(1) ORDER PROHIBITING PUBLICATION OF NAME OR IDENTIFYING PARTICULARS OF AGGRIEVED PERSON, HER DAUGHTER AND THE DAUGHTER'S FATHER

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

IN THE HUMAN RIGHTS REVIEW TRIBUNAL **[2020] NZHRRT 18**

	Reference No. HRRT 005/2020
UNDER	**SECTION 50 OF THE HEALTH AND DISABILITY COMMISSIONER ACT 1994**
BETWEEN	**DIRECTOR OF PROCEEDINGS**
	PLAINTIFF
AND	**VICKI ANNE MCMILLAN**
	DEFENDANT

AT WELLINGTON

BEFORE:
Ms G J Goodwin, Deputy Chairperson
Dr SJ Hickey MNZM, Member
Dr JAG Fountain, Member

REPRESENTATION:
Ms K Eckersley, Director of Proceedings
Ms C Humphrey for defendant

DATE OF DECISION: 28 May 2020

(REDACTED) DECISION OF TRIBUNAL[1]

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[1] [This decision is to be cited as: *Director of Proceedings v McMillan* [2020] NZHRRT 18.]

[1] These proceedings under s 50 of the Health and Disability Commissioner Act 1994 were filed on 4 February 2020.

[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 Redacted Consent Memorandum dated 30 January 2020.

[2.2] A Redacted Agreed Summary of Facts, a copy of which is annexed and marked "A".

[3] The Redacted 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 parties request that the Tribunal exercises its jurisdiction and issues:
>
> (a) A declaration pursuant to s54(1)(a) of the Health and Disability Commissioner Act 1994 ("the Act") that the defendant has breached the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 ("the Code") in respect of:
>
> (i) Right 4(1) by failing to provide services to the aggrieved person with reasonable care and skill;
> (ii) Right 6(1) by failing to provide the aggrieved person with the information that a reasonable consumer in her circumstances would have expected to receive; and
> (iii) Right 7(1) by failing to obtain the consumer's informed consent.
>
> 3. The parties also request a final order prohibiting the name and identifying details of the aggrieved person (Mrs H), her daughter (Baby A), and her daughter's father (Mr L) The defendant consents to such final orders being granted.
> 4. In relation to the declaration being sought at 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.
> 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 Redacted 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 Redacted Consent Memorandum.

[5] The Tribunal is also satisfied that it is desirable to make a final order prohibiting publication of the name and identifying details of the aggrieved person (Mrs H), her

daughter (Baby A), and her daughter's father (Mr L) as sought in paragraph 3 of the Redacted Consent Memorandum.

DECISION

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

[6.1] 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:

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

[6.1.2] Right 6(1) by failing to provide the aggrieved person with the information that a reasonable consumer in her circumstances would have expected to receive.

[6.1.3] Right 7(1) by failing to obtain the consumer's informed consent.

[6.2] A final order is made prohibiting publication of the name and any other details which might lead to the identification of the aggrieved person (Mrs H), her daughter (Baby A), and her daughter's father (Mr L). There is to be no search of the Tribunal file without leave of the Tribunal or of the Chairperson.

.....	.....	.....
Ms G J Goodwin	**Dr SJ Hickey MNZM**	**Dr JAG Fountain**
Deputy 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 28 May 2020

BEFORE THE HUMAN RIGHTS REVIEW TRIBUNAL

HRRT /20

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

AND **VICKI ANNE MCMILLAN** of Waiheke Island, Registered Midwife

---

REDACTED 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

Kerrin Eckersley – Director of Proceedings

REDACTED 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 Mrs H.

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 began practising midwifery in 2007.

4. At all material times the defendant was a healthcare provider within the meaning of s 3 of the Act, and was providing healthcare services to the aggrieved person.

5. On 23 June 2015, the aggrieved person made a complaint to the Health and Disability Commissioner about the services provided by the defendant.

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 Services 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 all material times, the aggrieved person was 29 years old and pregnant with her second child. The aggrieved person was born in Fiji and moved

to New Zealand in May 2014. At the material time, the aggrieved person was living in Motueka.

8. The aggrieved person's first child was born in Fiji by vaginal delivery after a prolonged labour, weighing 3.5kg.

9. The aggrieved person had lived in New Zealand for only a short time when she became pregnant with her second child and was unfamiliar with the New Zealand maternity system. She saw a general practitioner who gave her the defendant's contact details.

10. The aggrieved person booked the defendant as her LMC on 7 December 2014, when she was 21+5 weeks pregnant. The aggrieved person's due date ("EDD") was 15 April 2015.

Lakes District Hospital (LDH), Queenstown

11. LDH is a rural hospital, housing a primary maternity facility, designed for well women who have no complications during pregnancy. The maternity facility is run and staffed by midwives. Pain relief available at LDH's maternity facility is limited to Entonox, pethidine, and water (birthing pool). No emergency obstetric or paediatric services are available at LDH.

12. LDH has an Emergency Department ("ED") staffed by two doctors with nursing support.

Southland Hospital, Invercargill

13. Southland Hospital houses a secondary maternity facility, designed for women and babies who experience complications and may require assistance from an obstetrician, anaesthetist, or paediatrician, as well as a

midwife. Neonatal Intensive Care Unit ("NICU") (Level 2)[2] services are available at Southland Hospital.

