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

(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 19**

	Reference No. HRRT 004/2020
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] These proceedings under s 50 of the Health and Disability Commissioner Act 1994 were filed on 4 February 2020.

[1] [This decision is to be cited as: *Director of Proceedings v McMillan* [2020] NZHRRT 19.]

[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 4(2) by failing to provide services that complied with legal, professional, ethical, and other relevant standards;
>
> (iii) Right 4(5) by failing to co-operate with other providers to ensure quality and continuity of services to the aggrieved person;
>
> (iv) 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
>
> (v) 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 S) and her son (Baby N). 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 S) and her son (Baby N) 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 4(2) by failing to provide services that complied with legal, professional, ethical, and other relevant standards.

[6.1.3] Right 4(5) by failing to co-operate with other providers to ensure quality and continuity of services to the aggrieved person.

[6.1.4] 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.

[6.1.5] 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 S) or her son (Baby N). 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

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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 Ms S.

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 2 February 2016, the Midwifery Council of New Zealand ("the Council") forwarded to the Health and Disability Commissioner ("the HDC"), a complaint it received on 29 January 2016 from the Southern District Health Board, about the services provided to the aggrieved person by the defendant. The Council was required to forward the complaint to the HDC under s 64(1) of the Health Practitioners Competence Assurance Act 2003.

6. On 18 September 2018, the HDC (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. The aggrieved person is Brazilian and moved to New Zealand in 2015. The aggrieved person had been living in Queenstown for approximately five months at the time she became pregnant.

8. The aggrieved person booked the defendant as her LMC on 1 August 2015, when she was 19 weeks and 5 days pregnant ("19+5 weeks").

Lakes District Hospital ("LDH"), Queenstown

9. 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,[2] pethidine,[3] and water (birthing pool). No emergency obstetric or paediatric services are available at LDH.

10. LDH has an Emergency Department staffed by two doctors with nursing support.

Southland Hospital, Invercargill

11. 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)[4] services are available at Southland Hospital.

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[2] A pain relieving gas mixture consisting of two gases: 50% nitrous oxide and 50% oxygen, and is more commonly known as gas and air.

[3] A synthetic compound used as a painkilling drug, especially for women in labour.

[4] Level 2 units generally care for babies of 32 weeks' gestation and above, or babies who have been transferred from Level 3 (see footnote 4) units 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 who 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.

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

Dunedin Hospital

13. Dunedin Hospital houses a tertiary maternity facility, for women with complex maternity needs which require specialist multidisciplinary care. NICU (Level 2 and Level 3)[5] services are available at Dunedin Hospital.

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

ESTIMATED DATE OF DELIVERY ("EDD")

15. The aggrieved person's EDD, according to her last menstrual period ("LMP"), was 24 December 2015. An ultrasound scan carried out on 18 June 2015, when the aggrieved person was 13+3 weeks pregnant, estimated the aggrieved person's EDD as 21 December 2015.

16. On 1 August 2015 at the booking visit, the defendant documented the EDD as 21 December 2015. On 13 October, 27 October and 10 November 2015, the defendant recorded the EDD as 24 December 2015. From 23 November 2015 the defendant recorded the EDD variously as 21, 24, 25 and 26 December 2015. The defendant did not document any discussion with the aggrieved person about, or any rationale for, altering the EDD from what she had originally documented at the aggrieved person's booking visit, or the changing dates.

17. The aggrieved person understood the agreed EDD was 21 December 2015.

18. The defendant did not establish an agreed or consistent EDD with the aggrieved person, and did not record the EDD or gestational age

[5] 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.

consistently throughout the aggrieved person's pregnancy, even within records of the same date.

19. A list of the EDDs and gestational ages recorded by the defendant throughout the aggrieved person's pregnancy is appended to this agreed summary of facts and marked "A".

ALTERATIONS MADE TO CLINICAL NOTES

20. Sometime between 6 January 2016 (when the defendant faxed a copy of the aggrieved person's maternity notes to Southland Hospital) and 29 February 2016 (when the defendant returned the aggrieved person's maternity notes to her), the defendant made multiple amendments to the aggrieved person's maternity notes. The defendant did not mark these amendments as having been made retrospectively, or identify them as not being part of the original clinical record.

21. Sometime between 29 February 2016 and 7 March 2016 (when the defendant provided a copy of the aggrieved person's midwifery notes to the HDC), the defendant altered the EDD in the 'client profile summary' from 21 December 2015 to 24 December 2015. The defendant did not mark this alteration as having been made retrospectively.

22. A list of the alterations made by the defendant and not marked as retrospective is appended to this agreed summary of facts, and marked "B".

CARE PLAN

23. At the time of booking, the defendant discussed place of birth with the aggrieved person. The defendant advised the aggrieved person that her pregnancy was normal and low risk, and therefore she could have her baby at her own home in Queenstown.

24. The aggrieved person intended to have a home birth, with a plan that she would transfer to hospital should anything go wrong.

