(1) ORDER PROHIBITING PUBLICATION OF NAME, ADDRESS AND ANY OTHER IDENTIFYING PARTICULARS OF THE DEFENDANT.

(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 38

	Reference No. HRRT 092/2016
UNDER	SECTION 50 OF THE HEALTH AND DISABILITY COMMISSIONER ACT 1994
BETWEEN	DIRECTOR OF PROCEEDINGS
	PLAINTIFF
AND	MRS N
	DEFENDANT

AT WELLINGTON

BEFORE:
Mr RPG Haines ONZM QC, Chairperson
Ms K Anderson, Member
Ms W Gilchrist, Member

REPRESENTATION:
Ms V Casey QC and Ms J Herschell for plaintiff
Mr L Taylor QC and Ms R Scott for defendant

DATE OF DECISION: 2 August 2019

(REDACTED) DECISION OF TRIBUNAL[1]

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[1] [This decision is to be cited as *Director of Proceedings v N* [2019] NZHRRT 38.]

[1] These proceedings under s 50 of the Health and Disability Commissioner Act 1994 were filed on 22 December 2016.

[2] The parties have subsequently 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 24 September 2018.

[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 the defendant have agreed upon a summary of facts, a signed copy of which is filed with this memorandum.
> 2. The plaintiff requests that the Tribunal exercises its jurisdiction and issues 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.
> 3. In relation to the declaration sought in paragraph 2 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 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 facts set out in the agreed summary of facts.
> 5. The aggrieved person (Mrs Cerise Lawn) and her husband (Mr Timothy Lawn) do not seek any order prohibiting publication of their names or the name of their daughter (Miss Ariana Lawn).
> 6. Any application (and supporting affidavit) for name suppression by the defendant is to be filed by Friday 5 October 2018. Any notice of opposition to that application by the plaintiff is to be filed by Friday 12 October 2018.
> 7. In the statement of claim the plaintiff also sought damages pursuant to s 57(1). This aspect of the relief claimed by the plaintiff has been resolved between the parties by negotiated agreement. There is no issue as to costs.

[4] The application by the defendant for a permanent order prohibiting publication of her name was granted by the Tribunal in *Director of Proceedings v Smith (Application for Final Non-Publication Orders)* [2019] NZHRRT 32 (17 June 2019). The Tribunal made final orders that:

> **[141.1]** Publication of the name, address, occupation and of any other details which could lead to the identification of the defendant in these proceedings is prohibited.
>
> **[141.2]** There is to be no search of the Tribunal file without leave of the Chairperson or of the Tribunal. The plaintiff and defendant are to be notified of any request to search the file and given opportunity to be heard on that application.
>
> **[141.3]** The decision of the Tribunal, once redacted to comply with the above suppression orders, is to be released for reporting as *Director of Proceedings v Smith (Application for Final Non-Publication Orders)* [2019] NZHRRT 32.

[5] 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

[6] By consent the decision of the Tribunal is that 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.

.....	.....	.....
Mr RPG Haines ONZM QC	**Ms K Anderson**	**Ms W Gilchrist**
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 2 August 2019.

BEFORE THE HUMAN RIGHTS REVIEW TRIBUNAL

HRRT 092/16

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	**MRS N**, Midwife **Defendant**

AGREED SUMMARY OF FACTS
(Redacted)

Health and Disability Commissioner
Te Tohau Hauora, Hauātanga

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

Kerrin Eckersley – 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. In 2011 the "aggrieved person" (Mrs Cerise Lawn) was aged 20 years and pregnant with her first child. At all material times the aggrieved person was a consumer of health services.

3. At all material times the defendant, Mrs N, was a registered midwife employed by Taranaki District Health Board ("TDHB") as a hospital midwife at Taranaki Base Hospital ("the hospital").

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 and her baby within the meaning of s 2 of the Act.

5. In April 2012, the aggrieved person and her husband complained to the Health and Disability Commissioner ("HDC") about the care provided to the aggrieved person by the defendant and the aggrieved person's Lead Maternity Carer ("LMC") obstetrician during the labour and birth of their baby, Ariana Lawn ("Ariana").

6. In 2014, the HDC (appointed under s 9 of the Act) finalised his opinion that the defendant and the aggrieved person's LMC obstetrician had breached the aggrieved person'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 them to the plaintiff. The HDC also found TDHB in breach of the Code for failing to provide adequate systems to ensure that women such as the aggrieved person received safe care; that the

guidelines in place at the time were suboptimal and/or not routinely complied with; and that a culture existed on the ward that compromised the standard of care provided to the aggrieved person.

7. The plaintiff has lodged separate proceedings against the aggrieved person's LMC obstetrician.

ANTENATAL CARE

8. Throughout her pregnancy the aggrieved person's antenatal care was shared between her LMC obstetrician and her General Practitioner ("GP"). The LMC obstetrician had overall responsibility for the aggrieved person's care. The LMC obstetrician did not document the shared care arrangement between himself and the aggrieved person's GP.