14. Southland Hospital is situated approximately 2.5 hours from Queenstown, by road.

Dunedin Hospital

15. Dunedin Hospital houses a tertiary maternity facility, for women with complex maternity needs which require specialist multidisciplinary care. NICU (Level 2 and Level 3)[3] services are available at Dunedin Hospital.

16. Dunedin Hospital is situated approximately 3.5 hours from Queenstown, by road.

ANTENATAL CARE

17. On 7 December 2014, the aggrieved person attended a booking appointment with the defendant. The defendant recorded in the clinical notes that she carried out a full assessment of the aggrieved person, including urinalysis, blood pressure, pulse, and fetal heart rate ("FHR") monitoring, all of which were normal. The defendant recorded the aggrieved person's body mass index ("BMI") as 27.1[4] and that the aggrieved person's father is diabetic.

18. The defendant also recorded that she and the aggrieved person discussed when and how the aggrieved person should make contact with the

[2] Level 2 units generally care for babies of 32 weeks' gestation and above, or babies who have been transferred from Level 3 units (see footnote 2) after being stabilised. Level 2 units do not ventilate babies (except in emergencies) and generally use less invasive forms of ventilation (such as continuous positive airways pressure (CPAP)) for babies that are clinically stable. All Level 2 units are involved at times in stabilising infants who are born or become sick before they can reach a Level 3 unit.
[3] Level 3 units provide neonatal intensive care and high dependency care. They have facilities to care for extremely premature infants (from 24 weeks' gestation) and babies requiring ventilation, intravenous feeding and other types of intensive care monitoring and treatment.
[4] A BMI of 25-29.9 is considered overweight.

defendant when labour started, and that the aggrieved person was very keen to deliver her baby at LDH, which the defendant supported.

19. The defendant indicated in the 'guide for care plan discussion' form that she had discussed 'maternity services' with the aggrieved person but did not specify what was discussed.

20. There is no record that the defendant discussed with the aggrieved person: what pain relief was available at LDH; the circumstances in which a transfer to a secondary or tertiary maternity facility would take place; and the difficulties and challenges of transferring to Southland Hospital or Dunedin Hospital, especially when labour was advanced or in adverse weather conditions.

21. During the booking visit, the defendant performed abdominal palpation, using anatomical landmarks,[5] to assess fetal growth. The defendant recorded that the uterus was measuring according to dates.[6] The defendant did not measure fundal-symphysis height.[7]

22. Throughout her care of the aggrieved person, the defendant measured fetal growth using only abdominal palpation and anatomical landmarks, and recorded at each antenatal appointment that the uterus was measuring according to dates.

23. The New Zealand College of Midwives ("NZCOM") Consensus Statement – 'Assessment of fetal wellbeing during pregnancy' (2012) ("the consensus statement") sets out:

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[5] The "landmarks" used are the symphysis pubis (the midline cartilaginous joint uniting the left and right pubic bones), the umbilicus, and the xiphisternum (the lowest part of the sternum).
[6] Meaning that the height of the uterus accorded with what would be expected at the current gestational age.
[7] The distance between the pubic bone and the top of the uterus, measured in centimetres, using a tape measure.

> "There is emerging evidence that the use of individualised fetal growth charts (which incorporate fundal-symphysis height measurements) may both reassure a woman that her baby is growing well and alert the midwife and the woman to possible concerns regarding the baby's growth.
>
> Plotting fundal-symphysis height measurements using a tape measure on a customised growth chart may alert midwives that a baby's growth is above or below normal parameters for that baby. A growth scan and more frequent assessments may be indicated at this point."

24. The consensus statement recommends: "From 24 weeks' gestation it is recommended that the fundal-symphysis height should be measured and recorded in centimetres at each antenatal appointment, preferably by the same person." The consensus statement also sets out that there is no evidence to support assessment using either abdominal palpation/inspection alone, or fundal-symphysis height measurement alone.

25. NICE clinical guideline 1.10 Fetal growth and well-being sets out that symphysis-fundal height should be measured and recorded at each antenatal appointment from 24 weeks.[8]

26. Contrary to recommended midwifery practice, the defendant failed to measure the fundal-symphysis height to assess fetal growth throughout the aggrieved person's pregnancy.

27. The defendant did not inform the aggrieved person that she was measuring fetal growth using anatomical landmarks only, and not fundal-symphysis height.

[8] National Institute for Health and Clinical Excellence (NICE) 'Antenatal care for uncomplicated pregnancies' – Clinical guideline (2014).

28. On 5 January 2015, during a routine antenatal appointment, the defendant recorded that she and the aggrieved person discussed what to bring to the hospital, and contacting Plunket to hire a car seat.

29. On 2 February 2015, during a routine antenatal appointment, the defendant recorded that she discussed screening for gestational diabetes with the aggrieved person, and the aggrieved person declined to have a polycose test[9] or a glucose tolerance test,[10] but agreed to a HbA1c test.[11] The HbA1c test result was within normal range.

30. On 2 March 2015, during a routine antenatal appointment, the defendant recorded that she and the aggrieved person discussed how long the aggrieved person needed to stay in hospital after the baby was born.

31. On 14 or 15 March 2015, the aggrieved person contacted the defendant and advised that she was having pain in her side. The defendant advised the aggrieved person to take paracetamol.

32. The defendant documented this conversation retrospectively, on 16 March 2015: "[The aggrieved person] did contact me over weekend as she was experiencing some pelvic discomfort as baby had descended into pelvis. [The aggrieved person] felt this happen; is still a little uncomfortable". The defendant did not record her advice to the aggrieved person to take paracetamol.

[9] The oral glucose challenge test. This measures how well the body can process sugar. The patient is offered a sugary drink and a blood sample is taken one hour later. This is a non-fasting test.
[10] A fasting test where the patient does not eat or drink anything for eight hours before the test. An initial blood test is taken to determine fasting blood sugar level. Then a sugary drink is administered and another blood test taken two hours later, to determine how sugar is processed.
[11] A blood test, usually given during the first antenatal blood tests, which shows average sugar level for the past 4 – 6 weeks.

33. On 23 March 2015, during a routine antenatal appointment, the defendant recorded the aggrieved person was going to talk to her husband about a water birth.[12]

34. On 29 March 2015, the aggrieved person texted the defendant, advising that she had "a little blood discharge yesterday [and a] bit 2day". The aggrieved person also said that she was experiencing some clear vaginal discharge and some hip pain, but that it was not like labour pain.

35. The defendant responded that this was "ok" and that "you will know when it is labour pain. The discharge is probably increased vaginal discharge which is normal". The defendant followed up with the aggrieved person later that evening by telephone, asking if there was any change at all. The aggrieved person confirmed that there had been no change.

36. The defendant did not make any record of these text messages, or her advice to the aggrieved person.

37. On 31 March 2015, the aggrieved person met with the defendant's backup midwife, for a routine antenatal appointment. At this appointment the backup midwife recorded that the aggrieved person had had a "possible show"[13] on 29 March 2015, and some lower back pain.

[12] Birthing the baby underwater in a birthing pool.

[13] Towards the end of pregnancy, the cervix begins to ripen and soften, and some of the mucus plug may come away. The mucus plug is usually clear or a cloudy creamy white colour. It can be tinged with pink, red or brown if blood gets caught in the mucus plug, from small blood vessels breaking when the cervix begins to thin and dilate.

7 APRIL 2015

First stage of labour

38. Early in the morning of 7 April 2015, the aggrieved person began experiencing contractions. The aggrieved person was 38+6 weeks pregnant.

39. At approximately 6.30 am, the aggrieved person telephoned the defendant and reported that she had been experiencing mild, irregular contractions since 2.00 am that morning.

40. At 9.15 am, the aggrieved person sent the defendant a text message stating that her contractions were approximately six minutes apart and one minute in duration. The defendant and the aggrieved person agreed to meet at LDH, for an assessment.

41. At 10.30 am, the aggrieved person and the defendant met at LDH. The defendant undertook an assessment of the aggrieved person by abdominal palpation and recorded in the clinical notes that the baby was in a longitudinal lie,[14] in left occipito-anterior position ("LOA"),[15] and with the baby's head well engaged in the pelvis. The defendant recorded the aggrieved person's urinalysis, blood pressure, and pulse, which were all within normal range. The defendant did not assess the aggrieved person's temperature.

42. The defendant then undertook a vaginal examination ("VE") of the aggrieved person and recorded in the clinical notes that the aggrieved person's cervix was anterior,[16] fully effaced,[17] 6-7 cm dilated,[18] and with

[14] The long axis of the baby is longitudinal to the long axis of the mother.
[15] The back of the baby's head facing forward with the baby's back towards the mother's left side and the baby's face towards the mother's right side.
[16] When a woman's cervix lies towards the front of the baby's head.
[17] When the cervix has completely thinned out in preparation for birth.

the membranes still intact and bulging.[19] The defendant recorded that the vertex[20] was confirmed at "station -2 →-3".[21] The auscultated fetal heart rate ("FHR")[22] was recorded as 142-155 beats per minute ("bpm"), which was within normal range.[23] The defendant recorded her impression: "[Aggrieved person] in established labour??", and her plan for the aggrieved person to remain upright and walking around.

43. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists 'Intrapartum Fetal Surveillance Clinical Guideline' – Third Edition (2014)[24] ("the RANZCOG Guideline") defines established (active) labour as: "regular painful contractions (contractions occurring every five minutes and persisting for 30 seconds or more) which may be associated with a show, ruptured membranes or cervical change (full effacement, 4cm or more dilation)."

44. By 11.30 am, the aggrieved person's contractions were becoming stronger, and occurring every three minutes.

45. At 11.40 am, the defendant recorded the FHR at 148 bpm, following a contraction.

46. At 11.50 am, the defendant brought uterotonics[25] into the room, in preparation for birth, and recorded the FHR at 137 bpm.

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[18] The opening of the cervix during labour from zero centimetres (no dilation) to 10 centimetres (fully dilated) in preparation for birth.
[19] When the amniotic sac has not yet ruptured and is protruding into the dilated opening of the cervix.
[20] The baby's head.
[21] Stations are described in numbers from 5 to -5, representing centimetres of descent into the birth canal. When the baby is high, and not yet engaged at all, it is at -5, when the baby is engaged in the birth canal, it is at 0, and when between 1 and 5, it is moving down the birth canal.
[22] Listening to the FHR using a hand-held device.
[23] Normal baseline FHR is between 110-160 bpm.
[24] Endorsed by the New Zealand College of Midwives.
[25] An agent used to induce contractions. Uterotonics are used to induce labour, and to reduce postpartum hemorrhage.