25. The defendant did not discuss the risks of having a home birth in Queenstown with the aggrieved person, including that the nearest hospital, LDH, did not have obstetric staff, that should the aggrieved person require secondary care she would have to transfer to Southland Hospital, and that Southland Hospital was 2.5 hours away by road.

26. The aggrieved person's maternity notes contain a sheet headed "guide for care plan discussion" and next to "planned place of birth" is written "home". The entry is dated "2/12/15". There is no other written care plan or birth plan. There is nothing documented in the section "childbirth preparation" other than the date "2/12/15".

ANTENATAL CARE

Booking appointment

27. Prior to 1 August 2015, the aggrieved person and the defendant met to discuss the defendant acting as the aggrieved person's LMC. The defendant did not make any record of that meeting.

28. On 1 August 2015, the aggrieved person attended a booking appointment with the defendant. The defendant recorded the aggrieved person's EDD as 21 December 2015. The defendant recorded in the clinical notes that she carried out an assessment of the aggrieved person, including urinalysis, blood pressure, pulse, and fetal heart rate ("FHR") monitoring, all of which were within normal range. The defendant recorded she had discussed "maternity services" with the aggrieved person. The defendant did not record any details of what was discussed, except to note that the aggrieved person was planning a home birth and had declined to attend childbirth and parenting education classes.

29. During the visit, the defendant performed abdominal palpation, and used anatomical landmarks[6] to assess fetal growth. The defendant recorded that the uterus was measuring according to dates.[7] The defendant did not measure fundal-symphysis height.[8]

30. 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.

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

> "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."

32. 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

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[6] 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).

[7] Meaning that the height of the uterus accorded with what would be expected at the current gestational age.

[8] The distance between the pubic bone and the top of the uterus, measured in centimetres, using a tape measure.

palpation/inspection alone, or fundal-symphysis height measurement alone.

33. 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.[9]

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

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

36. During the booking appointment, the defendant recorded in the 'maternity history summary' that the aggrieved person had previously undergone high-frequency surgery on her cervix[10] and had a history of urinary tract infection.

37. The Ministry of Health *Guidelines for Consultation with Obstetric and Related Medical Services* (2012) ("the Referral Guidelines") outline certain conditions where consultation with, or transfer to, a specialist is recommended. Where a woman has had previous cervical surgery, consultation with a specialist is recommended and ought to be discussed with the woman.

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

[10] Where radio-frequency current is used to remove abnormal cells from the cervix. Also known as 'loop electrosurgical excision procedure' or LEEP.

38. The Referral Guidelines also set out that where a woman has had recurrent urinary tract infections, a consultation is likewise recommended and ought to be discussed.

39. Specifically, where a consultation is recommended the Referral Guidelines direct that "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 (of the baby) is or may be affected by the condition…".

40. Contrary to accepted midwifery practice, the defendant did not recommend to the aggrieved person, or discuss with her at all, that due to her medical history, consultation with an obstetric specialist was warranted.

Ongoing antenatal care

41. On 26 August 2015, during a routine antenatal appointment, the defendant recorded that she and the aggrieved person had discussed "blood tests screening for Gestational Diabetes". The defendant's notes record that the aggrieved person might not undertake further screening.

42. On 27 October 2015, during a routine antenatal appointment, the defendant recorded the urinalysis showed the aggrieved person had glucose in her urine. The defendant recommended blood tests to check haemoglobin,[11] ferritin,[12] and glucose levels.[13]

43. On 10 November 2015, during a routine antenatal appointment, the defendant recorded the results of the blood tests recommended on 27

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[11] The oxygen-carrying pigment and predominant protein in red blood cells.

[12] A protein found in blood capable of storing iron.

[13] The amount of glucose (a sugar) in the blood.

October 2015. The blood tests showed the aggrieved person's iron level was low, in response to which the defendant recommended the aggrieved person take an iron supplement. The aggrieved person's glucose blood test was high, but still within normal range. The defendant recommended the aggrieved person remove sugar from her diet.

44. On 23 November 2015, the aggrieved person underwent an ultrasound to check fetal wellbeing and growth. The scan report noted the aggrieved person was 36 weeks pregnant by scan and that the EDD was 21 December 2015. Fetal growth, amniotic fluid levels and Dopplers[14] were all normal.

45. On 30 November 2015, the defendant issued the aggrieved person with a medical certificate which stated the "estimated date of birth" was 21 December 2015.

46. On 2 December 2015, during a routine antenatal appointment, the defendant recorded: "Some discussion regarding transfer during labour and how this occurs; would go to Lakes District Hospital (Drive in own car) and then transfer via ambulance to Invercargill; after obstetric consultation".

Post-date antenatal care

47. On 21 December 2015, the aggrieved person was 40 weeks pregnant, by scan. The aggrieved person and the defendant met for a routine antenatal appointment during which the defendant recorded: "no signs of baby wanting to share his birthday with us". The defendant's plan was to continue weekly visits.

[14] Doppler ultrasound uses sound waves to detect the movement of blood in the vessels. In pregnancy it is used to study blood circulation in the baby, uterus, and placenta.

48. The Referral Guidelines set out that in the event of a prolonged pregnancy, consultation with a specialist is recommended and describe the need to "refer in a timely manner for planned induction by 42 weeks".

49. Contrary to accepted midwifery practice, the defendant failed to recommend to the aggrieved person, or discuss with her at all, that now she had reached her EDD, timely consultation with an obstetric specialist was warranted.

50. On 28 December 2015, the aggrieved person was 41 weeks pregnant, by scan. The aggrieved person attended the defendant for a scheduled antenatal appointment. The aggrieved person requested an induction. The defendant recorded: "[The aggrieved person] is well but everyone is becoming anxious regarding babies [sic] arrival; explained and discussed with [the aggrieved person] that Induction of Labour does not occur before 42 weeks." The defendant concluded: "Impression well woman, well baby, all wellness checks within normal range, no further midwifery action required".

51. Contrary to accepted midwifery practice, the defendant failed to recommend to the aggrieved person, or discuss with her at all, that now she had passed her EDD, timely consultation with an obstetric specialist was warranted in order to plan for induction by 42 weeks.

52. On 31 December 2015, when the aggrieved person was 41+3 weeks pregnant by scan, the defendant met with the aggrieved person at LDH to undertake a CTG[15] to monitor the wellness of the baby.

53. Contrary to accepted midwifery practice, the defendant again failed to recommend to the aggrieved person, or discuss with her at all, that due to

[15] Cardiotocograph (CTG) is the electronic monitoring of the woman's contractions and the baby's FHR.

the fact she had passed her EDD, timely consultation with an obstetric specialist was warranted, for planned induction by 42 weeks.

54. Sometime after 31 December 2015, the defendant retrospectively recorded on separate sheets of paper to the aggrieved person's midwifery book, that the defendant had discussed with the aggrieved person, on 31 December 2015, that a consultation with an obstetric specialist was recommended for planned induction of labour by 42 weeks, and that the aggrieved person had declined consultation with a specialist at that stage. The defendant's retrospective notes are not an accurate record of what occurred during the appointment. The defendant did not have that discussion with the aggrieved person.

LABOUR

4 January 2016 – Start of labour

55. On 4 January 2016, the aggrieved person began to experience contractions. The aggrieved person was 42 weeks pregnant, by scan. At 5.54 pm, the aggrieved person texted the defendant: "This afternoon I started some uncomfortable cramps on my [sic] lower abdomen. Can it be a [sic] early stage of labour? The cramps take 60 seconds and come every 15/18 minutes". There is no record the defendant responded to this text message.

56. At 10.41 pm, the aggrieved person sent the defendant another text message: "… I'm feeling strong contractions each 10 minutes now. I took one paracetamol 500mg at 8.32pm, but it didn't improve the pain. Is it normal? Other question: when I can [sic] fill the pool? I wanted to sleep, but it is impossible with the contractions".

57. The defendant responded by text message advising that the aggrieved person should have taken two 500 mg paracetamol tablets and that she should take another one. The defendant wrote: "Still very early … Still try

to sleep. I [am] going to sleep now … Contractions need to be every 3 minutes to be in labour …".

58. Around 12.00 am on 5 January 2016, the aggrieved person telephoned the defendant and said that her contractions were very painful, and asked for support. The defendant asked how regular the contractions were, and told the aggrieved person that she did not need to worry.

59. At approximately 2.00 am, the aggrieved person telephoned the defendant again, because her contractions were extremely painful. The defendant told the aggrieved person that she (the defendant) needed to sleep and that the aggrieved person should try to sleep as well. The defendant told the aggrieved person to relax and that someone would come to see her in the morning. The defendant also told the aggrieved person that she should count her contractions. The aggrieved person and her partner spent the rest of the night counting contractions.

60. At 4.44 am, the aggrieved person sent the defendant a series of text messages, stating that she thought she was now in active labour, that her contractions were "so strong and each 5/3 minutes", that she had taken another two paracetamol, and that she was bleeding. The defendant responded via text message that another midwife would come to the aggrieved person to undertake an assessment.

61. The defendant did not make any record of these overnight communications, or her advice to the aggrieved person.

5 January 2016 – 6.00 am – assessment

62. At 6.00 am, the defendant's back-up midwife arrived at the aggrieved person's home to carry out an assessment. The midwife recorded that the aggrieved person's contractions were occurring at a rate of two every 10 minutes and lasting 60 seconds. The aggrieved person's blood pressure

was raised at 138/98 mmHg. The midwife undertook an abdominal assessment and recorded that, on palpation, the baby was in an ROA longitudinal lie,[16] cephalic[17] presentation, with 3/5ths of the presenting part palpable.[18] The midwife then conducted a vaginal examination ("VE") and noted the presenting part of the baby's head was at station -1,[19] the membranes were intact and bulging,[20] and the cervix was 6 or 7 cm dilated and 90% effaced.[21] The FHR was recorded at 155 beats per minute ("bpm").

63. The back-up midwife documented that she had informed the defendant of her findings and that the defendant planned to come to the aggrieved person's home. The midwife then left the aggrieved person's home.

64. The back-up midwife recorded the aggrieved person's dilation by initially writing 6 cm, and then writing a 7 over the top. Retrospectively, the defendant altered this notation to read "6-7 cm". The defendant did not identify this alteration as having been made retrospectively, or as having been made by someone other than the back-up midwife who made the original record.

Defendant's arrival

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[16] Right Occiput Anterior. The occiput (prominent bone at the back of the head) faces towards the mother's front, and towards the right. This position is not associated with labour complications.

[17] Head down.

[18] The descent and engagement of the head is assessed by feeling how many fifths of the head are palpable above the brim of the pelvis. '3/5 of the head palpable' means that the head cannot be lifted out of the pelvis.

[19] 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.

[20] When the amniotic sac has not yet ruptured and is protruding into the dilated opening of the cervix.

[21] Effacement is when the cervix stretches and thins out in preparation for birth. When the cervix has completely thinned out, the woman is said to be "fully effaced".

65. At 7.15 am, the defendant arrived at the aggrieved person's home. The defendant recorded that the aggrieved person continued to have "regular strong contractions" which she was "breathing through quietly", and that the birthing pool had been filled, but needed heating. The defendant did not record the onset of the aggrieved person's labour and when labour was officially established.[22]

66. At 7.40 am, the defendant recorded the FHR at 126 bpm.

67. At 7.52 am, the defendant undertook urinalysis which showed "protein ++" in the aggrieved person's urine. The defendant recorded that the aggrieved person was nauseous, and had vomited. The defendant did not record the aggrieved person's pulse or blood pressure despite the elevated blood pressure recorded at 6am. As per paragraph 20 above, the defendant amended the maternity notes retrospectively to include readings of the aggrieved person's blood pressure at 126/82 mmHg and pulse rate of 88 bpm. The defendant did not identify the amendments as having been made retrospectively or identify them as not being part of the original clinical record.

68. It is recommended practice that maternal temperature and blood pressure are monitored four hourly in established labour.[23]

69. Contrary to the recommended practice, the defendant did not record the aggrieved person's temperature until 3.30 pm, and did not record or follow up on the aggrieved person's elevated blood pressure again until 3.30 pm.

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[22] Established labour is the period of time during which the cervix dilates from about four cm to ten cm (fully dilated) and a woman experiences regular and painful contractions.

[23] NICE 'Intrapartum care for healthy women and babies' – Clinical guideline (2014), 1.12 First stage of labour.

70. At 8.15 am, the aggrieved person got into the birthing pool.

71. By 8.30 am, the aggrieved person's contractions appeared to be becoming more intense.

72. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists 'Intrapartum Fetal Surveillance Clinical Guideline' – Third Edition (2014)[24] ("the RANZCOG Guideline") sets out that, where there are no recognised risk factors and continuous CTG is not recommended the FHR should still be monitored by intermittent auscultation[25] every 15 – 30 minutes in the 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.

73. The defendant retrospectively amended the maternity notes to include FHR readings at 8.15 am (138 bpm) and 8.40 am (142 bpm). The defendant did not identify the amendments as having been made retrospectively or identify them as not being part of the original clinical record.

74. At 9.00 am, the defendant recorded the FHR at 152 bpm, after a contraction.

75. The defendant also retrospectively amended the maternity notes to include a FHR reading at 9.30 am (132 bpm). The defendant did not identify the amendment as having been made retrospectively.

10.00 am – assessment

76. At 10.00 am, the defendant undertook an assessment of the aggrieved person and recorded the baby was still in a ROA longitudinal lie, and that 3/5ths of the presenting part was palpable. The defendant performed a VE

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[24] Endorsed by the NZCOM.

[25] When the FHR is listened to using a hand-held device.

and recorded the aggrieved person's cervix was fully effaced, 8 – 9 cm dilated (more on the right side), and that her membranes were still intact and bulging. The FHR was recorded at 142 bpm. The defendant recorded that the aggrieved person's contractions had spaced out and recommended the aggrieved person sleep, and that she take 1 gram of paracetamol.

77. The defendant recorded that she was "away to do a visit or two", that she would be back at 12.00 pm, and that the aggrieved person should call if she needed the defendant sooner. The defendant left the aggrieved person unattended at home in established, late first stage labour.

78. Contrary to accepted midwifery practice, the defendant did not monitor the FHR between 10.00 am and 12.00 pm.

Defendant's return

79. Shortly before 11.45 am, one hour and 25 minutes later, the aggrieved person contacted the defendant and advised that her contractions had become more regular and strong again.

80. At 11.45 am, the defendant arrived back at the aggrieved person's home and recorded that the aggrieved person appeared to be in transition phase. The aggrieved person told the defendant that the pain was difficult to deal with, but was not offered any pain relief options.

81. At 12.00 pm, the defendant recorded the FHR at 126 bpm.

82. At 12.10 pm, the defendant recorded the FHR at 144 bpm.

83. At 12.42 pm, the defendant recorded the FHR at 138 bpm.

84. Contrary to accepted midwifery practice, the defendant did not monitor the FHR between 12.42 pm and 1.30 pm.

85. At 1.30 pm, the defendant recorded the FHR at 126 bpm.

1.45 pm – assessment

86. At 1.45 pm, the defendant performed a VE and recorded the vertex was at station 0, the membranes were still intact, and the aggrieved person's cervix was 9.5 cm dilated with an anterior lip, which the defendant attempted to push away but which the aggrieved person found too painful. The defendant recorded that her impression was the aggrieved person was "nearly there" and the plan was to have patience, and for the aggrieved person to lie on her left side and wait for the anterior lip to go away.

87. The Referral Guidelines describe a "prolonged first stage of labour" as: "< 2 cm in 4 hours for nullipara[26] and primipara".[27] The referral category for prolonged first stage of labour is "consultation" with a specialist.

88. Contrary to accepted midwifery practice, the defendant did not recommend to the aggrieved person, or discuss with her at all, that a consultation with a specialist was warranted in light of her prolonged labour.

89. At 2.30 pm, the defendant recorded the FHR at 138 bpm.

90. Contrary to accepted midwifery practice, the defendant did not monitor the FHR between 2.30 pm and 3.30 pm.

Transfer to LDH

91. At 2.45 pm, the defendant recorded that the aggrieved person was not coping well, and that a plan had been discussed to: recheck the aggrieved person's cervix; transfer the aggrieved person to LDH; and arrange for an

[26] A woman who has not previously given birth.

[27] A woman who has given birth to one child.

ambulance transfer to Southland Hospital, and an epidural[28] or syntocinon.[29] Retrospectively, the defendant added "talk with [doctors]" to her record of this discussion in the maternity notes. The defendant did not identify the amendment as having been made retrospectively.

92. At 3.00 pm, the defendant assessed the aggrieved person through palpation and a VE and recorded the baby was still in a longitudinal lie in an ROA position, a small anterior lip was present and that the vertex was at station -1 or 0. The defendant recorded: "Decision to transfer to Lakes for CTG and assessment with another midwife, to confirm findings. Then transfer to Invercargill via Ambulance". The defendant retrospectively added the words "to confirm findings". The defendant did not identify the amendment as having been made retrospectively or identify them as not being part of the original clinical record.

93. LDH was approximately 20 minutes from the aggrieved person's home by car. The defendant left the aggrieved person's house and advised she would meet the aggrieved person and her partner at LDH. The aggrieved person and her partner organised themselves to go to the hospital and left for LDH approximately 20 minutes after the defendant. The aggrieved person continued to experience painful contractions during the drive to LDH.

Arrival at LDH

94. At 3.30 pm, the aggrieved person arrived at LDH. The defendant commenced CTG monitoring which she documented as reassuring, and recorded the baseline FHR at 135 bpm. The defendant undertook

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[28] An analgesic or anaesthetic drug is injected into the epidural space of the spinal cord to relieve pain or to provide an anaesthetic.

[29] Syntocinon contains oxytocin, which is a naturally occurring hormone. It is used as an intravenous infusion for starting (inducing) labour or for stimulating labour when the contractions are weak.

observations and recorded the aggrieved person's blood pressure at 143/96 mmHg (still elevated), a pulse rate of 102 bpm, and noted that she had "protein: 2+" in her urine. The aggrieved person began using Entonox gas.

95. The defendant did not record any FHR readings after 3.30 pm. The CTG printout ceases shortly after 4.30 pm. Contrary to accepted midwifery practice, the defendant did not monitor the FHR between 4.30 pm and 8.30 pm.

96. At 4.30 pm, the defendant recorded that she had contacted the on-call obstetric registrar at Southland Hospital, to discuss transfer of the aggrieved person by ambulance. The defendant did not record the details or outcome of this conversation.

97. At 5.00 pm, the defendant recorded that she and the aggrieved person were waiting for a call back regarding when the ambulance would arrive. The defendant's back-up midwife, who was at LDH, undertook a VE of the aggrieved person. The defendant recorded that there was an anterior lip on the right and front of the cervix, the vertex was at station 0, the baby was in an OP position,[30] and the aggrieved person's membranes had ruptured. The defendant recorded that the plan, when the aggrieved person got to Southland Hospital, was for the administration of an epidural and syntocinon, and a vaginal birth.

98. At 6.00 pm, the aggrieved person and the defendant left LDH in an ambulance. The defendant recorded "no concerns with FHR on way down". Contrary to accepted midwifery practice, the defendant did not record the FHR during the transfer to Southland Hospital.

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[30] The occiput is facing towards the woman's back.

Arrival at Southland Hospital

99. The aggrieved person and the defendant arrived at Southland Hospital at approximately 8.30 pm.

100. At approximately 8.47 pm, the on-call obstetric registrar reviewed the aggrieved person. The defendant advised the obstetric registrar that the aggrieved person was "at term". On examination the obstetric registrar noted that the aggrieved person was distressed with pain, the fetus was cephalic with 1/5th of the fetal head palpable in the abdomen. The aggrieved person's contractions were strong: two in every ten minutes, lasting 60 seconds. The cervix was 8-9cm dilated, with the fetus in an OP asynclitic[31] fetal position, with no caput moulding.[32] The registrar's impression was "Malpresentation. Analgesia requirement."

101. The Referral Guidelines set out a 'Process for transfer of clinical responsibility for care' that require:

> - a three-way conversation between the LMC, the woman and the specialist to determine that the transfer of care is appropriate and acceptable
> - the LMC to provide all relevant information, including any relevant maternity notes, test results, and histories, to the specialist…"

102. The defendant did not provide an adequate handover to the obstetric staff at Southland Hospital, including advising them of the fact the aggrieved person was two weeks past her EDD. Contrary to accepted midwifery practice, the defendant did not provide staff with the aggrieved person's maternity notes, instead she gave the on-call obstetric registrar one page of progress notes. The defendant told the registrar that the aggrieved

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[31] A subtle malposition in which the baby's head is tilted and the top of the head is not centred on the cervix. It can result in back pain or prolonged active labour.

[32] Swelling of the baby's scalp caused by the pressure of the scalp against the dilating cervix during labour.

person's maternity notes had to return to Queenstown with the defendant, but that copies would be provided.

103. Following the obstetric registrar's review of the aggrieved person, the defendant left Southland Hospital, and returned to Queenstown with the ambulance.

104. At 12.51 am on 6 January 2016 the aggrieved person gave birth to Baby N. Baby N was delivered with the umbilical cord around his neck and body, with some meconium liquor (fetal stool) present, making no respiratory effort and with poor Apgar scores.[33] Resuscitation was commenced and Baby N was subsequently diagnosed with stage 2 hypoxic ischaemic encephalopathy.[34]

105. At 1.38 am on 6 January 2016, the obstetric registrar found the aggrieved person's maternity notes on a desk in the midwifery station, and was advised by one of the core midwives that they had just been faxed in.

106. The obstetric registrar recorded that the additional LMC notes and scans showed the aggrieved person was 42+2 weeks' gestation based on an EDD of 21 December 2105. This was the first time the obstetric registrar had become aware of this information.

SUBSEQUENT EVENTS

107. 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

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[33] 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. Baby N's were 2 at 5 minutes.

[34] A brain injury caused by oxygen deprivation; also commonly known as intrapartum asphyxia.

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.

108. Following these events, the aggrieved person has suffered with post-natal depression.

MIDWIFERY PROFESSIONAL STANDARDS

109. The relevant standards for midwives are contained in the NZCOM *Midwives Handbook for Practice* (2008) and the Council's *Code of Conduct* (2010). The standards are appended to this agreed summary of facts and marked "C", and are accepted by the defendant as being applicable at the time of the events subject to this claim.

EXPERT ADVICE

110. Dr Carolyn Young, registered midwife, provided expert advice to the HDC. Dr Young found the defendant had departed from accepted standards of midwifery practice in the care she provided to the aggrieved person in the following ways:

Antenatal care

110.1. The need to measure and record fundal-symphysis height as part of the routine antenatal assessment for fetal wellbeing, whether it is subsequently graphed on a customised growth chart or not, is recognised as part of the professional standards of care.

110.2. In relation to prolonged pregnancy, the Referral Guidelines recommend consultation and describe the need to 'refer in a timely manner for planned induction by 42 weeks'. There is an

ongoing discrepancy around the EDD. Based on a scan date of 21 December 2015 the defendant was outside of the recommended postdates referral point for a planned induction by 42 weeks.

31 December 2015 appointment

110.3. On 31 December 2015, the defendant met with the aggrieved person and undertook a CTG.

110.4. The defendant documented a discussion around induction of labour during this appointment. If the defendant's documentation around this discussion was added retrospectively, the lack of discussion, information sharing, and mutual formulation of an agreed plan would represent a departure from accepted standards of midwifery care because it was a critical decision point in the midwifery care.

Labour

110.5. Recommended practice is that maternal blood pressure and temperature are monitored four hourly and maternal pulse measured two hourly in established labour, as changes in maternal recordings can be indicative of maternal distress. The defendant did not follow the recommended practice.

110.6. The aggrieved person's initial blood pressure reading in labour was 138/98. A diastolic reading of 98 is seen as elevated and should be responded to and followed up. The blood pressure assessment is part of the component for creating a baseline as to maternal wellbeing; this should include the pulse, respiratory rate and temperature. This initial assessment creates a benchmark to refer back to in subsequent monitoring for indications of maternal distress and is therefore of importance to the provision of care. Where blood pressure is elevated it should be rechecked again

relatively quickly (e.g. within an hour). The failure to establish a baseline for maternal wellbeing and to follow up on an elevated blood pressure recording at the initial assessment was a departure from accepted standards of midwifery care.

110.7. The defendant's decision to leave the aggrieved person while she was in advanced first stage labour, to go and undertake home visits with other clients, was a departure from acceptable standards of care. Assurance of the continued wellbeing of the baby was dependent on FHR monitoring, which the aggrieved person and her partner did not have the ability to do. If fetal or maternal compromise had occurred during this period, it would have gone undetected until the defendant's return.

Decision to transfer

110.8. The recognition of prolonged labour requires a timeline from the onset of established labour. The defendant's clinical notes do not clearly identify the time labour established.

110.9. The VE undertaken at 1.45 pm showed less than optimal progress, minimal descent of the presenting part of the baby's head, the presence of an anterior lip of cervix, and uneven dilation, which can be further indication of a malpresentation. There was no documented discussion between the defendant, the aggrieved person, and her family as to whether transfer should be considered and, if declined, if there was then a decision point of when to accept the need for transfer. There were clear indicators that labour was not progressing well with minimal dilation and descent and the slowing and decreasing intensity of contractions.

110.10. As well as the progress of the labour, external factors also needed to be considered: LDH is a primary birthing unit; transfer to

Southland Hospital involved travel time of around two and a half hours by road; in addition, there was uncertainty as to the amount of time it would take to access an ambulance for the transfer. As a rule, the further away a labouring woman is from a base hospital, the lesser the tolerance of any deviation from normal labour.

110.11. While the aggrieved person and her baby's observations were stable at 1.45 pm, there was a failure by the defendant to discuss her clinical findings and their implications with the aggrieved person and to communicate the need for consultation and transfer.

Transfer of care

110.12. The documentation relating to the aggrieved person's care up to the point of handover was an important component of the management of her ongoing care as it confirmed the degree and length of the obstructed labour as well as presenting a record of her antenatal care. The Referral Guidelines state that the LMC is to provide all relevant information, including any maternity notes, test results, and histories. The defendant did not do this.

110.13. The antenatal care notes were relevant to ongoing management because of the discrepancy in the EDD and the radiology results around this were therefore of relevance, particularly when verbal misinformation had been given around the duration of pregnancy. The labour notes are of importance as they provide a written record of what had occurred thus far in the labour helping to inform subsequent care providers of the best plan of care from the point of admission to SDHB. The need for the notes to inform the ongoing care plan for the aggrieved person was of greater priority than the defendant continuing to hold them.

110.14. Withholding notes at the point of transfer of care of a difficult labour to secondary services where there was no backup booking and known history of the woman, does not meet accepted standards.

Documentation

110.15. The clinical notes did not detail the actual discussions that occurred between the defendant and the aggrieved person. Time sequences were not always well recorded. There was no documentation as to when labour was established. There is no partogram, which graphs the progress in labour and the observations. It enables an instant overview of the progress of labour, the dilatation of the cervix, the descent of the baby, the frequency of contractions, the recording of maternal observations and the FHR. In prolonged labour the graphing of this information is a useful tool in recognising when labour slows and may provide an early warning of the possibility of obstructing labour and/or uterine inertia, as well as maternal or fetal distress.

110.16. Retrospective documentation should be entered as closely as possible to the time of the event which occurred, the date and time of entering the additional information recorded, and it being clearly indicated as being retrospective. Inaccurate or misleading documentation can fall into the category of an 'action or omission' on the part of the midwife that places the woman at risk.

110.17. Clinical documentation standards require that after an entry is made, a line is drawn through any space not written in, prior to the entry being signed to prevent the addition of further information without indicating that this information is being

added retrospectively. The defendant's documentation does not uphold this criterion.

110.18. Unfortunately, when documentation is altered after the event and there is no indication that this has been done retrospectively, it cannot help but call into question the integrity of the clinical records and raise the concern of whether the additional information entered is accurate.

DEFENDANT'S RESPONSE TO COMPLAINT

111. 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.

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

BREACH OF THE CODE

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

114. Right 4(2) of the Code states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards".

115. Right 4(5) of the Code states: "Every consumer has the right to co-operation among providers to ensure quality and continuity of services".

116. 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".

117. 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".

118. The defendant accepts that her conduct as outlined above constitutes a breach of Rights 4(1), (2) and (5), Right 6(1), and Right 7(1) of the Code. In particular, the defendant accepts:

a) antenatally, the defendant failed to discuss with the aggrieved person, and record, a care plan;

b) antenatally, the defendant failed to recommend to, or discuss with, the aggrieved person that consultation with an obstetric specialist was warranted, on the basis that she had previously had surgery on her cervix, and had a history of urinary tract infection;

