Midwife, Ms B

A Report by the

Health and Disability Commissioner

(Case 11HDC00596)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Executive summary

1. In 2011, Ms A was pregnant with her first child. Around two weeks before her due date, her Lead Maternity Carer (LMC)[1] went on leave, and a "back-up" midwife, Ms B, took over Ms A's care.

2. Ms A's pregnancy had been normal. However, about a week before her due date, Ms A sent Ms B a text message, indicating concerns about a lack of fetal movement and increased vaginal discharge with black spots. This was Ms A's first contact with Ms B. Ms B replied to Ms A by text message, advising her that she should drink ice-cold water and sit quietly on the couch to feel the baby move. Although Ms A received the message, it confused her and she therefore did not follow the advice. Ms B did not follow up on Ms A's concerns that day or ensure that Ms A was reassured and/or had felt fetal movement.

3. The following day, Ms A met Ms B and a student midwife (the midwives) for the first time for a clinic visit. The midwives assessed Ms A. After some discussion about what fetal movement was expected, the student midwife, Ms C, recorded that the movements were not as hard as they had been previously. Both midwives experienced difficulty detecting the fetal heart rate (FHR), but Ms B said she eventually heard it "in the background".

4. At around 3am the next day, Ms A began having contractions. At 2.20pm, the midwives visited and assessed Ms A at her home. Ms A was in established labour. Again, the midwives had difficulty finding the FHR. They left Ms A, advising her to call them when she felt bowel pressure.

5. At 7.35pm, after being advised that Ms A was feeling bowel pressure, the midwives returned to Ms A's home and conducted a further assessment. Ms A's mother drove Ms A to the hospital and the midwives travelled separately. Ms A gave birth to Baby A minutes after arriving at the delivery suite. Sadly, Baby A was born with no heartbeat or respiratory effort, and resuscitation was unsuccessful.

Findings

6. Ms B had not met Ms A when Ms A sent her a text message. Accordingly, responding to Ms A's concerns by text message was not an appropriate method of communication to ensure that Ms A's concerns were adequately assessed and addressed. Ms B should have followed up Ms A's concerns and her advice to Ms A with a telephone call that day.

7. On the two days prior to the birth, FHR was difficult to detect. It is extremely unusual to have difficulty detecting the fetal heart rate in a full-term pregnancy. Ms B should have noted the history of reduced fetal movement, checked the maternal pulse and arranged a CTG.[2]

[1] An LMC is the designated health professional who co-ordinates a woman's maternity care.
[2] A CTG (cardiotocograph) records the fetal heartbeat and uterine activity onto graph paper for analysis of fetal well-being and uterine activity.

8. Once Ms A was in established labour, the FHR remained difficult to detect, yet Ms B left Ms A for around five hours. Ms B should have stayed with Ms A to monitor her and her baby's well-being.

9. Ms A was driven to the hospital by her mother when she was close to delivery, while the midwives drove separately. Ms B should not have left Ms A unsupported, and in advanced labour, while her mother drove her to hospital.

10. Ms B did not provide services to Ms A with reasonable care and skill, and therefore breached Right 4(1)[3] of the Code of Health and Disability Services Consumers' Rights (the Code).

Complaint and investigation

11. Ms A complained to the Commissioner about the services provided by midwife Ms B. The following issue was identified for investigation:

The appropriateness of the care provided to Ms A by Ms B in early 2011.

12. An investigation was commenced on 17 November 2011.

13. The following people provided information:

Ms A	Consumer/Complainant
Ms B	Back-up lead maternity carer/midwife
Ms C	Student midwife
Ms D	Ms A's sister
Mrs E	Ms A's mother

Also mentioned in this report:

Baby A	Ms A's baby (dec)
Ms F	Lead maternity carer

14. Independent expert midwifery advice was obtained from midwife Juliet Thorpe (**Appendix A**).

15. This report is the opinion of Anthony Hill, Health and Disability Commissioner.

[3] Right 4(1): Every consumer has the right to have services provided with reasonable care and skill.

Information gathered during investigation

Maternity services in New Zealand

16. Pregnant women in New Zealand are entitled to free maternity services from midwives or general practitioners to cover their pregnancy, birth, and postnatal care.

17. To access these services, the woman must choose a Lead Maternity Carer (LMC) who is funded by the Ministry of Health to provide maternity services. LMC responsibilities are set out in the Primary Maternity Services Notice, issued under section 88 of the New Zealand Public Health and Disability Act 2000. The Primary Maternity Services Notice states that the LMC is responsible for the care provided to the woman throughout her pregnancy and postpartum period.

Background

18. In early 2011, Ms A, aged 24, was pregnant with her first child. Antenatal care was provided by LMC Ms F and a midwifery student, Ms C.