47. At 12.03 pm, the defendant recorded that the aggrieved person did not think her contractions were as regular or as strong as when she was at home.

48. At 12.12 pm, the aggrieved person was still contracting frequently, every three to four minutes.

49. At 12.15 pm, the aggrieved person felt some pressure on her bowel when contracting.

50. At 12.25 pm, the defendant recorded the FHR at 145 bpm, following a contraction.

51. At 12.38 pm, the aggrieved person told the defendant that she was feeling tired, and would try to rest or sleep between contractions. The defendant recorded the FHR at 142 bpm.

52. At 12.45 pm, the aggrieved person reported that the last contraction was the strongest one she had felt yet.

53. By 1.00 pm, the aggrieved person's contractions had begun to space out, and were coming every five minutes, but were reported to be much more intense. The defendant recorded the FHR at 137 bpm.

54. At 1.20 pm, the defendant recorded that the aggrieved person's contractions had slowed down, and were coming every 10-15 minutes. The defendant recommended the aggrieved person have lunch, and get moving again.

55. The RANZCOG Guideline sets out that, where there are no recognised risk factors and continuous CTG[26] is not recommended, the FHR should still be monitored by intermittent auscultation every 15 – 30 minutes in the

[26] Continuous cardiotocograph is the continuous electronic monitoring of the woman's contractions and baby's FHR.

active phase of the first stage of labour, and after each contraction or at least every five minutes in the active second stage of labour.

56. Contrary to accepted midwifery practice, the defendant did not monitor the FHR every 15-30 minutes during the active first stage of the aggrieved person's labour, between 10.30 am and 2.15 pm.

57. At 2.15 pm, the defendant performed another VE and recorded the aggrieved person's cervix was anterior, not well applied, and still at 6-7 cm dilated, and the vertex was still at station -2 →-3 meaning that the aggrieved person had not progressed since the previous examination at 10.30 am, 3¾ hours earlier.

58. The defendant recorded that her impression was the aggrieved person's baby was in an occiput posterior ("OP") position.[27] The defendant recorded the FHR at 146 bpm.

59. The Ministry of Health *Guidelines for Consultation with Obstetric and Related Medical Services* (2012) ("the Referral Guidelines") describe "prolonged first stage of labour" as: "< 2 cm in 4 hours for nullipara and primipara. Slowing in the progress of labour for second and subsequent labours. Take into consideration descent and rotation of fetal head, and changes in strength, duration and frequency of contractions". The referral category for prolonged first state of labour is "consultation".

60. Where the referral category is consultation: "The LMC must recommend to the woman (or parent(s) in the case of the baby) that a consultation with a specialist is warranted given that her pregnancy, labour, birth or puerperium (or the baby) is or may be affected by the condition..."

[27] The back of the baby's head lies against the mother's back.

61. The defendant did not advise the aggrieved person that her labour was not progressing normally and, contrary to the Referral Guidelines, failed to advise the aggrieved person that consultation with an obstetric specialist was warranted.

62. The defendant did not discuss with the aggrieved person transfer to a secondary or tertiary hospital.

63. The defendant failed to document any discussions or recommendations with the aggrieved person, including specialist referral or transfer.

64. At this time (2.15pm), a plan was made for the aggrieved person to go home, and return to LDH when she was having contractions every three minutes.

65. At 4.50 pm, the aggrieved person texted the defendant and advised that her contractions were more regular and painful, about three minutes apart, although some were six minutes apart. The aggrieved person wrote: "[B]ut it's very strong and I can't take it". The defendant responded that she would meet the aggrieved person back at LDH at 5.45 pm.

66. The aggrieved person arrived back at LDH at 6.00 pm. The defendant recorded the aggrieved person's contractions were now more regular and painful, with contractions every three to six minutes. The defendant noted the aggrieved person was looking "very uncomfortable".

67. Contrary to accepted midwifery practice, the defendant did not record the FHR at all between 2.15 pm and 6.20 pm.

68. At 6.20 pm, the defendant recorded the FHR at 137 bpm and that the aggrieved person was dropping to her knees on the floor during contractions.

69. The defendant texted the LDH core midwife on call ("the core midwife"), and requested that she attend as second midwife. The defendant advised she had a woman in labour who "[seemed] to be progressing well and [had] pushy urges". The core midwife was on rostered night duty and as there were no in-patients on the LDH maternity unit, she was at home when she received the defendant's text.

70. At 6.34 pm, four hours since her last assessment, the aggrieved person requested a VE, which the defendant carried out. The defendant recorded the aggrieved person was only 8 – 9 cm dilated, the vertex was at station -2, and that bulging membranes were present. The defendant encouraged the aggrieved person to lie on her left side with a pillow between her legs. The defendant recorded the FHR at 147 bpm.

71. The defendant did not advise the aggrieved person at this time that her labour was not progressing normally and, contrary to the Referral Guidelines, failed to advise the aggrieved person that consultation with an obstetric specialist was warranted.

72. The defendant did not discuss with the aggrieved person transfer to a secondary or tertiary hospital, including the fact that the nearest one was 2.5 hours away by road.

73. The defendant failed to document any discussions or recommendations with the aggrieved person, including specialist referral or transfer.

74. At approximately 6.45 pm, the core midwife arrived at LDH and spoke to the defendant who advised that the aggrieved person had taken a while to become fully established in labour, and that this was possibly due to the baby's OP position. The defendant advised the aggrieved person was 8 – 9 cm dilated and that contractions were regular.

75. The core midwife advised the doctor in LDH's ED that there was a woman in labour in the maternity department.

76. At 7.10 pm, the defendant recorded the FHR at 127 bpm.

77. Contrary to accepted midwifery standards, the defendant did not record the FHR between 7.10 pm and 8.20 pm.

78. At 7.35 pm, the defendant recorded the aggrieved person was beginning to experience some involuntary urges to push with the contractions.

79. At 7.50 pm, the defendant recorded "STROM ?? clear - ??",[28] indicating that the aggrieved person's membranes might have ruptured, but the defendant was not sure.

80. At 8.00 pm the aggrieved person reported that she felt "something" happening.

81. At 8.10 pm, the aggrieved person requested another VE, which the defendant carried out, recording that the aggrieved person was 9 cm dilated and the membranes were still intact. The defendant attempted to push the cervix over the baby's head during a contraction, but it was too uncomfortable for the aggrieved person. The defendant recorded the aggrieved person would begin using Entonox gas for pain relief.

82. At 8.20 pm, the defendant recorded the aggrieved person was using Entonox gas, and that the FHR was 158 bpm.

83. At 8.43 pm, the defendant recorded the FHR at 138 bpm.

84. At 9.10 pm, the defendant recorded the FHR at 143 bpm, following a contraction.

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[28] Spontaneous rupture of membranes. When the amniotic sac ruptures naturally. Also known as a woman's "waters breaking". "Clear" refers to the colour of the liquor, meaning no meconium is present.

85. At 9.40 pm, the defendant performed another VE, and pushed the remaining cervix over the baby's head. The aggrieved person's membranes ruptured. The defendant recorded the liquor was clear. The defendant recorded the vertex was at station 0 and that she could feel the posterior fontanelle.[29] The defendant also recorded the FHR at 137 bpm. This was the last time the defendant recorded the FHR during labour.

86. The defendant advised the core midwife the aggrieved person's membranes had ruptured and it was planned that the defendant would call the core midwife when assistance was required for the birth.

Second stage of labour

87. At 9.55 pm, the defendant called the core midwife into the delivery room. The aggrieved person was pushing spontaneously with contractions. The core midwife checked the resuscitaire[30] in preparation for delivery.

88. At 10.00 pm, the core midwife recorded the aggrieved person was pushing well and a peep of the baby's head was visible.

89. The defendant recorded the delivery retrospectively, at 1.33 am on 8 April 2015. The core midwife also made retrospective notes of the birth. The defendant recorded that at 10.00 pm on 7 April, the aggrieved person was pushing and the baby was coming down, and slipping back with pushes. The perineum was stretching well. The aggrieved person asked the defendant to "cut her" to help her birth the baby. The defendant advised that an episiotomy[31] was not needed at that stage.

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[29] A triangle-shaped open area in the skull covered by a tough membrane, where the two parietal bones adjoin the occipital bone.
[30] Baby resuscitation table.
[31] A surgical cut to the muscular area between the vagina and the anus (the area called the perineum), made just before delivery to enlarge the vaginal opening, to assist with birth and reduce the chance of tearing.

90. At approximately 10.15 pm, the baby's head was birthed, and some turtling[32] was noticed by the defendant.

91. The defendant lowered the head of the bed and placed the aggrieved person in the McRoberts position.[33] The core midwife pressed the buzzer for assistance from ED.

92. The defendant instructed the aggrieved person to push as hard as she could. The defendant also noted the umbilical cord was around the baby's neck and slipped it over the baby's head.

93. The defendant did not direct the core midwife to apply suprapubic pressure,[34] or advise her of the position of the baby, to assist her to apply suprapubic pressure.

94. The core midwife recorded retrospectively that she had tried, but was unable to perform suprapubic pressure at this time, because she was unable to determine the position of the anterior shoulder.

95. The core midwife then left the birthing room to advise the ED nurse that she and the defendant were birthing a baby with shoulder dystocia[35] and required assistance, as no one had responded to the emergency buzzer.

96. The defendant directed the aggrieved person to move onto her hands and knees.[36] The defendant did not attempt any other techniques to correct the

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[32] Where the baby's head is delivered, but retracts against the perineum.
[33] An obstetric manoeuvre used to assist in childbirth. It involves hyper-flexing the mother's legs tightly to her abdomen. The manoeuvre increases mobility at the sacroiliac joint, allowing rotation of the pelvis and facilitating the release of the baby's shoulders.
[34] The attempt to manually dislodge the anterior shoulder from behind the symphysis pubis during a shoulder dystocia. It is performed by an attendant making a fist, placing it just above the maternal pubic bone, and pushing the fetal shoulder in one direction or the other.
[35] When the baby's head has been born but one shoulder becomes stuck behind the mother's pubic bone, delaying birth of the baby's body. It is diagnosed when the shoulders fail to deliver shortly after the head. Shoulder dystocia is considered an obstetric emergency.
[36] The Gaskin Manoeuvre, or "all fours" position.

shoulder dystocia before directing the aggrieved person to move onto her hands and knees.

