competency programme, the defendant has undertaken additional training. The defendant has successfully attended:

    a) RANZCOG FSTEP[16] Full Program (10 August 2017);

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[14] The Apgar scoring system is a widely used method of summarising the health of a newborn using five criteria (appearance, pulse, grimace (reflex), activity, and respiration). Scores range from 0 – 10, with 10 being optimal.

[15] A brain injury caused by oxygen deprivation.

b) Dotting I's and Crossing T's – Midwives and Recordkeeping (23 January 2018); and

c) Preeclampsia and Fetal Growth Restriction: Practical knowledge to enhance management of pregnancy (11 May 2018).

BREACH OF RIGHT 4(1) OF THE CODE

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

99. The defendant acknowledges that her conduct as outlined above constitutes a breach of Right 4(1) of the Code. In particular, the defendant accepts that:

a) prior to labour, the defendant did not attempt to access the USS report from Medex Ultrasound to clarify her understanding of the USS results and, as a result, failed to recognise that the aggrieved person's labour would be "high risk", requiring continuous CTG monitoring;

b) the defendant incorrectly interpreted the CTG report at 7.70pm – 8.20pm as being "reassuring";

c) the defendant did not communicate effectively with the hospital midwife about the hospital midwife's concern with the aggrieved person using the birthing pool during labour;

d) the defendant did not recommend the aggrieved person get out of the birthing pool and did not undertake closer FRH monitoring at 9.55pm, when the FHR was 100bpm;

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[16] Fetal Surveillance Education Program.

e) between 9.55pm and 10.15pm the defendant did not document the auscultated FHR after each contraction or every five minutes during the active second stage of labour;

f) when the FHR was detected at 100bpm on several occasions between 9.55pm and 10.15pm, the defendant did not check the maternal pulse to ensure that she was hearing the FHR;

g) the defendant did not prepare the birthing and resuscitation equipment adequately; and

h) the defendant failed to recognise that Baby N's condition was severely compromised at birth, and immediately press the emergency call bell, and clamp and cut the umbilical cord.

_____

Jane Herschell
Acting Director of Proceedings
Date:

I, **Pamela Nell Hurst** agree that the facts set out in this Summary of Facts are true and correct.

_____

Pamela Nell Hurst
Date: