ADVANCED CLNC®
Practice-Building Program

Deliver the Best Outcomes for Your Attorney-Clients in Obstetrical Cases

EDITED BY
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THE PIONEER OF LEGAL NURSE CONSULTING

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DELIVER THE BEST OUTCOMES FOR YOUR ATTORNEY-CLIENTS IN OBSTETRICAL CASES

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DELIVER THE BEST OUTCOMES FOR YOUR ATTORNEY-CLIENTS IN OBSTETRICAL CASES

I. INTRODUCTION

A. Monitoring the Fetal Heart Rate (FHR) During Labor

B. Assessment of the Fetus During Labor Is Challenging

C. Primary Goal of Fetal Heart Rate Monitoring

D. Position Statements as Standards of Care (SOC)
   1. American Congress of Obstetricians and Gynecologists (ACOG).
   2. Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN).
   3. National Institute of Child Health and Human Development (NICHD) terminology.

II. COMMON BRAIN-INJURED BABY CASES

A. Cerebral Palsy

B. Neonatal Encephalopathy

C. Neurologically Impaired Infant

D. Stillbirth and Neonatal Death

E. Erb’s Palsy
F. Brachial Plexus Injury

G. Scalp Injury

III. COMMON PLAINTIFF ALLEGATIONS FOR OBSTETRICAL CASES

A. Nursing and Medical Negligence Resulting in Injury or Death
   1. Inappropriate oxytocin administration.
   2. Induction of labor before 39 weeks gestational age.
   3. Inappropriate intrauterine resuscitation or lack of interventions.
   4. Inappropriate use of electronic fetal monitoring (EFM).
   5. Errors in interpretation of antenatal fetal monitoring.
   6. Errors or omission in antenatal screening and diagnosis.

B. Failure of Nursing Staff to Recognize Maternal or Fetal Risk Patterns

C. Failure of Perinatal Team to Assess and Intervene

D. Failure of Perinatal Team to Recognize a Nonreassuring FHR Pattern

E. Failure of Nursing Staff and/or OB Provider to Timely Respond to Deteriorating Fetal Condition

F. Failure of Nursing Staff to Initiate and Perform Proper Intrauterine Resuscitation

G. Failure of Staff RN to Communicate with the Provider

H. Failure of Staff RN to Initiate the Chain of Command

I. Failure of Nursing Staff to Advocate for the Patient
J. Failure to Rescue (FHR) Resulting in Maternal or Fetal Complications

1. Nurse failed to provide adequate surveillance and timely identification of nonreassuring FHR pattern.

2. Nurse or charge nurse failed to initiate appropriate interventions by activating a team response in a timely manner.

3. Perinatal team (physician, midwife, OB department and hospital staff) failed to provide a timely and adequate response to expedite delivery and avoid a preventable adverse outcome.

IV. COMMON DEFENSES FOR OBSTETRICAL CASES

A. SOC Were Adhered to by the RN/Perinatal Team

B. Mother Was Noncompliant with the Recommended Plan of Care

C. Documentation by OB Team Members Was Congruent

D. Documentation Reflected Prompt and Appropriate Communication Between OB Team Members

E. Documentation Reflected Prompt and Appropriate Actions by OB Team Members

F. Electronic Fetal Monitoring Cannot Be Used as a Diagnostic Tool; Therefore, Birth Injury Cannot Be Attributed Solely to FHR Interpretation

G. The Fetal Insult or Injury Likely Occurred During the Antenatal Period; Therefore, Actions During Labor and Delivery Had No Impact on the Outcome
V. THE ROLE OF THE CERTIFIED LEGAL NURSE CONSULTANT\textsuperscript{CM} IN OBSTETRICAL CASES

A. Review and Analyze Medical Records
   1. Maternal records.
      a. Prenatal records.
      b. Primary care provider records.
   2. Child records.
      a. Electronic fetal monitor (EFM) or FHR strips.
      b. Neonatal records.
      c. Pediatric records.
   3. Labor and delivery records.
      a. Compare and contrast nurse and provider documentation.
      b. Compare and contrast the FHR record with the nursing notes.
   4. Create a timeline or chronology of events during the pregnancy.
   5. Create a timeline or chronology of the FHR record in relation to events and interventions from admission through delivery.

B. Identify Appropriate Experts for Consultation
   1. Labor and delivery nurses.
   2. Obstetricians.
   3. Certified nurse-midwives.
   4. Registered diagnostic medical sonographer (RDMS) ultrasonographers.
   5. Maternal-fetal medicine specialists.
   7. Pediatricians.

C. Educate the Attorney
2. SOC in perinatal medicine and nursing.
3. Birth injuries related to perinatal events.
4. Injuries or insults not specifically related to birth events.
5. Interpretation of arterial and venous umbilical cord gases.

D. Identify and Interpret SOC

1. Prenatal SOC.
   a. ACOG.
   b. American College of Nurse-Midwives (ACNM).
   c. American Academy of Family Physicians (AAFP).
   d. AWHONN.

2. Hospital standards.
   a. Policies and procedures.
      (1) EFM use and interpretation.
      (2) Oxytocin.
      (3) Misoprostol.
      (4) Cervidil® and Prepidil®.
      (5) Magnesium sulfate.
      (6) Shoulder dystocia.
      (7) Staffing policy and ratios for perinatal unit and labor and delivery unit.
      (8) Chain of command.
      (9) Nursing work hours and fatigue policy.

3. Association SOC.
   a. State nursing practice act.
   b. ACOG.
   c. ACNM.
   d. AAFP.
   e. AWHONN.

VI. INTERROGATORIES AND REQUESTS FOR PRODUCTION

A. Interrogatories Directed to the Defense

1. Please identify name and address of each healthcare provider that plaintiff __________ has seen for care related to the said pregnancy and delivery, from (Date) __________ to (Date) __________.
2. Please list names and addresses of persons answering interrogatories in place of, or on behalf of, the defendant(s).

3. For each healthcare provider identified previously, please list, in chronological order:
   a. Date(s) on which (Plaintiff) __________ saw provider.
   b. Reason for the visit.
   c. Summary of the encounter.

4. Please identify the ownership of the facility or corporate entity.

5. Please identify and describe the relationship between the named facility and other entities (Medical Schools, Health Networks, etc.).

6. Please explain the accreditation status of (Facility) __________ from (Date) __________ to (Date) __________.

7. Please describe (Facility) __________’s policy and process for granting credentialing and privileges in effect from (Date) __________ to (Date) __________.

8. Please describe or explain (Facility) __________’s organizational structure in effect from (Date) __________ to (Date) __________.

9. Please describe the named facility’s policy for determining staffing and determining patient requirements in the perinatal and labor and delivery units on (Date) __________.

10. Please identify the full names, titles and hours worked of all licensed personnel at (Facility) __________ who worked in labor and delivery on (Date) __________.

11. Please list and describe the patient care assignments of each licensed personnel identified above on (Date) __________.

12. Please identify the full names, titles and hours worked of all nonlicensed personnel at (Facility) __________ who worked in labor and delivery on (Date) __________.

13. For each of the individually named defendants, describe their education, specialty, credentials and experience.

14. For each of the individually named defendants, please describe their actions taken in response to the incident on (Date) __________.
15. For each of the individually named defendants, please describe their statement regarding the cause of alleged injuries and damages.

B. Interrogatories Directed to the Plaintiff

1. Please list the full name of all plaintiff(s).

2. Please list the following on behalf of each above named plaintiff:
   a. Name.
   b. Address.
   c. Title.
   d. Credentials.
   e. Positions.

3. Please list plaintiff(s) employers from (Date) __________ to (Date) __________.

4. Please list any injuries or claims of plaintiff injuries from (Date) __________ to (Date) __________.

5. Please list a complete medical history and background of plaintiff(s). Please identify and disclose all previous and current hospitalizations of plaintiff(s) and name of each hospital from (Date) __________ to (Date) __________.

6. For the delivery of the minor plaintiff (baby), please list the full name of each and every individual present during the labor and delivery.
   For each individual named, please identify:
   a. Last known residence address.
   b. Last known business address.
   c. Profession.
   d. Reason for attendance at said delivery on (Date) __________.

7. Please list the names of all healthcare providers seen in follow up or for treatment for alleged injuries from (Date) __________ to (Date) __________.

8. Describe physical, mental and emotional injuries and damages resulting from incident(s) at (Facility) __________ from (Date) __________ to (Date) __________.
C. Requests for Production Directed to the Defense

1. Please provide all plaintiff’s prenatal records for all pregnancies at (Facility) __________ from (Date) __________ to (Date) __________, including:
   a. All ultrasound images and written ultrasound reports.
   b. All fetal monitoring strips.
   c. All nonstress tests with written results.

2. Please provide a copy of the policy and procedure for fetal monitoring in labor and delivery at (Facility) __________ in effect from (Date) __________ to (Date) __________.

3. Please provide a copy of the competency requirements for fetal monitoring in labor and delivery at (Facility) __________ that was in effect from (Date) __________ to (Date) __________.

4. Please provide a copy of the table of contents from the nursing policy and procedure manual from the OB and labor and delivery units at (Facility) __________ on (Date) __________.

5. Please provide a list of all staff involved in plaintiff’s care in labor and delivery at (Facility) __________ from (Date) __________ to (Date) __________. For each individual identified, please provide documentation of:
   a. Duration of employment at (Facility) __________.
   b. Competencies of all registered nurses.
   c. Duration of employment in the OB and labor and delivery units at (Facility) __________.

6. Please provide evidence of the physician’s employment at (Facility) __________ from (Date) __________ to (Date) __________.

7. Please provide evidence of the physician’s credentials and the credentialing process at (Facility) __________ from (Date of Hire) __________ to (Date) __________.

8. Please provide the physician’s complete resume or CV.

9. Please provide evidence of employment for all named nurses at (Facility) __________ from (Date) __________ to (Date) __________.

10. Please provide complete resumes or CVs for all named nurses.
11. Please provide medical staff policies and procedures, protocols, practice parameters and practice guidelines for all named physicians at (Facility) __________ from (Date) __________ to (Date) __________.

12. Please provide relevant nursing policies and procedures, protocols, practice parameters and practice guidelines and clinical pathways for all named registered nurses at (Facility) ___________ from (Date) __________ to (Date) __________.

13. Please provide job descriptions, roles, functions, duties or responsibilities for all named registered nurses at (Facility) __________ from (Date) __________ to (Date) __________

14. Please provide all physician’s standing orders at (Facility) __________ from (Date) __________ to (Date) __________.

15. Please provide full name of all identified expert witnesses. For each individual, please also provide:
   a. Business address.
   b. Residential address.
   c. Resume or CV for clinical training.
   d. Documentation of continuing education.

16. Please provide all items prepared or reviewed by said expert witnesses.

D. Requests for Production Directed to the Plaintiff

1. Please provide all medical bills and other expenses related to alleged injuries at (Facility) __________ from (Date) __________ to (Date) __________.

2. Please provide all hospital records in possession of plaintiff from (Facility) __________ from (Date) __________ to (Date) __________.

3. Please provide medical records from all healthcare providers who have treated plaintiff from (Date) __________ to (Date) __________ at (Facility) __________. Please include all records pertaining to:
   a. Mother (plaintiff).
   b. Baby (minor plaintiff).

4. Please provide staffing schedules on the labor and delivery unit from (Date) __________ to (Date) __________ at (Facility) __________.
5. Please provide all video recordings, photographs and other tangible items related to alleged injuries from (Date) ____________ to (Date) ___________ at (Facility) ___________.

6. Please provide all diaries and journals kept by plaintiff related to alleged injury from (Date) ____________ to (Date) ___________.

7. Please provide complete employment records of named plaintiff (mother) from (Date) ____________ to (Date) ___________.

8. Please provide all medical consents and authorizations forms in plaintiff’s possession from (Date) ____________ to (Date) ___________.

9. Please provide full name, address, clinical training and continuing education for expert witnesses who will be testifying on behalf of the plaintiff. For each named individual, please also provide:
   a. Business address.
   b. Residential address.
   c. Resume or CV.
   d. Documentation of clinical training.
   e. Documentation of continuing education.

10. Please provide all reports and demonstrative evidence prepared by or to be used by said expert witnesses on behalf of the plaintiff.

VII. RECOMMENDED QUALIFICATIONS FOR CLNC® SUBCONTRACTORS FOR OBSTETRICAL CASES

A. Minimum of Ten Years as a Registered Nurse

B. Minimum of Five Years Working in Labor and Delivery

C. Current Certification in Advanced EFM

D. Certification in Inpatient Obstetrics

E. Evidence of Attendance at Minimum of Three Professional Conferences or Seminars on the Subject of EFM
F. Evidence of Continuing Education Contact Hours Earned for Subjects Related to Inpatient Obstetric Care

VIII. CASE STUDIES

A. Ms. C: Oxytocin Augmentation – Failure to Timely Respond to Deteriorating Fetal Condition (Exhibit A)

B. Ms. F: Insufficient Prenatal Care – Failure to Initiate and Perform a Cesarean Section in a Timely Manner (Nonreassuring FHR) (Exhibit B)

C. Ms. E: Failure to Initiate and Perform Intrauterine Resuscitation (Exhibit C)

D. Sample Brief Report – Ms. R: Patient Noncompliance with Follow Up (Exhibit D)

IX. EXHIBIT

A. Sample Opinion Letter – Ms. A.B.: Failure to Rescue Resulting in Fetal Neonatal Injury (Exhibit E)

X. RESOURCES

A. Associations and Organizations
   1. Agency for Healthcare Research and Quality (AHRQ). ahrq.gov
   3. American College of Nurse-Midwives (ACNM). midwife.org
   4. American Congress of Obstetricians and Gynecologists (ACOG). acog.org
5. American Nurses Association (ANA). ana.org
6. American Nurses Credentialing Center (ANCC). nursecredentialing.org
7. Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN). awhonn.org
8. March of Dimes (MOD). marchofdimes.org
10. National Certification Corporation for the Obstetric, Gynecologic and Neonatal Specialties (NCC). nccwebsite.org
11. National Council of State Boards of Nursing. ncsbn.org

B. Authoritative Textbooks


C. Journal Articles


**D. Websites**

1. periFACTS OB/GYN Academy. [urmc.rochester.edu/center-experiential-learning/conferences-courses-events/peri-facts.aspx](http://urmc.rochester.edu/center-experiential-learning/conferences-courses-events/peri-facts.aspx)
Exhibit A
Ms. C: Oxytocin Augmentation – Failure to Timely Respond to Deteriorating Fetal Condition

Ms. C., a 19-year-old primigravida, was admitted to the labor and delivery unit at 4:00am. After minimal progress was made in spontaneous labor, oxytocin (Pitocin) augmentation was initiated at 2:15pm. The fetal heart rate was normal from the time of admission until 5:33pm, when a prolonged deceleration to a nadir of 62 beats per minute occurred and lasted for a total of seven minutes. The OB provider was physically present on the unit and responded to the labor room at this time. Subsequently, repetitive severe variable and late decelerations of the fetal heart rate were observed over the next three hours. Ms. C. was transported to the delivery room at 8:52pm. Monitoring of the FHR was not done from the time of transport to the time of delivery because the monitor was removed for the transport and the provider felt that the birth was imminent upon arrival to the delivery room (14 minutes elapsed without assessment of the fetal heart rate.)

Baby Boy C was born with an initial Apgar of 1 and required CPR by the nurses. NICU staff was notified and the baby was evaluated by the neonatologist at 9:15pm. and transferred to the NICU.

Complaints against the nurse included failure to recognize fetal intolerance of labor; failure to take action that would have prompted a move to a cesarean section; failure to monitor/assess the fetal heart rate in the delivery room (which would have indicated terminal bradycardia); and failure to promptly notify the NICU staff/neonatologist upon transfer to the delivery room, resulting in delayed treatment of the infant's acidosis. (Connors, 2009).

Case study courtesy of PESI Healthcare.
Exhibit B

Ms. F: Insufficient Prenatal Care – Failure to Initiate and Perform a Cesarean Section in a Timely Manner (Nonreassuring FHR)

Ms. F., a 22-year-old G3P1102 arrived in labor and delivery on a busy night. Because of recent job changes and the loss of her insurance, Ms. F. had only had four prenatal visits throughout her pregnancy; however, her last menstrual period and an ultrasound performed at 19+3 weeks gestation confirmed that she was term, 39 weeks gestation. Since all of the rooms were occupied, Ms. F. had to wait 45 minutes to be put into a triage room, even though she was reporting constant, severe abdominal pain. The admission note indicated that the fetus was tachycardic with a baseline of 180 beats per minute and Ms. F. reported decreased fetal movements for the past eight hours. She also reported leaking “bloody water” from her vagina.

Ms. F. was finally transferred to a labor room 75 minutes after her arrival to the unit. After waiting in her room for 15 additional minutes, the OB technician arrived and initiated continuous electronic fetal monitoring. The RN entered the room 10 minutes later and noted the fetal heart rate had been bradycardic at 60-65 since the monitor was applied. The attending OB was notified by the charge RN as the staff nurse and OB technician prepared the woman for an emergency cesarean section. An abruption of the placenta was noted upon surgical entry into the uterus. The baby had Apgar scores of 0, 3 and 3 recorded before transport to the NICU and suffered profound neurologic damage.

The staff RN testified at deposition that she suspected a placental abruption, but was busy with her other patients and needed to wait for the OB technician to get a labor room ready for Ms. F. The nurse was found negligent in failing to notify the charge nurse/nurse manager and ask for immediate help assessing the patient and fetus with a possible placental abruption, leading to a delay in the emergent cesarean section. (Connors, 2009).

Case study courtesy of PESI Healthcare.
Exhibit C
Ms. E: Failure to Initiate and Perform Intrauterine Resuscitation

Ms. P., a 34-year-old G4P3003, was admitted to the labor and delivery unit in early
labor. Her last delivery was by scheduled cesarean section for a breech presentation
and she was planning a VBAC (vaginal birth after cesarean) with this pregnancy and
birth. Several hours after admission, Ms. P. experienced a sharp pain in her abdomen.
Within minutes, Ms. P. reported bright red vaginal bleeding and told the nurse, “It feels
like my stomach ripped open and the baby moved up towards my head.”

Thirty minutes later the nurse performed a vaginal examination and determined that Ms.
P.’s cervix was completely dilated. The fetal heart rate had dropped to 68 beats per
minute. The RN notified the OB provider of her assessment, but did not report the
sudden abdominal pain. Fifteen minutes later, the provider arrived to the room and
examined the patient. Finding her not completely dilated, the decision was made for
emergency cesarean section; this was approximately one full hour after the woman’s
report of sharp abdominal pain. Ms. P. had suffered a uterine rupture. Fetal distress
resulted as the baby was pushed out of the uterus into the abdominal cavity, causing
abruption of the placenta.

Baby Girl P. lived in a vegetative state for three years before she died. At trial, the nurse
was charged with failure to properly and completely assess the patient, failure to notify
the OB provider of the patient’s report of abdominal pain, and failure to initiate and
sustain intrauterine resuscitative measures for the fetus. (Connors, 2009)

Case study courtesy of PESI Healthcare.
Exhibit D
Sample Brief Report – Ms. R: Patient Noncompliance with Follow Up

I. SUMMARY OF CASE

Ms. R., a 23-year-old G1P0, was admitted to XYZ Medical Center on 04/03/0000 as a “transfer of care from a midwife for decreased fetal movement.” Prenatal records were not provided from the midwife and the EDD (estimated date of delivery) was uncertain, as “unsure dates” was noted by the admitting physician. Based upon the unknown EDD and the report of decreased fetal movement, antenatal testing was conducted to evaluate the status of the fetus. Ms. R. remained in the hospital for 48 hours and fetal well-being was clearly documented throughout the entire stay, as evidenced by:

- Formal ultrasound exam WNL.
- Amniotic fluid volume WNL.
- Biophysical profile score of 8/8.
- Attempted induction of labor (Cervidil/Pitocin) requiring continuous electronic fetal monitoring. Nursing and physician documentation all indicate fetal well-being (“average variability, accels present, no decels, negative prolonged OCT”) and reassuring fetal monitoring interpretation.
- Fetal movements: It is documented that the fetus was active and moving throughout the attempted induction of labor; this is also clearly noted at the time of discharge from the hospital.

Ms. R. did not go into labor. The trial induction was stopped and she was released on 04/05/0000. Physician notes and patient discharge instructions state that she was to call the ABC Family Medical Center for a follow-up visit on that same day and a physician visit on the next day. The telephone number to the ABC Family Medical Center was provided on the physician’s order sheet and Ms. R. did sign the discharge instruction form, indicating an understanding of these instructions. At this time, there is no documentation that she scheduled or presented at these appointments.