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

d) the defendant failed to discuss the risks of having a homebirth in Queenstown with the aggrieved person;

e) the defendant failed to establish an agreed and consistent EDD;

f) the defendant failed to formulate an appropriate plan for postdates care, by failing to recommend to, or discuss with, the aggrieved person that timely consultation with an obstetric specialist was warranted for planned induction by 42 weeks;

g) the defendant failed to document text message and telephone conversations with, and advice given to, the aggrieved person at the onset of labour;

h) the defendant failed to establish a clinical baseline for maternal well-being and to follow up on an elevated blood pressure recorded when the aggrieved person was in established labour, and failed to monitor the aggrieved person's maternal blood pressure and temperature four hourly during labour;

i) the defendant failed to monitor the FHR every 15 – 30 minutes during the active phase of the first stage of labour;

j) the defendant left the aggrieved person unattended for one hour and twenty-five minutes while she was in established late first stage labour;

k) at 1.45 pm, the defendant failed to act on clear indicators that the aggrieved person's labour was not progressing normally, and did not recommend to, or discuss with, the aggrieved person that consultation with a specialist was warranted;

l) the defendant failed to provide an adequate handover of the aggrieved person to maternity services at Southland Hospital, including failing to provide Southland Hospital with the aggrieved person's maternity history or notes;

m) the defendant failed to complete adequate clinical notes, including failing to record:

    a. EDD and gestational age consistently;

b. Onset of labour and when labour was officially established;

n) the defendant made multiple retrospective alterations and additions to her clinical notes without acknowledging those alterations and admissions as not being part of the original clinical record;

o) the defendant failed to provide the aggrieved person with information that a reasonable consumer in her circumstances would expect to receive in order for her to make informed choices about her pregnancy and labour.

_____

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"

Date	Document	Recorded gestation	Corresponding EDD
18.06.2015	Scan result – antenatal record	13+3	21.12.2015
01.08.2015	Antenatal record	19+5	21.12.2015
	Maternity notes	19+4	22.12.2015
12.08.2015	Scan result – antenatal record	21+2	21.12.2015
26.08.2015	Antenatal record & maternity notes	23+2	21.12.2015
23.09.2015	Antenatal record & maternity notes	27	23.12.2015
13.10.2015	Antenatal record & maternity notes	29+5	24.12.2015
27.10.2015	Antenatal record & maternity notes	31+5	24.12.2015
10.11.2015	Antenatal record & maternity notes	33+5	24.12.2015
23.11.2015	Scan result – antenatal record	36	21.12.2015
25.11.2015	Antenatal record & maternity notes	35+5	25.12.2015
30.11.2015	Medical certificate		21.12.2015
02.12.2015	Antenatal record & maternity notes	36+5	25.12.2015
07.12.2015	Antenatal record	38	21.12.2015
	Antenatal record (additional date)	37+3	25.12.2015
15.12.2015	Antenatal record & maternity notes	38+3	26.12.2015
21.12.2015	Antenatal record	39+3	25.12.2015
	Maternity notes	39+4	24.12.2015
28.12.2015	Antenatal record & maternity notes	40+3	25.12.2015
	'client profile summary' (as provided to SDHB on 06.01.2016)		21.12.2015
	'client profile summary' (as provided to HDC on 07.03.2016)		24.12.2015
	Maternity notes – final agreed EDD		24.12.2015
	Maternity booking form		25.12.2015

"B"

Date / time	Notes provided by DHB to HDC	Notes provided by defendant to HDC
4.01.2015 6.00 am	"7 cm dilated." [with the 7 overwritten on the number 6]	"6 – 7 cm dilated"
4.01.2015 7.52 am	"BP:"	"BP: 126/82"
4.01.2015 8.15 am		"FHR 138 bpm"
4.01.2015 8.40 am		"FHR 142 bpm"
4.01.2015 9.30 am		"FHR 132 bpm"
4.01.2015 10.00 am	"Call if needed sooner"	"1:8; 1:10" [referring to the easing off of contractions] "(1:15)" [referring to the contractions spacing out] "Call if needed sooner"
4.01.2015 2.05 pm		"FHR 145 bpm"
4.01.2015 2.45 pm	"transfer to Lakes"	"transfer to Lakes; talk with Dr's"
4.01.2015 3.00 pm	"posterior fontanelle felt at 12 o'clock." "Decision to transfer to Lakes for CTG and assessment with another midwife."	"posterior fontanelle felt at 12 o'clock.?" "Decision to transfer to Lakes for CTG and assessment with another midwife. to confirm findings"
Client profile summary	"EDD: 21/12/2015" [Note: copy given to aggrieved person by defendant on 29 February 2016 also recorded EDD as 21/12/2015]	"EDD: 24/12/2015" [the 21 having being changed to a 24]

"C"

MIDWIFERY PROFESSIONAL STANDARDS

119. 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;
> …
> 1.13 formulates and documents a care plan in partnership with the woman/wahine.
>
> **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 or 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 midwifery 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;

…

120. 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;

…

121. 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.
The midwife:

- collects and compiles information from the first visit for antenatal care or at the first formal contact with the woman.

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

…

- ensures information is legible, signed and dated at each entry.
- makes records accessible and available at all times to the woman and other relevant and appropriate persons with the woman's knowledge and consent.

…

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.

…

- 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.

122. A Guidance Statement in the Midwifery Council of New Zealand *Code of Conduct* (2010) sets out:

> "Text messaging can be an unreliable method of communication, with message transmission delayed at times or messages open to misinterpretation. While women may use texting to contact a midwife, midwives must consider the appropriateness of using text communications and ensure that their communication with women occurs through reliable methods such as telephone. All communication with women should be appropriately documented".