97. The defendant applied some traction to Baby A's head. Baby A was born at 10.20 pm. The cord was clamped. No cord gases were taken.

98. The core midwife took Baby A to the resuscitaire, where ventilation was commenced by ED doctors and an ED nurse.

99. Baby A's birth weight was recorded as 4,870 grams.[37] Her Apgar scores[38] were 2 at 1 minute and 3 at 5 minutes.

Third stage of labour and post-birth care

100. At 10.24 pm, the defendant administered Syntocinon[39] to the aggrieved person. The placenta was delivered at 10.26 pm, with controlled cord traction.

101. At 10.48 pm, the aggrieved person was noted to be bleeding moderately to heavily, and that her uterus was firm and deviated to the right.

102. At 11.00 pm, the defendant administered 1 mg of paracetamol to the aggrieved person, for pain.

103. At 11.26 pm, the defendant recorded the aggrieved person continued to bleed quite heavily. The defendant administered Syntometrine[40] to the aggrieved person, intramuscularly.

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[37] Baby A's weight was over the 100th percentile for her gestational age. A baby is classified as an LGA baby (large for gestational age) if it has a birthweight greater than the 90th percentile for its gestational age.

[38] An Apgar score is determined by evaluating the newborn baby on five criteria (Activity/muscle tone, Pulse, Grimace/reflex irritability, Appearance/skin colour, and Respiration) on a scale from zero to two, and totalling the sum of the five values. The resulting Apgar score ranges from zero to 10, with 10 being the most reassuring.

[39] Synthetic form of oxytocin. Used to induce labour, assist the delivery of the placenta, and prevent or treat excessive post-birth bleeding.

[40] Synthetic hormone.

104. At 11.38 pm, the defendant recorded the aggrieved person's blood pressure as 132/79 mmHg and her pulse at 94 bpm. The defendant estimated the aggrieved person's blood loss at 400 – 500 ml.

105. The defendant assessed the aggrieved person and recorded that she had a second or third degree perineal tear[41] which was not bleeding. The defendant was not able to repair the tear herself and advised the aggrieved person she would have to transfer to Dunedin Hospital for suturing. There is no record of any discussion between the defendant and the aggrieved person as to how the aggrieved person would get to Dunedin Hospital.

106. The defendant did not make any clinical notes of the aggrieved person's care between 11.38 pm and 2.15 am on 8 April 2015.

107. At 2.15 am, the defendant recorded the aggrieved person was "back down to postnatal" but did not record where the aggrieved person had been. The defendant did not make any further clinical notes.

108. There is no record that the defendant provided any further postnatal care to the aggrieved person, or provided her with any information regarding the wellbeing of her daughter, Baby A.

109. At some time after 2.41 am, an ED Doctor spoke to the aggrieved person and her family in the maternity unit. Dr B advised the aggrieved person that Baby A may have been starved of oxygen at birth and that the doctors were treating the complications as they arose, including the fact that Baby A was having seizures. Dr B also told the aggrieved person that a retrieval

[41] A second degree perineal tear affects the muscle of the perineum (the area between the vaginal opening and the anus) as well as the skin. A third degree tear extends downwards from the vaginal wall and the perineum to the anal sphincter (the muscle that controls the anus).

team was on its way and would transfer Baby A to the neonatal unit at Dunedin Hospital when she was stable.

110. At 7.06 am, Baby A was transferred to Dunedin Hospital, by helicopter. The aggrieved person remained at LDH, as there was not room in the helicopter.

111. At an unrecorded time, the aggrieved person was transported from LDH to Dunedin Hospital by ambulance. A family friend travelled with the aggrieved person. The defendant did not accompany the aggrieved person or organise for another midwife or an appropriate clinical alternative to travel with her. Accordingly, the aggrieved person was transferred to Dunedin Hospital without clinical oversight, despite having delivered a baby with shoulder dystocia, and having suffered a significant perineal tear and post-partum bleeding.

112. The defendant did not document the aggrieved person's transfer from LDH to Dunedin Hospital.

113. The Southern District Health Board's *Maternity Inter-hospital Transfers from Lakes District Hospital* guidelines state that the LMC retains clinical responsibility for the woman's care until she is formally transferred to a specialist.

114. The defendant did not undertake or document any formal handover of the aggrieved person from the defendant's care to obstetric staff at Dunedin Hospital.

115. The defendant did not provide staff at Dunedin Hospital with any of the aggrieved person's clinical notes in anticipation of her arrival and admission.

116. At Dunedin Hospital, the aggrieved person underwent an examination, under anaesthesia, where it was determined that she had suffered a fourth degree perineal tear.[42] The tear was repaired by a consultant obstetrician and gynaecologist.

SUBSEQUENT EVENTS

117. On 12 April 2016, the Midwifery Council of New Zealand ("the Council") made an order for the interim suspension of the defendant's practising certificate on the grounds that its concerns about the defendant's competence were so serious that they constituted reasonable grounds for believing that she posed a risk of serious harm to the public by practising below the required minimum standards of competence. The Council placed a condition on the defendant's practice requiring her to successfully undertake a re-education programme before she would be allowed to practise again.