19. Ms A attended her last appointment with Ms F at 38 weeks' gestation.[4] Ms F went on leave after this appointment, so her back-up midwife, Ms B, took over responsibility for Ms A's care. Ms B used Ms F's cell phone while Ms F was on leave.

20. Ms B describes herself as a self-employed LMC practitioner. She qualified as a midwife in November 2008 and was registered with the Midwifery Council of New Zealand in December 2008. Ms B told HDC that she met with Ms F before Ms F went on leave to discuss the clients she would be taking over. Ms B does not recall discussing Ms A's care, except that Ms F understood that Ms A was moving out of town prior to the birth.

Text contact

21. Ms A's first contact with Ms B was on Monday or Tuesday (a week before her due date), when Ms A sent her a text message, expressing concern about black spots in her underwear, and that she had not felt her baby move for a couple of hours. Ms A recalled that she sent the text on Tuesday, but Ms B's diary records having received the text on Monday.[5]

22. Ms B told HDC that her advice to Ms A was to quickly drink a very cold glass of water and sit quietly on the couch for 40 minutes (to feel the baby move). Ms B told HDC that she had not heard of black spots before. However, she was not concerned about the black spots and said that she believed these had no clinical significance.

23. The note in Ms B's diary, under Monday, reads:

> "— [text] from 1 of [Ms F's] [women].
>
> — hasn't felt [fetal movements] for a couple of [hours] and has increased discharge that has a couple of black specks in it.

[4] The age of the fetus. The normal period of gestation is 40 weeks.
[5] The Telecom records were requested but were inconclusive as to the date this text message was sent.

— asked [what] sort of discharge [and] how many weeks gestation.

— white, mucousy discharge, almost 39 [weeks].

— increased vaginal discharge is common, may even wet her pants, called leucorrhoea. Black specks not a concern, no idea what it is — ?lint. Drink ice cold water and sit quietly on the couch to feel [foetal movements].

— happy with this."

24. Ms A recalls that Ms B replied by text message, instructing her to drink a glass of iced water and to relax. Ms A said that Ms B's text did not address her concern about the black spots. Ms A said she was confused by the advice and discussed it with her mother, Mrs E. She said her mother thought the advice was strange. Ms A did not drink the iced water, but did lie down.

25. Ms A did not contact Ms B again that day. Ms B told HDC that she assumed the cold water had "done the trick". Ms B also said that because she had received Ms A's text in the morning (7 or 8am), she thought that "the baby could move later that day".

26. Ms A told HDC that she did not feel any fetal movements on the day she sent the text message to Ms B. Ms B did not follow up Ms A's concerns that day.

Wednesday

27. Ms B met Ms A for the first time on Wednesday, in Ms B's clinic.[6] Ms A's sister, Ms D, and Ms D's baby were also present.

28. Ms C took the clinic while Ms B supervised. Ms C had previously cared for Ms A along with Ms A's LMC, Ms F. Ms B recorded their assessment in Ms A's Midwifery and Maternity Providers Organisation (MMPO) notes.

29. Ms A recalls Ms C mentioning her text to Ms B about the lack of fetal movement.

30. Ms D recalls Ms C asking Ms A about fetal movement. Ms D said that Ms A told the midwives she did not think she had felt movements for a couple of days. Ms D recalls Ms B saying, "Are you sure? Any small movements count." Ms D recalls Ms A being unsure about whether she had felt fetal movement.

31. The midwives explained to Ms A that the movements would be softer now that the baby did not have as much room as previously.

32. Ms B said she told Ms A that the movements were likely to be "more wiggles than kicks" and that she would not feel big kicking movements. Ms B remembers Ms A saying that the movements were softer than they used to be.

33. Ms A told HDC that she did not feel any fetal movements on Wednesday but that "[Ms B] made me question myself". Ms A told the midwives that there could have been small movements. Ms A told HDC:

[6] Ms B's clinic was held in rooms owned by a maternity information centre where self-employed midwives hire out rooms for clinic use as required.

> "[Ms C] said that any small movements can be counted, so I thought maybe I could have felt something; when she said any little movement counts, I figured there possibly could have been … I didn't know that still births happened, I didn't think anything could be wrong."

The midwifery notes for this appointment read in part: "Baby is active (although movements are not as hard) …"

34. Ms C used a Sonicaid[7] in an attempt to detect the fetal heart rate (FHR), but experienced difficulty. Ms C told HDC that she "did not hear the fetal heart rate on any occasion leading up to the birth of [Baby A]", and this is reflected in her retrospective note (written six days after the birth). Ms C passed the Sonicaid to Ms B, and Ms B palpated Ms A's stomach and tried to find the fetal heartbeat herself.

35. Ms B stated:

> "Eventually I thought I had found the fetal heartbeat and as it was around 120bpm … and [Ms A] had no other concerns I was satisfied that all was well."

36. Ms A, Ms D and Ms C were in close proximity to the Sonicaid and could hear some static from it. However, they did not hear any change in sound from when Ms C was using it.

37. Ms A remembers Ms B turning up the volume and listening for several minutes before saying that she could not get a definite heartbeat and would have to "go with the one in the background".

38. Ms D recalled that Ms B had the speaker right up to her ear and listened for a few minutes, longer than Ms C had. Ms D recalled Ms B saying, "I think I can hear [the fetal heart rate] in the background."

39. Ms C recalled that Ms B said she heard the FHR "in the distance".

40. Ms C completed the antenatal record that day and it shows an FHR of 130–140 beats per minute (bpm)[8] and fetal movements of "10+". The contemporaneous notes do not refer to Ms A's concerns about the fetal movements or the difficulty the midwives had experienced detecting the FHR.

41. Ms B told HDC that "with hindsight, [the heart rate] wasn't as loud as [it] should have been". Ms B noted that the battery sign on the Sonicaid was on low and stated, "I think I remember assuming the FHR [fetal heart rate] was taking so long to find because of it."

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[7] A Sonicaid is an instrument used to listen to the beating of the fetal heart. Ms B advised HDC that the Sonicaid did not have a display so the fetal heart rate was manually counted while looking at a clock or watch.

[8] A normal fetal heart rate is between 105 and 155bpm. The rate fluctuates slightly (5 to 15bpm) when a fetus moves or sleeps.

42. Ms B said that it is her standard practice to order a CTG immediately if she is aware of reduced fetal movements or concerned about the fetal heart rate. Ms B said she did not check the maternal pulse because she believed "there was nothing concerning in [Ms A's] case".

Thursday — first home visit

43. At 3.20am on Thursday, Ms A started having contractions. At 8:30am, she telephoned Ms B and advised her of "short and irregular" contractions. Ms B documented that she advised Ms A to ring back when she was in established labour.

44. Ms A's sister, Ms D, telephoned Ms B at 1.30pm, advising her that Ms A's contractions were three minutes apart. Ms B and Ms C then left in order to assess Ms A at her home.

45. At 2.20pm, Ms B and Ms C assessed Ms A at her home. Ms D was also in the room. Ms B told HDC that her midwifery notes for this visit were made contemporaneously. She was able to take contemporaneous notes because Ms C was assessing Ms A.

46. The midwives told HDC that at 2.20pm, Ms A was in established labour. The notes show that at this time, Ms A's contractions were one every three to five minutes, lasting 60 seconds, and that she was four centimetres dilated.[9]

47. Ms B also recorded: "Fetal movements good." Ms B advised HDC that it is her standard practice to ask about fetal movements at every assessment. Ms B recalls that Ms A said she had felt movement, but that they did not re-visit the discussion from the previous day regarding the types of movement.

48. Ms C also recalled that Ms A said she had felt fetal movements but Ms A did not elaborate.

49. In contrast, Ms A said that there was no discussion about fetal movements on Thursday.

50. The midwives tried to detect a fetal heart rate with a Sonicaid. The notes read in part:

> "FHR: difficult to find ~ 120s."

51. Ms B stated:

> "[Ms A] was making a lot of noise, moving around a lot which made [the fetal heart rate] hard to find."

52. Ms C told HDC that she did not think that Ms B was concerned about the fetal heart rate.

53. Ms D recalls that Ms B was not able to find the fetal heart rate, but reassured Ms A that it was nothing to worry about.

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[9] Dilation is the opening of the cervix.

54. The midwives advised Ms A to go for a walk, and to call them when she felt bowel pressure. Ms B told HDC that the appointment lasted 30–40 minutes, at which time the midwives left Ms A's home.

55. Ms B stated:

> "When I assessed [Ms A] she was only in early labour and not requiring assistance at that point … statistically birth was many hours away as 18 hours is considered a normal labour for a first time Mum … She was advised to contact me as soon as she needed me …"

56. Some time after the home visit, Ms A's mother, Mrs E, arrived to support Ms A. Mrs E remembers Ms A saying that she "hadn't really felt [the baby] move".

Thursday — second home visit

57. Just after 7pm, Mrs E contacted the midwives, as Ms A had begun to feel bowel pressure and her contractions were every 2–3 minutes, lasting 60 seconds. Ms B's note of this phone call reads in part:

> "Advised that I will contact [Ms C] and we will come straight round to [Ms A's home] for an assessment and hopefully she will be ready to [transfer] to hospital."

58. The midwives assessed Ms A at her home at 7.35pm. Ms C could not detect an FHR and Ms B took over attempts to detect one. Ms A said that contractions would come every time the midwives tried to use the Sonicaid. She said the midwives tried three or four times to detect a fetal heart rate.

59. Ms B wrote "FHR: difficult to find due to contraction" and a fetal heart rate was not documented.

60. As noted above, Ms A told HDC that there was no discussion about fetal movement on Thursday. However, Ms C told HDC that Ms A reported that she felt the baby moving throughout the labour, and the notes record that "baby has been moving well".

61. Ms C carried out a vaginal examination, which revealed that Ms A was at station +3.[10] Ms A's membranes ruptured during the vaginal examination and there was meconium present.[11] It was therefore decided to transfer Ms A to hospital.

62. Ms A and Mrs E recall that the midwives offered Ms A the choice of a home birth or transferring to the hospital. Ms A's home was less than five minutes' drive from the hospital. Ms A decided she wanted to go to hospital, and they prepared to transfer to hospital. Ms B called the hospital and asked the staff to have a wheelchair ready.

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[10] Station refers to the relationship of the presenting part of the baby to the level of the ischial spines (outlet) of the mother's pelvis. When the presenting part is at the level of the ischial spines, it is at station 0 (synonymous with engagement). If the presenting part is above the spines, the distance is measured and described as minus stations, which range from -1cm to -4cm. If the presenting part is below the ischial spines the distance is measured as plus stations (+1 to +4). At +3 or +4 the presenting part is at the perineum (synonymous with crowning).

[11] Meconium-stained liquor (amniotic fluid) can be a sign of fetal distress.

Transfer to hospital

63. Mrs E drove Ms A to the hospital in Mrs E's car, and the midwives drove in Ms B's car. Ms B told HDC that the reason she did not accompany Ms A was two-fold: Ms A's house was only a short drive from the hospital; and Ms B's car was full of medical equipment, and she did not want to waste time transferring it to Mrs E's car.

64. Mrs E told HDC that she assumed she would follow the midwives to the hospital. Ms A also understood that they were to follow the midwives to the hospital, but told HDC that by the time she and Mrs E were ready to leave, the midwives had already left. Conversely, Ms C told HDC that when she and Ms B were ready to leave, Ms A and Mrs E had already left.

65. Ms B acknowledged that she "wrongly assumed that between [Ms A] and her mother they would know how to get to delivery suite, especially considering the close proximity to [Ms A's] house."[12]

66. The hospital was only a few minutes' drive away but Mrs E was not from the area. Ms A was on all fours in the back seat. She said she was "having so many contractions and stressed out because [she] felt like the baby was going to birth in the car". Mrs E said she started panicking and got lost, and they did not find the delivery suite for 20 to 30 minutes. At one point, they crashed through a barrier and Ms A fell off the back seat.

67. The midwives set up the delivery suite at 7.55pm. When Ms A had not arrived by 8.10pm, they searched for her and, at 8.22pm, located her in the car park. Mrs E had been trying to find a wheelchair. The midwives rushed Ms A to the delivery room. Mrs E needed to lock the car and was left behind. Ms B said that her first concern was ensuring that Ms A did not birth in the car park on a cold night.

68. At 8.32pm (within a few minutes of their arrival) Ms A's baby was born with "[n]o heart rate or respiratory effort". Resuscitation was discontinued after 20 minutes as, sadly, Baby A died.

69. The post-mortem report indicated that the cause of Baby A's death was a "large fetomaternal haemorrhage". The pathologist noted that "[t]he cause is not understood and it is not a pathology that can be predicted or easily identified". The amount of haemorrhage was 50% of the baby's blood volume. The pathologist noted that "[w]hen an infant bleeds more than a third of the blood volume in a short period of time, there is a very high mortality".

70. Shortly after the birth, Ms D arrived to support Ms A. Ms C stayed with Ms A in the period after the birth to comfort her while Ms B completed the paperwork. Ms A told HDC that she believed Ms B should have been supporting her rather than completing the paperwork. However, Ms B said that she felt Ms A was well supported by the student midwife, Ms A's sister and mother, and the Stillborn and Neonatal Death Support Worker. Ms B further stated that she thought it was important to complete her

[12] Ms A attended antenatal classes, but a tour of the delivery suite was not included.

notes while they were fresh in her mind, but has since expressed her apologies that her absence caused Ms A more distress.

Changes to practice

71. Ms B outlined some changes to her practice:

- She now keeps fresh batteries for the Sonicaid.
- She now checks the maternal pulse to ensure that what she is hearing is the FHR.
- She will telephone a woman who expresses concerns by text message, to ensure that the woman understands the instructions given.
- She will use a phonendoscope[13] if not satisfied with the Sonicaid reading.
- She will accompany a woman to hospital even if the distance to the hospital is short.

Response to provisional opinion

72. Ms B said that prior to her text to Ms A she had not used text messaging in communicating with clients. She used a text message on this occasion as she understood that Ms A's LMC, Ms F, had communicated with her clients in this way.

73. Ms B regrets not making personal contact with Ms A to fully discuss her concerns, or following up her text advice with a phone call to ensure the advice was understood and to assess the ongoing care that Ms A required. She advised that it was her standard practice to ask clients to call her back if fetal movements did not improve within 40 minutes, at which time she would recommend a CTG.

74. Ms B advised that she has learned valuable lessons from this case.

Opinion: Breach — Ms B

75. The stillbirth of Baby A was a tragic event. According to the post-mortem report, his death was probably the result of a massive fetomaternal haemorrhage. It is important to note that my role does not extend to determining the cause of Baby A's death. I am primarily concerned with the quality of care Ms B provided to Ms A.

Advice by text message

76. Ms B took over Ms A's care at 38 weeks' gestation, having never met or cared for her previously. Ms A's first contact with Ms B was when Ms A sent her a text message raising two concerns: black spots in her underwear, and a lack of fetal movement.

77. Ms B replied by text message, telling Ms A to drink some iced water to encourage fetal movements. Ms B did not hear back from Ms A, and assumed that she had

[13] An instrument that amplifies small sounds, especially within the human body.

followed the instructions and felt her baby move. In fact, Ms A was confused by this advice and did not do as Ms B suggested.

78. Ms B disregarded Ms A's concerns about black spots, despite having "no idea" what the black spots were (querying whether they were lint). Ms B should have taken steps to ascertain whether the black spots were in fact of concern before disregarding Ms A's concerns, and ensured Ms A was informed accordingly.

79. Midwifery standard five (New Zealand College of Midwives)[14] requires a midwife to work in partnership with the woman. My expert midwifery advisor, Ms Juliet Thorpe, notes that compliance with this standard involves making a plan that analyses the information from the woman, and sets out specific midwifery decisions and actions taken in order to meet the woman's goals and expectations. She notes that "[t]his cannot be done by text especially when there has been no reply from the woman with regard to the advice given".

80. Ms B's actions in response to Ms A's text message did not constitute appropriate care. In this situation, as noted by Ms Thorpe, Ms B should have followed her text with a call to Ms A and spoken to her in person, in order to make a plan with Ms A, including follow-up advice if movements remained reduced. This would have allowed Ms B the chance to introduce herself, assess the degree of anxiety Ms A was feeling, and then determine whether a home visit would be warranted to check the baby's well-being.

81. The Midwifery Council of New Zealand has issued a guidance statement[15] advising midwives to exercise caution in using text messaging:

> "Text messaging can be an unreliable method of communication, with message transmission delayed at times or messages open to misinterpretation. […] 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."

82. In these circumstances, especially in light of Ms B having not met Ms A, it was inappropriate to reply to Ms A by text, without calling to clarify and follow up Ms A's concerns. Ms B should have called Ms A to ascertain whether she needed more information or reassurance.

Response to fetal movements and fetal heart rate on Wednesday

83. A midwife is required to identify deviations from the normal and, after discussion with the woman, consult and refer as appropriate.[16]

[14] Fourth edition, updated in 2008.
[15] The Midwifery Council's Code of Conduct contains this guidance statement alongside the section relating to professional behaviour. The Midwifery Council noted that all midwives were consulted over the Code and every midwife with an Annual Practising Certificate was sent one in February 2011.
[16] Standard Six, *Midwives Handbook for Practice*, 2008, New Zealand College of Midwives.

84. During Ms A's clinic appointment on Wednesday, Ms C asked Ms A about fetal movement. Initially, Ms A was not sure whether she had felt her baby move but, after some discussion with the midwives, she told them that there could have been small movements.

85. Ms C experienced difficulty detecting an FHR with the Sonicaid. Ms B told HDC that she too had difficulty, but eventually thought she had found an FHR at around 120bpm, and she had no other concerns. Ms B noted that with hindsight, the FHR was not as loud as it should have been. No one else present in the clinic heard the FHR, but they recall Ms B saying she heard the FHR in the distance.

86. Ms Thorpe notes that it is "extremely unusual" to have any difficulty locating the FHR of a full-term baby. She notes that the FHR can be difficult to hear clearly earlier in a pregnancy but, with a full-term baby, difficulty in detecting the FHR should "always be a flag for concern". I agree with Ms Thorpe that in light of Ms A's history of reduced fetal movements, and the difficulty in finding an FHR, Ms B should have checked the maternal pulse and arranged for a CTG for a more thorough assessment.

87. On Wednesday, the clinical picture for Ms A included a history of reduced movements and difficulty finding the FHR. By failing to respond appropriately, Ms B failed to provide services with reasonable care and skill.

88. Furthermore, the note-taking did not adequately reflect the difficulty the midwives experienced locating the FHR.

Monitoring of maternal and fetal well-being on Thursday

89. At 3.20am on Thursday, Ms A began having contractions, and the midwives assessed her at home at 2.20pm. At this time, Ms A was in established labour: her contractions were regular and she was four centimetres dilated.

90. Ms C was again unable to detect the FHR. When Ms B took over, she too had difficulty detecting the FHR. The notes record: "FHR: difficult to find ~ 120s." Ms B has subsequently acknowledged to HDC that she was probably hearing the maternal pulse.

91. Ms Thorpe advised that "[t]he maternal pulse is often raised in labour due to the pain being experienced during a contraction but rarely shows the variation in rate that a [fetal heart rate] would exhibit… When the FHR is repeatedly difficult to find, most midwives would check the maternal pulse."

92. Ms B told HDC that Ms A did not require assistance and Ms B believed the birth was many hours away. The midwives therefore left Ms A and told her to call them when she started feeling bowel pressure.

93. I am critical of Ms B's decision to leave Ms A. Ms A was having her first baby, was in established labour, had a history of reduced movements, and the FHR was difficult to hear. As Ms Thorpe states:

> "When a woman is making so much 'noise' that you can't hear the FHR, this would indicate to most midwives that the woman was in advancing labour and needing continuous support …"

94. Leaving Ms A at that time also meant that the FHR was not monitored throughout the second stage of labour. Ms Thorpe advised:

> "It is recommended that the FHR is taken approximately every 15–30 minutes once in established labour: i.e. regular painful contractions and >3cm dilated … Any persistent abnormal recordings are an indication for more frequent observations, which may include continuous electronic monitoring and consultation with another midwife or an obstetric specialist."

95. In leaving Ms A after that assessment and not regularly checking the FHR, Ms B did not provide services to Ms A with reasonable care and skill. Ms Thorpe notes that if Ms B had provided attentive labour care, they would likely have transferred to hospital earlier owing to ongoing difficulties finding the FHR. This may have avoided the need for Ms A to rush to hospital when she was fully dilated.

96. In the circumstances, including the difficulty experienced in detecting an FHR, Ms B should have stayed with Ms A to provide labour care and close assessment. In my view, Ms B's lack of support and attention at that time was inadequate care.

Transfer to hospital

97. Ms A contacted the midwives when she began feeling bowel pressure. At 7.35pm, the midwives assessed Ms A at her home and again attempted to detect an FHR. However, Ms A's contractions interrupted each attempt. Ms B could not find an FHR. During the vaginal examination, Ms A's membranes ruptured, and there was meconium present. Ms A and the midwives agreed to transfer Ms A to hospital.

98. Ms B and Ms C did not travel with Ms A to the hospital. Ms B said that this was because the hospital was so close, and she did not want to waste time transferring the medical equipment out of her car.

99. In my view, Ms B's decision not to accompany Ms A was unacceptable. Ms A could have birthed in the car and was left completely unsupported, given that her mother was driving. Ms A and her mother were placed in an unnecessarily stressful position. Ms Thorpe stated:

> "Women in labour deserve to have continuous support from their midwife even if the drive to the hospital is a short one …"

100. Ms Thorpe noted that a woman in second stage labour with ruptured membranes should never be left alone. Ms B should have accompanied Ms A when transferring to hospital, with towels and resuscitation equipment in case she gave birth in the car. Ms B could have asked Ms C to travel separately. Ms A was a first-time mother in advanced labour and needed support and reassurance. In my view this was very poor care.

Support provided after the stillbirth

101. Ms A was supported by her family, Ms C, and a support worker from whom the midwives had requested assistance. Ms B decided to complete the clinical record at this time while the events were fresh in her mind.

102. I accept Ms Thorpe's view that it was reasonable for Ms B to complete her paperwork at this time, as there is a large amount of paperwork involved with a stillbirth and it "takes a considerable amount of time and concentration". I note that Ms A appeared to be well supported by the support worker and by Ms C, who had cared for Ms A throughout her pregnancy.

Summary

103. The provision of midwifery advice by text message must be done cautiously. Text message communication does not allow a midwife to properly assess a woman's level of concern, or allow the midwife to be sure that the woman has received the advice and interpreted it as intended. Phoning the woman allows the midwife to better assess any concern that has been expressed and determine whether a physical consultation is necessary. At the very least, text message advice should be followed up by a phone call.