9. The aggrieved person was booked to deliver at the hospital on 18 January 2012 under the care of the LMC obstetrician. The LMC obstetrician did not discuss with the aggrieved person, or record, or implement a written care plan regarding the aggrieved person's labour or delivery.

10. The LMC obstetrician expected to be notified by the hospital midwives when a woman was admitted to the labour ward, and as soon as there were any problems or, if there were no problems, as soon as the woman was fully dilated. Mrs N was aware of the LMC obstetrician's expectations regarding being contacted.

11. The aggrieved person's pregnancy was uncomplicated and she carried her baby to full term. The hospital Birth Booking Form identified no obstetric risk factors for the aggrieved person.

HOSPITAL ADMISSION ON 23 JANUARY 2012 (40 WEEKS PLUS FIVE DAYS)

12. At around midday on 23 January 2012, the aggrieved person was admitted to the hospital. The admitting midwife did not notify the LMC obstetrician that the aggrieved person had been admitted.

13. Admission observations of maternal temperature, pulse and blood pressure were within normal limits.

14. At around midday, cardiotocography ("CTG") monitoring of the fetal heart rate ("FHR") was commenced and then discontinued at around 12:22pm as the FHR baseline was 130 beats per minute ("bpm").[1] Following this the FHR monitoring was by way of intermittent auscultation.[2]

15. At around 12:45pm a vaginal examination revealed that the aggrieved person's cervix was 5cm dilated and she was establishing in labour.[3] The baby's position was left occipito posterior.[4] The auscultated FHR was normal at 137–142bpm.

16. At around 5:30pm (nearly five hours later) a vaginal examination revealed that the aggrieved person was only 6–7cm dilated and the forewaters were bulging. The aggrieved person's contractions were recorded as two every ten minutes. The duty midwife artificially ruptured the aggrieved person's membranes ("ARM"). The duty midwife recorded the presence of liquor (amniotic fluid) stained with old meconium (fetal stool). The TDHB "Meconium Liquor in Labour" (2008)

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[1] A cardiotocogram (CTG) is a machine used to electronically monitor a baby's heart rate and a mother's contractions while the baby is in the uterus. It continuously prints out on paper record. A normal FHR during labour is between 110 and 160 beats per minute.

[2] Listening to the FHR intermittently using a hand-held ultrasound device called a doppler.

[3] Established (or active) labour is when the cervix is dilating from 4 to 10cms accompanied by regular and strong contractions. The first stage of labour consists of early (latent) labour, then established (active) labour, then the transition phase. The second stage of labour is when the cervix is fully dilated and a woman is pushing. The second stage ends with delivery of the baby. The third stage is delivery of the placenta.

[4] The baby is head-down with the back of its head towards the back, left side of the mother's pelvis.

protocol recommended a period of "continuous electronic monitoring for a minimum of 30 minutes" when meconium stained liquor is observed "if old, thin, meconium is present in liquor and CTG tracing is normal, continuous electronic monitoring may be stopped and intermittent electronic monitoring commenced for a 20-30 minute period in every 90 minute period." Contrary to the TDHB protocol, the midwife did not institute CTG recording following the finding of old meconium and did not inform the LMC obstetrician.

17. The partogram[5] and clinical notes record the aggrieved person's pulse as 96bpm at 6:30pm and the auscultated FHR was 152bpm. Contractions had increased in length, strength and frequency to three to four contractions every ten minutes, lasting around 60 seconds. The aggrieved person entered a birthing bath at about 7:15pm to help with labour pains and was noted to be "coping beautifully". She then transferred to a bigger pool at about 9pm.

18. At 9pm the clinical notes identify the aggrieved person's pulse was 100bpm and the auscultated FHR was 152bpm. At 9:30pm the aggrieved person was noted to be "quietly labouring" and "coping well".

19. At around 10:25pm a vaginal examination revealed that the aggrieved person's cervix was 8cm dilated and that moulding[6] and caput[7] were present. During the midday to 11pm time frame the partogram records the baby's baseline heart rate increasing from 130-140bpm before 6:30pm to mid-140-160bpm as the evening progressed.

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[5] A graphical representation of the progress of a labour from the time when there is significant cervical dilatation, on which various physiological parameters of the mother and foetus are recorded periodically along with details of medical intervention.

[6] Movement in the structures of the fontanels which allows the bones to overlap each other to some extent as the head is forced down the birth canal by the contractions of the uterus.

[7] The description of oedema or swelling on the presenting part of the baby's head as it descends through the mother's pelvis.

20. A rise in the baseline FHR can occur due to, amongst other things, an increase in maternal temperature,[8] fetal hypoxia[9] or fetal infection, although the normal range for a full term fetal heat rate is between 110–160bpm.

21. The aggrieved person's LMC obstetrician was not informed of the aggrieved person's admission or progress at any time during this shift.