Ms. R. returned to the XYZ Medical Center shortly after 10:00pm on 04/21/0000. She arrived via ambulance for “transfer of care from midwife for lack of progress” after six hours of labor. Continuous external electronic fetal monitoring was initiated. The fetal heart rate pattern was nonreactive and exhibited a deceleration to the 80s after the first 15 minutes of monitoring. Nursing staff administered interventions for intrauterine resuscitation (IV fluids, oxygen administration, repositioning Ms. R. from side to side) and observed for fetal response and recovery. Dr. Q. was notified of the situation at 10:44pm.
Dr. Q. was present at the bedside at 11:18pm. A vaginal exam was performed to assess labor status and amniotomy was performed to evaluate the amniotic fluid. Thick meconium stained fluid was noted. A fetal scalp electrode was placed by Dr. Q. at 11:22pm in order to provide the most accurate, direct monitoring of the fetal heart rate. The decision was made to perform an emergency cesarean section for nonreassuring fetal heart rate at 11:32pm.

Ms. R. was consented and prepared for surgery and the anesthesiologist was present to administer a spinal block at 11:40pm. Fetal monitors were removed at 11:42pm and Ms. R. was transported to the surgical suite, arriving at 11:45pm. Surgery was started (skin incision) at 12:07am on 04/22/0000 and Baby A. was born at 12:13am. Baby A. was flaccid, dusky, without respiratory effort and had a heart rate of 80 beats per minute. She required extensive resuscitation and transport to the neonatal intensive care unit. Apgar scores were 2, 5, and 8 at 1, 5, and 10 minutes, respectively. Baby A.’s condition continued to deteriorate over the next 12 hours and the decision was made to transfer her to DEF Children’s Hospital for ongoing intensive care. She remained in that hospital for 45 days.

Baby A. has been diagnosed with meconium aspiration syndrome, hypoxic ischemic encephalopathy, West's Syndrome and microcephaly. She does not speak or walk and receives medication for seizures. She does not eat and is fed via a gastrostomy feeding tube. Dr. N., pediatric neurologist, has managed Baby A.’s care and describes her prognosis as “extremely poor.”

II. PROFESSIONAL OPINION

This is a case about a severely damaged child with a poor prognosis for recovery. In utero, fetal well-being was clearly and appropriately evaluated and documented from 04/03/0000 to 04/05/0000. When Ms. R. returned to the XYZ Medical Center 16 days later, the fetal monitor tracing was nonreassuring and indicative of a compromised fetus.

Review of all available medical records to date do not indicate a breach of duty by the nursing staff, physicians, anesthesia staff, NICU staff or hospital.

Admission/triage: RN care appropriate.  
Physician notification/response: Appropriate.  
Decision for emergent cesarean delivery: Appropriate.  
Operative procedure: Appropriate.  
Neonatal resuscitation: Appropriate.  
NICU treatment/decision for transfer of neonate: Appropriate.

It is my professional opinion that the fetal event/injury occurred at some point between 04/05/0000 and 04/21/0000. It is crucial to this case to obtain records and copies of prenatal visits, consultations and fetal surveillance/testing that took place during this identified time period.
III. DEFINITIONS

AFI: The amniotic fluid index represents the sum of the measurements (in centimeters) of the deepest umbilical cord free pockets of amniotic fluid in all four abdominal quadrants. Normal AFI at term is > 5 cm. Ms. R.’s AFI was > 13 cm.

BPP: The biophysical profile is an antenatal assessment of fetal well-being using real-time ultrasound to evaluate fetal breathing movements, tone, gross body movements and amniotic fluid volume. The BPP is used to predict chronic or acute asphyxia. A score of 8/8 is interpreted as no chronic or acute asphyxia.

EDD: The estimated date of delivery or “due date” is calculated by adding 280 days (40 weeks) to the date of the first day of the last normal menstrual period.

NST: The nonstress test evolved from early evidence that FHR accelerations were highly associated with fetal well-being. A reactive NST indicates at least two accelerations of the FHR (15 beats above the baseline for 15 seconds) in 20 minutes. A reactive NST with a normal AFI is indicative of fetal well-being in 99% of pregnancies.

OCT: The oxytocin challenge test, or contraction stress test, correlates the fetal response to spontaneous or stimulated contractions in order to assess fetal reserves. Negative CSTs (no late decelerations) correlate with a good fetal outcome.

IV. REQUESTS FOR PRODUCTION

Missing medical records are crucial to this case. I recommend obtaining:

- Antenatal records from the midwife.
- Medical records from ABC Family Medical Center between 04/05/0000 and 04/21/0000.
- Fetal surveillance/all tests of fetal well-being done between 04/05/0000 and 04/21/0000.
- Labor records from the midwife from 04/21/0000.
- Ambulance report from 04/21/0000.
- Umbilical cord gas values obtained during the cesarean section 04/22/0000.
V. ADDITIONAL MEDICAL RESEARCH

I would be happy to conduct research and provide written reports on conditions diagnosed in Baby A., including:

- Meconium aspiration syndrome.
- Hypoxic ischemic encephalopathy.
- West’s Syndrome.
- Microcephaly.