118. Following these events, the aggrieved person has suffered from depression and incontinence issues.

MIDWIFERY PROFESSIONAL STANDARDS

119. The relevant standards for midwives are contained in the New Zealand College of Midwives (NZCOM) Handbook for Practice (2008). The standards are appended to this agreed summary of facts and are accepted by the defendant as being applicable at the time of the events subject to this claim.

[42] A fourth degree tear is the most severe. It extends through the anal sphincter and into the mucous membrane that lines the rectum (rectal mucosa).

EXPERT ADVICE

120. Ms Mary Wood, registered midwife, provided expert advice to the Health and Disability Commissioner. Ms Wood found the defendant had departed from accepted standards of midwifery practice in the care she provided to the aggrieved person. Ms Wood's advice to the Commissioner included the following:

120.1. The antenatal assessments provided by the defendant included assessment of fetal growth by way of comparison to 'anatomical landmarks', rather than by fundal height measurement. Given the aggrieved person's size, fundal height measurement would have been a more accurate gauge than palpation alone, and is the recommended practice standard for assessment of fetal growth.

120.2. At 2.30 pm on 7 April 2015, the defendant conducted a VE, which revealed there had been no progress since the previous VE at 10.30 am. The defendant's thinking at this time was that the baby was in OP position, and the plan was for the aggrieved person to go home to wait for contractions to accelerate again. There does not appear to have been any consideration given to the possibility that this was a non-progressive labour, or to consulting an obstetrician. The aggrieved person went home at that time.

120.3. Rather than sending the aggrieved person home at 2.15 pm, consultation with the obstetric team at the local base hospital should have been considered at this point. Whatever the reason for the stalled progress, the notes indicate that the aggrieved person was in established labour, but was not progressing. As such, her labour was no longer within the range of normal labour.

120.4. When the aggrieved person returned to the hospital at 6.34 pm, she had progressed a further 1 – 2 cm. If a consultation did not occur at 2.15 pm (as it should have), then it certainly should have occurred at 6.34 pm, when it should have been clear that the labour was not progressing normally. Consultation at this time would have been especially relevant in light of the fact that the aggrieved person was giving birth in a rural setting, 2.5 hours away from the nearest base hospital.

120.5. There is no documentation reflecting any discussion between the defendant and the aggrieved person about the possibility of transfer, nor consideration of consultation with an obstetrician.

120.6. It does not appear, from the clinical notes that any consideration was given to the possibility that the aggrieved person's labour was not progressing normally until the aggrieved person was pushing.

120.7. When shoulder dystocia became evident during labour, the defendant attempted the McRoberts position and then the Gaskin Manoeuvre, with traction, to achieve birth. No internal manoeuvres were tried to facilitate the birth, other than repositioning and traction.

120.8. The defendant's last clinical note was made at 2.15 am on 8 April 2015. There is a significant amount of time when the aggrieved person's wellbeing and care have not been documented. The documentation following the birth is inadequate and does not meet the standard expected.

120.9. Following her long labour and the birth of a baby with shoulder dystocia, the aggrieved person was at risk of postpartum hemorrhage. While the defendant should not have accompanied the aggrieved person herself, given the length of time she had been awake, the aggrieved person should have been escorted by a midwife, nurse or paramedic. It was inappropriate for the aggrieved person to be transferred to Dunedin hospital with only an ambulance officer (and a family friend).

DEFENDANT'S RESPONSE TO COMPLAINT

121. The defendant has given an undertaking that she will not seek to renew her annual practising certificate or to practise midwifery again in New Zealand.

122. The defendant has provided a written apology to the aggrieved person.

BREACH OF THE CODE

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

124. Right 6(1) of the Code states: "Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including:

a) an explanation of his or her condition; and

b) an explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; and

c) advice of the estimated time within which the services will be provided; and

d) notification of any proposed participation in teaching or research, including whether the research requires and has ethical approval; and

e) any other information required by legal, professional, ethical, and other relevant standards; and

f) the results of tests; and

g) the results of procedures."

125. Right 7(1) of the Code states: "Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise."

126. The defendant accepts that her conduct as outlined above constitutes a breach of Rights 4(1), 6(1), and 7(1) of the Code. In particular, the defendant accepts that:

a) antenatally, the defendant failed to measure fundal-symphysis height, and instead used abdominal palpation alone to assess fetal size;

b) antenatally, the defendant failed to adequately inform the aggrieved person of the circumstances that might require a transfer to Dunedin or Southland Hospital, and travel issues that might arise if that transfer was required during labour;

c) the defendant failed to recognise the aggrieved person's labour was not progressing normally at 2.15pm and at 6.34pm;

d) the defendant failed to recommend to the aggrieved person that a consultation with an obstetric specialist was warranted at 2.15 pm and at 6.34 pm, given that her labour, birth (or baby) might be affected by her prolonged first stage labour;

e) the defendant failed to discuss the possibility of a transfer to Dunedin or Southland Hospital at 2.15 pm, and at 6.34 pm;

f) the defendant failed to monitor the FHR every 15 – 30 minutes during the active phase of the first stage of labour, and at all during the second stage of labour;

g) the defendant sent the aggrieved person home for a four-hour period while she was in active labour, knowing that the aggrieved person would be without midwifery support and that the FHR would not be monitored during that time;