MRS N TAKES OVER MIDWIFERY CARE

22. Mrs N took over midwifery care of the aggrieved person at 11pm on 23 January 2012.

23. The aggrieved person had been in hospital for around 11 hours, in established labour for around ten hours and in the birthing bath and pool for four hours when Mrs N took over her care. Mrs N was informed at handover that the aggrieved person wanted to stay in the birthing pool for the delivery and that hot water had been recently added to the pool in the expectation that delivery was imminent.

24. In line with accepted midwifery practice at the time[10] the pool temperature should have been ascertained prior to the aggrieved person entering the pool at 7.15pm and should have been recorded regularly during the time she remained in the pool. There is no record of the pool temperature either during the previous shift or when Mrs N assumed care.

25. Mrs N carried out a full assessment of the aggrieved person who was in transition and recorded in the notes that she was "Coping beautifully. Breathing through contractions". She reiterated the earlier midwife's advice, that the LMC obstetrician did not do water births. Mrs N

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[8] A raised body temperature in the mother causes the baby in utero to become hot and have a high heart rate.
[9] The baby in utero does not receive sufficient oxygen.
[10] New Zealand College of Midwives ("NZCOM") Consensus Statement 'The Use of Water for Labour and Birth' (2002).

confirmed that she was happy for the aggrieved person to labour in the bath but that she would need to leave the bath for the delivery.

26. At 11pm Mrs N undertook a set of baseline observations. The aggrieved person's blood pressure was normal, but her pulse was high at 135bpm ("tachycardia")[11] and her body temperature was raised at 37.9°C ("pyrexia").[12] The auscultated FHR was normal at 146bpm. Mrs N assessed the recent increase in temperature of the birthing pool and the four hours' time that the aggrieved person had been in the bath as the likely cause of the aggrieved person's elevated temperature and pulse and took steps to institute cooling and hydrating measures.

27. The aggrieved person had begun to feel tired, hot and thirsty. In response to the maternal pyrexia, Mrs N told the aggrieved person that her temperature and pulse was up and that she needed to get up out of the water to cool down. She gave the aggrieved person cold drinks, a cooling face cloth and encouraged her to stand up out of the water.

28. On rechecking the maternal temperature at 11:30pm the aggrieved person's temperature had returned to normal at 36.9°C. However, the aggrieved person's pulse remained significantly raised above normal limits (tachycardic) and had increased over the previous 30 minutes to 149bpm.

29. A pulse rate of 149bpm is abnormal. Mrs N recognised that a pulse of 149bpm was elevated even though the temperature had returned to normal with cooling measures. Mrs N considered that this may have been attributable to exhaustion after the slow labour, a long latent phase, an increase in stress due to the transition period of labour, no pain relief, and/or dehydration.

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[11] The normal pulse for healthy adults ranges from 60-100bpm. Lower is bradycardia and higher is tachycardia.

[12] A normal adult temperature is around 36.5°C.

30. Contrary to accepted midwifery practice, Mrs N did not discuss this finding of abnormal pulse (or the episode of maternal pyrexia at 11pm that had returned to a normal temperature) with the LMC obstetrician or, in his absence, the duty obstetrician.

31. Maternal tachycardia and maternal pyrexia can be indicators of infection, for example, Group B Streptococcus (GBS)[13] and chorioamnionitis.[14]

32. In light of an episode of maternal pyrexia, even though the temperature returned to a normal range, and even though the aggrieved person had no identified risk factors for infection on the basis of the TDHB Group Streptococcus (GBS) Guidelines (March 2007),[15] it would have been accepted midwifery practice to recheck the temperature in another hour to confirm it remained normal, especially in light of the ongoing maternal tachycardia and the aggrieved person's slow labouring progress.

33. Further, in the presence of such a raised maternal pulse, no matter what the assumption of the cause, the accepted practice would have been to reassess the maternal pulse at least half hourly and inform the LMC obstetrician or the duty obstetrician. Contrary to accepted midwifery practice, Mrs N did not assess the aggrieved person's pulse or temperature again until around 2:20am (almost three hours later).

34. The auscultated FHR was 145-153bpm which was normal, and was very similar to the aggrieved person's pulse. Given the similar heart rates,

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[13] GBS is bacteria that occur naturally in the vagina and bowel in some women which can be transferred to the baby as it passes through the birth canal. Carrying GBS in the body is normal and rarely harmful to healthy, non-pregnant women. However, the bacteria can pass to a baby in the birth canal during labour and cause the baby to become seriously ill. Giving antibiotics to the mother during labour reduces the risk of a baby developing a GBS infection during or soon after birth. The NZCOM Consensus Statement on GBS (2004) "supports a risk-based approach as an effective strategy for preventing GBS transmission to babies."

[14] Infection of the maternal membranes and amniotic fluid. Chorioamnionitis is generally defined by the presence of maternal fever and two or more additional signs including a raised maternal and/or fetal heart rate.