104. Where the clinical picture includes a history of reduced fetal movements and an FHR that is difficult to find, midwives should check the maternal pulse and, in most cases, arrange a CTG for a more thorough assessment. Close monitoring of a baby's heart rate in these circumstances is important.

105. When a woman is in established labour, a midwife should be available to provide continuous support and close assessment of the woman and baby, including assessing the FHR approximately every 15 to 30 minutes. This support extends to providing support during a transfer (even if this is a short trip), particularly if a woman is close to giving birth.

106. Ms B should not have responded to Ms A's concerns via text message without also calling her to clarify and follow up her concerns. Ms B failed to respond appropriately to the history of reduced fetal movement by not checking the maternal pulse and not arranging a CTG. She also did not remain with Ms A to monitor the maternal and fetal well-being when the FHR was still difficult to find and Ms A was in established labour. Furthermore, Ms B left Ms A unsupported in travelling to the hospital when she was about to give birth. Ms B therefore did not provide services to Ms A with reasonable care and skill and breached Right 4(1) of the Code.

Recommendations

- As per the recommendation in my provisional opinion, Ms B has provided HDC with a written apology, which will be forwarded to Ms A.

- I recommend that Ms B complete a competency review with the Midwifery Council of New Zealand.

Follow-up actions

- Ms B will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Midwifery Council of New Zealand. The Council will be advised of Ms B's name, and I will ask the Council to report back to me on the progress of the competency review in place for Ms B.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the DHB and the New Zealand College of Midwives, and they will be advised of Ms B's name.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

The Director of Proceedings filed a statement of claim in the Human Rights Review Tribunal against the midwife. The claim was able to proceed by agreement and compensation for Ms A was resolved between the parties by negotiated agreement.

The Tribunal's decision can be found at:

http://www.nzlii.org/nz/cases/NZHRRT/2013/40.html

Appendix A — Independent midwifery advice to the Commissioner

"*[Deleted for brevity]*

I have been asked to provide midwifery advice to you, the Health and Disability Commissioner, regarding the midwifery care provided by midwife [Ms B] for [Ms A].

I am an independent midwife who has been registered for twenty years and has been providing an independent midwifery service to the women of Christchurch for eighteen years. I also have a Masters Degree in Midwifery. I am an active member of the New Zealand College of Midwives (NZCOM) and have been a midwifery reviewer for the Canterbury/West Coast region NZCOM Standards Review Committee for over twelve years. I have also worked for the New Zealand Midwifery Council on Competence Review Panels and Professional Conduct Committees.

I have read and agreed to follow the Commissioner's Guidelines for Independent Advisors.

I have also closely read the following information prior to writing this advice.

Supporting Information
a. [Ms A's] complaint, received 1 June 2011 (marked A)
b. Phone conversation with [Ms F], 25 July 2011 (B)
c. Letter from lead maternity carer [Ms F], 24 July 2011 (C)
d. Email from student midwife [Ms C], 1 August 2011 (D).
e. Email from [the DHB], 20 July 2011 (E)
f. Response from registered midwife [Ms B], 7 July 2011 (F)
g. Medical records from [the public hospital], pages 1–78 (G).
h. Clinical notes from lead maternity carer [Ms F], pages 1–48 (H).

Summary of events
Having read the above information I will outline my understanding of events leading to and following the birth of [Baby A].

[Ms A's] antenatal care for her first ongoing pregnancy was provided by lead maternity carer midwife [Ms F]. All appeared to progress normally. When [Ms A] was 38 weeks [Ms F] saw her for their final visit as she was then on leave. Midwifery care was handed over to locum midwife [Ms B]. The initial contact with [Ms A] was when [Ms A] texted [Ms B] on [Monday] at 39/40 to say that she was concerned about her baby's movements and that she had black spots in her underwear. [Ms B] texted her back suggesting that she drink a glass of cold water and to make contact again if she was still concerned. [Ms B] did not hear back from [Ms A] so assumed that all was well. [Ms A] had a student midwife, [Ms C] involved in her care for several weeks prior to this time (? from 34/40).

[Ms B] first met with [Ms A] on [Wednesday] at her clinic with [Ms C] providing the care under supervision. The majority of the documentation from this point is provided by [Ms C]. She notes that 'baby is active although the movements are not as hard…[Ms A] feels that her baby has dropped ever (sic) further into pelvis now'. [Ms

C] is unable to detect a foetal heart beat with the doppler and documents in her retrospective statement 'Asked midwife to take over the auscultation. Midwife advised that she heard the foetal heart rate (FHR) at 120bpm. FHR not heard by student' (G:pg42). All is assessed as well by [Ms B] and the appointment is over.