h) the defendant failed to document any discussions or recommendations with the aggrieved person during her labour, including specialist consultation or transfer;

i) the defendant failed to provide the aggrieved person with essential information in order for her to make informed choices about her ongoing care and the delivery of her baby;

j) during delivery of a baby with shoulder dystocia, the defendant did not try recommended manoeuvres to facilitate the delivery of Baby A's shoulders, other than repositioning and traction;

k) during delivery, the defendant did not provide adequate instructions to, or communicate effectively with, the core midwife;

l) the defendant failed to document any post-delivery care to the aggrieved person;

m) the defendant did not make arrangements for the aggrieved person to be escorted in the ambulance to Dunedin Hospital by an appropriate clinical practitioner;

n) the defendant did not complete adequate formal handover of care of the aggrieved person to Dunedin Hospital; and

o) the defendant failed to document the transport and transfer of the aggrieved person to Dunedin Hospital.

_____

Kerrin Eckersley
Director of Proceedings

_____

Date

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

_____

By or on behalf of the defendant,
Vicki McMillan

_____

Date

"A"

The NZCOM *Midwives Handbook for Practice* (2008) ("the NZCOM *Handbook for Practice*") – *Competencies for entry to the Register of Midwives* provides:

> **Competency One:** The midwife works in partnership with the woman/wahine throughout the maternity experience.
> …
> The midwife:
> …
> 1.9 communicates effectively with the woman/wahine and her family/ whānau as defined by the woman/wahine;
> 1.10 provides up to date information and supports the woman/wahine with informed decision-making;
> …
>
> **Competency Two:** The midwife applies comprehensive theoretical and scientific knowledge with the affective and technical skills needed to provide effective and safe midwifery care.
> …
> The midwife:
> …
> 2.3 assesses the health and well-being of the woman/wahine and her baby/tamariki throughout pregnancy, recognising any condition which necessitates consultation with or referral to another midwife, medical practitioner, or other health professional;
> …
> 2.5 attends, supports and regularly assesses the woman/wahine and her baby/tamariki and makes appropriate, timely midwifery interventions throughout labour and birth;
> 2.6 identifies factors in the woman/wahine and her baby/tamariki during labour and birth which indicate the necessity for consultation with, or referral to, another midwife or a specialist medical practitioner;
> …
> 2.8 recognises and responds to any indication of difficulty and any emergency situation with timely and appropriate intervention, referral and resources;
> …
> 2.15 shares decision making with the woman/wahine and documents those decisions;

2.16 provides accurate and timely written progress notes and relevant documented evidence of all decisions made and midwifery care offered and provided;

…

Competency Four: The midwife upholds professional standards and uses professional judgment as a reflective and critical practitioner when providing midwifery care.

…

The midwife:

4.1 accepts personal accountability to the woman/wahine, to the midwifery profession, the community and the Midwifery Council of New Zealand for midwifery practice;

…

4.4 recognises strengths and limitations in skill, knowledge and experience and shares or seeks counsel, consults with, or refers to, a relevant resource, other midwives, or other health practitioners;

…

The NZCOM *Handbook for Practice - Code of Ethics* provides:

Responsibilities to the woman

…

c) Midwives accept that the woman is responsible for decisions that affect herself, her baby and her family/whānau;

d) Midwives uphold each woman's right to free, informed choice and consent throughout her childbirth experience;

…

j) Midwives have a responsibility to ensure that no action or omission on their part places the woman at risk;

k) Midwives have a professional responsibility to refer to others when they have reached the limit of their experience;

…

The NZCOM *Handbook for Practice – Standards of Midwifery Practice* provides:

Standard One: The midwife works in partnership with the woman.

The midwife:

…

- facilitates open interactive communication and negotiates choices and decisions;

- shares relevant information within the partnership;

…

Standard Two: the midwife upholds each woman's right to free and informed choice and consent throughout the childbirth experience.
The midwife:

- shares relevant information, including birth options, and is satisfied that the woman understands the implications of her choices;

…

- develops a plan for midwifery care together with the woman;

…

- documents decisions and her midwifery actions;

Standard Three: The midwife collates and documents comprehensive assessments of the woman and/or baby's health and wellbeing.

Standard Four: The midwife maintains purposeful, on-going, updated records and makes them available to the woman and other relevant persons.

Standard Five: Midwifery care is planned with the woman.
The midwife:

…

- facilitates the decision-making process;

…

- sets out specific midwifery decisions and actions in an effort to meet the woman's goals and expectations and documents these;
- considers the safety of the woman and baby in all planning and prescribing of care;

…

Standard Six: Midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk.
The midwife:

- plans midwifery actions on the basis of current and reliable knowledge and in accordance with Acts, Regulations and relevant policies;
- ensures assessment is ongoing and modifies the midwifery plan accordingly;
- ensures potentially life threatening situations take priority;
- demonstrates competency to act efficiently in any maternity emergency situation;
- identifies deviations from the normal, and after discussion with the woman, consults and refers as appropriate;

…

- has the responsibility to refer to the appropriate health professional when she has reached the limit of her experience

…

Standard Seven: The midwife is accountable to herself, to the midwifery profession, and to the wider community for her practice.
The midwife:

- clearly documents her decisions and professional actions;
- ensures relevant information is available to the woman.