[15] The TDHB protocol identifies the following as risk factors for early GBS: (a) Previous GBS-infected baby; (b) GBS bacteriuria this pregnancy; (c) Preterm (<37 weeks) labour and imminent birth; (d) Intrapartum fever ≥38°C (Note: if chorioamnionitis is suspected, GBS chemoprophylaxis requires broad-spectrum antibiotics); (e) Membrane rupture > 18 hours (with or without signs of labour); (f) OR a positive maternal screening test for GBS at 35-37 weeks of the current pregnancy.

accepted midwifery practice[16] was that the midwife should attempt to ascertain whether the same rate was being identified for both the mother and the baby. Although the clinical notes do not document whether Mrs N attempted to identify whether both heart rates were being heard or the same one mistaken for both, Mrs N did take care to identify the different heart rates based on the very different sounds associated with each and was confident, after 25 years' experience, that she had separately and correctly identified these. The recordings were documented.

35. At around 11:45pm Mrs N performed a vaginal examination in the pool which revealed the aggrieved person's cervix to be 9cm dilated and which identified that the labour was continuing to progress. Mrs N encouraged the aggrieved person to drink to keep hydrated as she considered hydration was an issue that was responsible for the elevated observations. Mrs N requested the aggrieved person to leave the birthing pool and move to the labour room. The aggrieved person then left the pool. Mrs N made a retrospective note at 4pm the following day noting that the aggrieved person got out of the pool "at my advice due to ↑ p[ulse] & t[emperature]". The aggrieved person is recorded as being tired and thirsty.

36. At around midnight on 24 January 2012 the aggrieved person was out of the bath and back in her room. The auscultated FHR was normal at 145–150bpm.

37. The clinical notes record that "fresh watery thin" meconium was identified on the pad at that time. Mrs N added the words "watery thin" to the clinical records retrospectively but did not date or time the

[16] NZCOM Consensus Statement 'Foetal monitoring in labour' (2005) recommends that "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."

addition. Mrs N accepts that the accepted midwifery practice[17] is to date and time any retrospective addition to the notes.

38. Accepted applicable guidelines in place at the time[18] identified meconium stained liquor as requiring continuous electronic (CTG) fetal monitoring to assess the wellbeing of the baby to ascertain whether the meconium was a sign of fetal distress. The hospital's 'Meconium Liquor in Labour' protocol (2008) stated that the presence of meconium stained liquor was an indication for continuous CTG monitoring for at least 30 minutes every 90 minutes and, if accompanied by fetal distress, for notifying the neonatal unit ("NNU") and the LMC obstetrician. Mrs N did not follow these guidelines.

39. By 12:30am on 24 January 2012, the aggrieved person was feeling like pushing and displaying some signs of the cervix coming to full dilation. At 12:45am the auscultated FHR was 160-165bpm. The partogram overview of the auscultated FHR shows that between 11pm and 2:50am the FHR baseline was consistently between 145-165bpm.

40. Accepted applicable guidelines in place at the time[19] identified abnormal auscultation of the FHR as requiring continuous electronic (CTG) fetal monitoring and transfer to obstetric input, as fetal tachycardia may be associated with significant fetal compromise. The hospital's 'Meconium Liquor in Labour' protocol (2008) stated that any abnormalities of the FHR were an indication for continuous CTG monitoring and should be reported to the LMC and NNU staff. Contrary to these guidelines, Mrs N did not institute CTG monitoring to assess the FHR in response to the fetal tachycardia or notify the LMC obstetrician or, in his absence, the duty obstetrician. At the time, she considered the variations in fetal heart

[17] Standard 4, NZCOM 'Standards of Midwifery Practice' 2008.
[18] Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), Intrapartum Fetal Surveillance Clinical Guidelines (Second Edition, 2006).
[19] RANZCOG, Intrapartum Fetal Surveillance Clinical Guidelines; National Institute for Health and Clinical Excellence (NICE), Intrapartum Care, clinical guideline 55 (2007).

rate were not a sign of fetal distress unless persistent accelerations or any decelerations were present. Mrs N continued to monitor the fetal heart rate at regular intervals, including before, during and after most contractions, using the doppler fetal monitor. Although Mrs N felt reassured by this interpretation she accepts that she should at this point have instituted a CTG to confirm whether the FHR was a cause for concern or not.

41. At around 1am the auscultated FHR was recorded in the notes as 170-172-160bpm (tachycardic). At 1:10 am, the FHR was 156-160bpm.

42. At around 1am Mrs N also recorded fresh watery meconium draining. Mrs N added the word "watery" to the clinical record in retrospect but did not date or time the addition.

43. Mrs N did not institute CTG monitoring, or discuss with the aggrieved person the episodes of fresh meconium or the fetal tachycardia, or their significance (potential fetal compromise), nor did she notify the LMC obstetrician. Mrs N also did not discuss or recommend the need for specialist obstetric consultation in light of the increased FHR and fresh meconium.

44. At around 1:10am a vaginal examination revealed a small rim of cervix[20] present and large caput on the baby's head. These indicate that the aggrieved person was about to enter the second (pushing) stage of labour but that, as a first-time mother, birth was not imminent; she may have a few hours of labour left. The aggrieved person was draining more meconium liquor and the auscultated FHR was at 156–160bpm.

45. Mrs N added the word "liquor" to the 1:10am clinical note retrospectively but did not date or time the addition.

[20] This means the cervix is 9-10cms dilated – close to full dilation.

46. Mrs N called the NNU at around 1:10am to inform them of the meconium and the increased FHR earlier. Mrs N did not commence CTG monitoring, or inform the LMC obstetrician or, in his absence, the duty obstetrician.

47. At around 1:40am the aggrieved person was in the second stage of labour and had begun pushing actively on each contraction with the contractions lasting between 20–30 seconds. The FHR was 148-152bpm. At 1:40am the aggrieved person was recorded as on the toilet and then on her knees, FHR 148bpm. At 1:45bpm the FHR was 150bpm and with contractions lasting 20-30 seconds and with the records showing "pushing well" and "nothing on view".

48. At 1:50am the FHR was 150-152-158bpm. At 2am the FHR was recorded as 150-156-160bpm.

49. At 2:10am the notes record that the aggrieved person was having short contractions of 20-30 seconds, and that she was pushing well. The auscultated FHR was 164bpm. During her shift Mrs N had not notified the LMC obstetrician that the aggrieved person was in hospital and by 2:10am she had not notified the LMC obstetrician that the aggrieved person was now in the second stage of labour.

50. At around 2:20am the aggrieved person's blood pressure was normal, but her pulse was tachycardic at 164bpm, and her temperature was high at 39.5°C (pyrexia). The auscultated FHR was 150–160bpm.

51. Mrs N asked the aggrieved person to get onto the bed so that she could undertake a full set of observations, including a vaginal examination. This had to be done in between contractions.

52. The clinical notes record that the aggrieved person was "pushing hard" with "contractions short still". The notes record that at 2:25am the aggrieved person was back "onto [the] bed".

53. At 2:25am Mrs N recorded that there was "nil on view" and that the FHR was 156bpm. At 2:30am she undertook the vaginal examination and recorded "baby was moving well with contractions" and "still at spines caput +1".[21] Mrs N was applying cold face clothes to cool the aggrieved person.

54. Contrary to accepted guidelines, Mrs N did not institute continuous CTG monitoring despite the presence of fresh meconium, fetal tachycardia, maternal tachycardia and maternal pyrexia. The next day Mrs N recorded that at around 2:37am she contacted the LMC obstetrician to provide him with information including the aggrieved person's temperatures and pulse, that she was fully dilated, had been pushing for one hour, was nil on view, and that the meconium liquor was now fresh but watery thin.

55. From 2:37am the LMC obstetrician took over the care of the aggrieved person and was responsible for all clinical decisions. At around 2:40am the auscultated FHR had increased to 176bpm (tachycardic).

56. From 2:40am Mrs N continued to monitor the FHR intermittently as between 164 and 182bpm. Mrs N still did not commence CTG monitoring despite the significantly elevated FHR.

ARRIVAL OF LMC OBSTETRICIAN

57. At around 2:50am the LMC obstetrician arrived in the delivery suite.

58. From the time the LMC obstetrician was in the room Mrs N had the fetal doppler on audible so that he could hear the FHR rising and was calling out the FHR at approximate 5-minute intervals.

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[21] The position (station) of the baby's head in relation to the bony projections in the pelvis as it descends through the birth canal.

59. At around 3am the aggrieved person had been in the second stage of labour (pushing) for 1 hour and 20 minutes and the fetal head was on view. The aggrieved person's pulse was very high at 150bpm.

60. There is no record of the LMC obstetrician examining the aggrieved person or performing a vaginal examination. The LMC obstetrician made no entries in the clinical notes.

61. The LMC obstetrician did not discuss with the aggrieved person the significance of her pyrexia, her tachycardia, the fetal tachycardia or the meconium, the possibility of maternal infection or the possibility of fetal compromise. The LMC obstetrician did not discuss instituting CTG monitoring of the FHR with the aggrieved person. As the specialist obstetrician and the aggrieved person's LMC it was his responsibility to assess the situation, explain to the aggrieved person what was happening, what he would like to do, and record the information and her response in the clinical notes.

62. Contrary to accepted guidelines, neither Mrs N nor the LMC obstetrician instituted CTG monitoring in the presence of fresh meconium, fetal tachycardia and maternal pyrexia to assess the FHR.

63. The aggrieved person's symptoms were symptoms of an intrauterine infection; she had an elevated temperature, a very elevated heart rate and there was also fetal tachycardia. This is a potentially serious condition for both mother and baby. The mother is at risk of infection in her uterus, infection in her abdominal cavity, septicaemia, adult respiratory distress syndrome and, rarely, death. In these circumstances, accepted obstetric practice is that intravenous ("IV") broad spectrum antibiotics should be administered immediately with the aim of both treating the infection and preventing serious maternal infection. The baby is also at risk of serious infection, pneumonia, meningitis, widespread sepsis and death. The

LMC obstetrician did not administer IV antibiotics to the aggrieved person in light of her clinical presentation and indicators of fetal compromise and/or maternal infection.