I am happy to provide additional information at your request. I look forward to obtaining and reviewing the additional medical records, as they are clearly at the heart of this unfortunate case.

Respectfully submitted,

Jody L. Perez, RN, MS, CNM, SANE, CLNC
July 10, 2012

Dear Mr. Attorney;

Pursuant to your request to screen the case of Baby Girl B, daughter of Ms. A.B. and Mr. B.B., it is my opinion that there are deviations from the standards of care that directly contributed to Baby B.’s injuries.

I have been a registered nurse since 1987 and a practicing Certified Nurse-Midwife since 1998. I hold an Associate of Arts degree, a Bachelor of Science in Nursing degree, and a Master of Science in Midwifery degree. I am currently employed with Healthnet Community Health Centers and I practice at Indiana University Health – Methodist Hospital, a tertiary care facility in which CNMs attend more than 200 deliveries each month. To date, I have personally attended more than 1500 births. In addition to active clinical practice, I am an assistant professor in the School of Nursing at the University of Indianapolis. I am involved in both classroom and clinical instruction for midwifery students in the MSN program as well as maternity nursing for the undergraduate and graduate students. My experience renders me qualified to review the antenatal, intrapartum and neonatal resuscitation aspects of this particular case. I am familiar with standards of care for prenatal care, labor and delivery and neonatal care and stabilization, including the need for individuals experienced in neonatal resuscitation to be physically present at every birth.

A review of the medical records of Ms. A.B. and Baby B. reveals that there were definite breaches of the standard of care. Specifically, there were incidents that should have prompted the attending midwife to initiate continuous electronic fetal monitoring, necessitating transfer of Ms. A.B. to the hospital setting for delivery. Evaluating the “whole picture” of Ms. A.B.’s labor, specifically the fact that this was her first pregnancy/labor, she was at 41+2 weeks gestation, had meconium-stained amniotic fluid, and had a prolonged second stage of labor should have had CC, CNM, in anticipation of a complicated delivery and at a low threshold for transfer from the Have Your Baby Here Birth Center to the hospital. Any one of these facts, evaluated on an individual basis, would not significantly increase a woman’s risk in the birth center setting, but the combination of all of them indicates a labor that has deviated from normal and is no longer at a low-risk status.

In addition, the fetal monitoring of Baby B. prior to her delivery was substandard. The Neonatal Resuscitation Documentation Form and the Labor and Delivery Summary both document the presence of variable decelerations of the fetal heart rate, identified with
intermittent auscultation. Intrauterine resuscitation measures were implemented, including position changes and the administration of oxygen and IV fluids to Ms. A.B. Continuous electronic fetal monitoring should have been initiated, in order to provide an ongoing recording and evaluation of the decelerations. Furthermore, the Labor/Observation Record describes the auscultation of late decelerations, which are indicative of uteroplacental insufficiency and are an ominous finding. These late decelerations are identified more than an hour before the delivery. Again, this indicates the need for continuous monitoring and transfer to the hospital. There is no documentation of communication about the labor status with the supervising physician, Dr. C.

Failure to properly provide endotracheal intubation for Baby B. indicates a gross breach of the standard of care. At the Have Your Baby Here Birth Center, the endotracheal tube was not of the proper size and was not properly placed in the trachea. Reintubation by the ambulance crew was again performed utilizing a tube that was of improper size and was not placed correctly in the trachea. This necessitated immediate reintubation, again, upon arrival to the emergency department at Receiving Metropolitan Hospital. This delay in providing competent endotracheal intubation and oxygenation to Baby B. certainly caused significant hypoxia and injury.

Because the staff at the Have Your Baby Here Birth Center failed to properly identify the need for transfer of Ms. A.B. to the hospital for delivery and failed to properly intubate Baby B. after her birth, significant injury occurred. Because the EMS crew failed to properly intubate Baby B., adequate oxygenation was delayed, contributing to the severity of her devastating injury.

Thank you for the opportunity to consult on this matter.

Very truly yours,

Jody L. Perez, RN, MS, CNM, SANE, CLNC