64. Contrary to the hospital's 'Guidelines for Calling Neonatal Unit Staff (2010)", the LMC obstetrician did not call the NNU to be present at the birth given the presence of fresh meconium, maternal pyrexia and fetal tachycardia.

65. At around 3:20am the LMC obstetrician commenced an IV infusion of syntocinon in order to augment the aggrieved person's labour.[22] Syntocinon was contraindicated by the presence of fetal compromise. Contrary to accepted guidelines,[23] the LMC obstetrician did not institute continuous CTG monitoring when administering syntocinon so that both contraction frequency and the baby's wellbeing could be closely monitored, especially when there were already signs of possible fetal compromise.

66. Although the LMC obstetrician was the responsible clinician, Mrs N accepts she should have spoken up and challenged his decisions, which she believed to be wrong, regardless of the Unit culture at that time, which did not support midwives challenging obstetric decisions.[24] Neither the LMC obstetrician nor Mrs N ensured that there was CTG monitoring despite the requirement for CTG monitoring with the use of

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[22] Syntocinon is a synthetic version of the naturally occurring hormone oxytocin (which causes the uterus to contract) and is used in cases of slow progress in labour to increase the frequency and strength of contractions. Because it is artificial stimulation it can cause overstimulation or prolonged contractions and further reducing oxygen supply to the baby leading to fetal distress.

[23] RANZCOG and NICE Guidelines.

[24] Following Ariana's birth, TDHB revised multiple existing polices and introduced new practices into the Unit to improve patient safety. These included changes to specifically address identified cultural issues in the Unit. These included changes to key medical and management staff appointed in the Unit; the introduction of an orientation programme for midwife/registered nurse staff to ensure that all staff were aware they had the support of TDHB management to raise concerns and to challenge clinical decisions of colleagues; the introduction of a formal complaint system (Datix); the introduction of the Maternity Quality and Safety Programme to monitor the quality of patient care and the introduction of patient feedback forms throughout the Unit.

syntocinon to augment the labour or when the FHR remained tachycardic.

67. Despite the clinical picture (indicators of fetal compromise and/or maternal infection), and that syntocinon was contraindicated, the LMC obstetrician did not expedite delivery of the baby by instrumental delivery or caesarean section.

68. Contrary to accepted obstetric practice, the LMC obstetrician did not discuss with the aggrieved person the progress of her labour and the options for expediting delivery (including instrumental delivery or caesarean section), or obtain her informed consent to discount them.

69. Between around 3:25am and 3:45am Mrs N recorded the auscultated FHR as 168–170bpm, 170–180bpm, 182bpm, 164bpm and 164–172bpm (consistently tachycardic).

DELIVERY OF BABY ARIANA

70. At around 3:50am baby Ariana was born covered in meconium, pale and floppy, in respiratory distress. In line with the TDHB Guidelines for Calling Neonatal Unit Staff Protocol (May 2010), Mrs N asked the LMC obstetrician if she could call the NNU to be present to provide assistance.

71. The hospital's 'Guidelines for Calling Neonatal Unit Staff' required the NNU to be called to assist with babies requiring resuscitation at birth to ensure optimum wellbeing of the baby. NNU staff are experts in resuscitation techniques. The presence of NNU staff at the birth means that appropriate resuscitation is accessible immediately. The NNU should be called as soon as an 'at risk' situation is identified. Indications of a baby at risk include the presence of maternal fever, meconium stained liquor, and fetal distress (in this case, tachycardia). The indications of fetal distress were on the basis of the assessment of the obstetrician, in this case the LMC obstetrician. Ariana was 'at risk' prior

to her birth and she was in need of significant assistance when she was born. The LMC obstetrician did not call the NNU to be present at the delivery or call the NNU to assist immediately after Ariana was born.

72. Immediately after Ariana was born and while still at the bedside, Mrs N asked the LMC obstetrician if she could call the NNU for assistance. The LMC obstetrician did not respond to Mrs N.

73. The LMC obstetrician moved to the resuscitaire and attempted to resuscitate the baby himself with fetal stimulation and oral and nasal suction. He applied positive pressure ventilation with an ambu bag. The hospital's 'Neonatal Resuscitation' protocol (2007) for babies born with fresh meconium, not breathing and floppy (in respiratory distress) like Ariana specified that the LMC obstetrician first suction the trachea under direct vision to prevent inhalation of meconium before drying and stimulation and before applying positive pressure ventilation.

74. Mrs N asked the LMC obstetrician a second time if she could call NNU and he did not respond a second time. Mrs N did not call NNU herself as she understood she had to wait for the LMC obstetrician's permission to call NNU herself.

75. Ariana's Apgar Scores[25] were recorded as "two" at one minute, which is consistent with severe asphyxia,[26] and "four" at five minutes. This indicated that her condition at birth was very poor and the resuscitation was not having a significant effect. The first five minutes are a crucial window for taking effective steps to resuscitate a baby and effective

[25] The Apgar scores are an accepted and universally used method to assess the physical condition of a new born infant immediately after birth. An Apgar score (2, 1, or 0) is given for each sign (heart rate, respiratory effort, muscle tone, response to stimulation, and skin colouration) and are added to make an overall score out of 10. Scores are given at one minute and five minutes after the birth. If there are problems with the baby an additional score is given at ten minutes. A score of 7–10 is considered normal, while 4–7 might require some resuscitative measures, and a baby with Apgars of 3 and below requires immediate resuscitation.

[26] Deprivation of oxygen to a new born infant that lasts long enough during the birth process to cause physical harm, usually to the brain.

resuscitation must be given as early as possible. At ten minutes Ariana's score was "six", which was still significantly reduced.

76. At around 3:55am the LMC obstetrician consented to Mrs N's third request to call the NNU, once his own attempts to resuscitate Ariana had failed.

77. At around 3:57am (seven minutes after delivery) NNU staff arrived. At that stage Ariana was covered in meconium, had gasping respirations, was floppy and unresponsive. Resuscitation continued for around 12 minutes, after which time she was transferred to Continuous Positive Airway Pressure ("CPAP") at the NNU. Ariana's temperature was 38.3°C.

78. At around 3:58am Mrs N gave the aggrieved person an injection and the LMC obstetrician delivered the placenta. The LMC obstetrician did not communicate with the aggrieved person about the process of delivering the placenta or discuss the options for placental delivery (for example, waiting for it to come away naturally or expediting it with an injection). Accordingly, the LMC obstetrician did not obtain informed consent from the aggrieved person to deliver the placenta this way.

79. Contrary to accepted standards,[27] the LMC obstetrician did not make any notes of the care he provided during or following the aggrieved person's labour and delivery.

POST NATAL

80. At around 8am on 24 January 2012 the aggrieved person was in her hospital room alone. At that time, the LMC obstetrician walked into the aggrieved person's room, looked at her, and then walked out. The LMC obstetrician did not say anything to the aggrieved person.

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[27] Section 88 Primary Maternity Services Notice (2007) [Standards for LMCs].

81. Contrary to accepted guidelines,[28] the LMC obstetrician (as the senior clinician present) failed to make an appropriate and timely disclosure to the aggrieved person of the harm that had occurred following the adverse event.

82. At 4:50am (1 hour of age) a neonatal lactate (lactic acid) blood level was done on Ariana in the NNU.[29] Ariana's result was 19.7mmol/L which was significantly high.[30]

83. At about midday on 24 January 2012, Ariana was transferred by air ambulance to Waikato Hospital. At the time of transfer, Ariana was experiencing respiratory distress, hypoxic ischaemic encephalopathy ("HIE")[31] with seizures and suspected sepsis. Two hours later the aggrieved person and her husband were flown to be with Ariana.

84. Following Ariana's admission to Waikato Hospital, she was cooled for 72 hours and was intubated and ventilated for five days, during which time she was fed intravenously. Ariana required morphine, midazalom, anticonvulsants, and the antibiotics amoxicillin and cefotaxime, as blood cultures had confirmed a diagnosis of Group B Streptococcus sepsis ("GBS") and resulting GBS meningitis was presumed.

85. On 1 February 2012 Ariana was transferred back to Taranaki Base Hospital for ongoing care. At the time of Ariana's transfer, her seizures had stopped and she was not on any respiratory support, but was being treated for presumed GBS meningitis.

86. On 7 February 2012 Ariana was discharged home.

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[28] Medical Council of New Zealand, 'Disclosure of harm following an adverse event' (December 2010).
[29] Lactate levels are increased when the production of lactate exceeds lactate clearance, usually this is caused by impaired tissue oxygenation produced by decreased oxygen delivery. High lactate levels are a marker that there has been a significant period of inadequate oxygenation.
[30] A normal result is less than two. Most babies do not survive a result of 20 or higher.
[31] HIE is a term used to describe brain injury occurring at or near the time of birth caused by oxygen deprivation to the brain, also commonly known as "birth asphyxia" and more recently as "neonatal encephalopathy". Neonatal encephalopathy is a clinically defined syndrome of disturbed neurological function in the earliest days of life in the term infant. HIE is a subset of neonatal encephalopathy.

87. As a result of the HIE, Ariana has since experienced significant and complex health difficulties and developmental problems, including:

    a. Spastic/dystonic quadriplegic cerebral palsy;[32]

    b. Feeding difficulties requiring PEG (tube) feeding;

    c. Microcephaly (an abnormally small head, associated with incomplete brain development);

    d. Strabismus (eyes are not aligned);

    e. Seizures;

    f. Severe global developmental delays;

    g. Constipation;

    h. Poor growth;

    i. Poor sleeping patterns.

88. HIE is caused by oxygen deprivation to the brain. There are many conditions that can cause limited oxygen flow to a baby's brain. In some circumstances many of these conditions are preventable including GBS sepsis (infected fetuses have an increased oxygen requirement), delay in delivery and inadequate resuscitation after birth.

89. Ariana is significantly cognitively impaired and her physical and intellectual disabilities are life-long. She will always require full care, 24 hours a day, seven days a week. Due to her cerebral palsy, Ariana requires support for all aspects of her personal daily cares, including dressing and undressing, all her grooming and hygiene needs mobilisation, positioning, transfers, toileting, feeding. She will be unable to care for herself and be safe in any situation without supervision.

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[32] Spastic means increased muscle tone; dystonic means abnormal movements; quadriplegic means all four limbs are involved.

90. Ariana does not sleep well and overnight she wakes frequently for long periods of time due to seizure activity, being unable to reposition herself in bed, pain or discomfort due to increased muscle tone and muscle spasms. Ariana also needs assistance with completion of her daily exercises, stretching and lower limb massage, physiotherapy and speech language therapy.

91. Ariana experiences significant life-threatening seizures, often when she is unwell or fatigued but they can happen at any time. They are currently controlled by medication but she does still have sudden seizures unexpectedly.

IMPACT ON THE AGGRIEVED PERSON

92. Ariana's complex needs have required the aggrieved person's ongoing care and attention with minimal respite. The intense care and lack of free time and sleep deprivation for the aggrieved person has resulted in burnout and exhaustion.

93. The aggrieved person has been unable to have the type of positive interactions with Ariana or experience the parental pleasures, enjoyment and satisfactions that she thought she would have with a healthy child.

94. Following Ariana's birth, the aggrieved person has been unable to pursue, enjoy and develop her life in the way she intended before Ariana was born. The aggrieved person's quality of life and her life choices have diminished following Ariana's birth.

95. Prior to Ariana's birth, the aggrieved person completed a Bachelor of Social Work degree, which she has been unable to use. Due to the significant health challenges for Ariana and the corresponding demands on the aggrieved person, sleep deprivation, and the emotional distress, grief and trauma she has suffered as a result of Ariana's condition, the

aggrieved person has lost the chance to develop her career as she intended.

96. As a consequence of the actions and inactions of Mrs N and the aggrieved person's LMC obstetrician as pleaded in HRRT 93/16, the aggrieved person lost:

a. the benefit of receiving appropriate midwifery care and, in particular, the timely detection and/or appropriate treatment of maternal infection and/or fetal compromise and/or the benefit of earlier specialist intervention;

b. the benefit of receiving appropriate obstetric care and in particular, the timely detection and/or appropriate treatment of maternal infection and/or fetal compromise;

c. the benefit of making informed decisions about her delivery;

d. the benefit of receiving timely and/or appropriate resuscitation of Ariana;

e. the benefit of the ability to place trust in the midwifery profession;

f. the benefit of the ability to place trust in the medical profession;

g. the benefit of positive interactions with a healthy child and/or the benefits/joys/pleasures of parental enjoyment and/or satisfaction involved in having a child with a healthy life;

h. the benefit of career development;

i. the ability to pursue and/or develop her life in the way she would otherwise have chosen and/or to lose future life enjoyment by restriction of her future life choices.

97. The aggrieved person has suffered significant and enduring emotional distress, grief and trauma, and injury to her feelings.

EXPERT ADVICE

Jaqueline Anderson, Midwifery Expert

98. Jaqueline Anderson, a Registered Midwife and General and Obstetric Nurse with a Master of Midwifery, provided independent expert midwifery advice to the HDC in relation to the care provided to the aggrieved person by Mrs N.

99. In Ms Anderson's expert opinion, on 23 and 24 January 2012 Mrs N provided attentive support to the aggrieved person. However, Mrs N did not provide midwifery care to a reasonable standard overall in that despite undertaking a number of assessments she did not institute closer monitoring measures of both the mother and the baby or otherwise act upon assessment results when there were indications of emerging risk factors. In the presence of maternal tachycardia, at least one raised maternal temperature recording, meconium stained amniotic fluid, an increasing fetal heart baseline (no matter that it was apparently just at the upper limit of the normal range), and episodes of fetal tachycardia Mrs N did not institute closer monitoring of the baby nor did she inform the LMC obstetrician or the obstetrician on duty.

BREACHES OF THE CODE

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

Mrs N's acceptances

101. Mrs N accepts that her actions outlined above breached Right 4(1) of the Code, in that she:

    i. Failed to take appropriate steps to monitor the aggrieved person in light of her presentation, and

ii. Failed to contact the LMC obstetrician to notify him in a timely manner of the aggrieved person's presentation;

iii. Failed to call NNU after delivery when the LMC obstetrician did not.[33]

102. Mrs N has stated that she deeply and sincerely regrets her actions and inactions and has acknowledged her shortcomings. Mrs N has apologised in person and in writing to the aggrieved person for her actions.

[33] Following Ariana's birth, TDHB revised the TDHB Guidelines for Calling Neonatal Unit Staff Protocol (May 2010) and removed under the heading "Indications for calling Paediatric staff to delivery" the phrases "Depending on LMC request" and "fetal distress as assessed by obstetric team" to make it clear that decision to call NNU to attend a birth were not just the LMC obstetrician's decision and could be made by any clinician.