The next point of contact is when [Ms A] is in labour the following day ([Thursday]). At a home visit at 2.20pm [Ms B] and [Ms C] assess [Ms A] which includes an abdominal palpation and vaginal examination. [Ms C] cannot detect a FHR and notes 'difficult to find — 120s' (G: pg 61). [Ms C] also states in retrospect '[Ms C] unable to locate FHR after attempting by electronic auscultation. Asked midwife to take over….Midwife advised that she heard the FHR at 120bpm and documented by midwife. FHR not heard by the student' (G:pg 42). The plan appears to be for [Ms A] to get up walking and I am assuming that [Ms B] and [Ms C] leave as there is no further documentation until later in the day.

[Ms A] next makes contact with [Ms B] when labour has advanced. At 7.35pm [Ms B] and [Ms C] assess [Ms A] again by abdominal palpation and vaginal examination and finds her to be close to birthing her baby. [Ms B] documents in the clinical notes 'FHR: difficult to find due to contractions' (G: pg 61). In [Ms C's] retrospective statement she notes 'Midwife advised FHR was difficult to find. FHR not documented. FHR not heard by student' (G: pg 42). [Ms A's] membranes rupture and there is meconium present. They advise immediate transfer to [hospital]. [Ms A] goes on her own with her mother, in a separate car to [Ms B] and [Ms C].

[Ms B] and [Ms C] arrive at the hospital and prepare the room for birthing. There is considerable delay for the arrival of [Ms A] due to her mother being unsure of where to go. When [Ms A] finally arrives at 2022hrs the birth is imminent. [Ms B] and [Ms C] assist [Ms A] into the birthing room and the baby is born 5 minutes later at 2027hrs. [Ms A's] mother is not present as once again, she is unsure of where to go.

[Baby A] is stillborn, although the paediatric team make an unsuccessful resuscitation attempt.

[Ms A's] mother arrives 40 minutes following [Baby A's] birth to support [Ms A] as are [Ms B] and [Ms C]. [Ms A's] placenta is born by active management.

[Ms B] arranges for a SANDS worker to provide additional support for [Ms A] and then spends time completing the necessary paperwork.

[Ms A] is discharged home on [Saturday] and a postmortem is arranged for [Baby A].

Expert Advice Required
To advise the Commissioner whether, in my opinion, [Ms B] provided services to [Ms A] of an appropriate standard and if there are any concerns about the care which require formal investigation.

In particular, I will comment on the following as you have requested:

A general comment about the care provided by [Ms B] to [Ms A] and whether [Ms B's] management of [Ms A's] labour met the accepted standards and in particular commenting on her intrapartum monitoring.

I have four main concerns with regard to the midwifery care provided by [Ms B].

Giving advice by text
When [Ms A] sent [Ms B] a text concerned about her baby's movements this was their first contact. From what I have read, [Ms B] had not met with [Ms A] prior to this point. Rather than replying by text, reasonable care would have been for [Ms B] to call [Ms A] and speak to her in person. This would have allowed [Ms B] the chance to introduce herself, assess the degree of anxiety [Ms A] was feeling and then determine whether a home visit would be warranted to check baby's wellbeing. Most midwives would then make a plan to either visit or arrange for another call within a certain timeframe. [Ms B] replied by text and did not hear back from [Ms A]. 'I did not hear from [Ms A] again so assumed the cold water had done the trick' (F). I don't believe that this is acceptable care as she could not have been absolutely sure that [Ms A] had received her text. [Ms B] had not checked to determine if her advice had been received or made a plan for [Ms A], with follow up advice if movements remained reduced.

Not recommending a cardiotocograph (CTG) when the fetal heart rate was difficult to hear and there was a history of reduced movements
When [Ms B] and [Ms C] met with [Ms A] on [Wednesday] at their clinic [Ms A] said that the baby's movements were softer. Locating the fetal heart rate (FHR) was difficult during this visit and [Ms C] states that she never heard it. [Ms B] however found a heart rate after some time and assumed it was foetal. It is extremely unusual to have any difficulty locating the FHR of a full term baby. With the history of reduced foetal movements and the difficulty of finding the heart rate most midwives would check the maternal pulse and then arrange for a CTG for a more thorough assessment. [Ms B] did not do or recommend this and I do not believe this is reasonable care.

Not staying with [Ms A] during her labour to monitor maternal and foetal wellbeing
When [Ms B] and [Ms C] visited [Ms A] at her home at 2.20pm on [Thursday] they did a midwifery assessment and found [Ms A] to be in established labour (cervix 4 cm dilated and having contractions lasting a minute and occurring every 3 minutes). Despite again having difficulty locating a FHR and [Ms A] in good labour, they left her and did not make any further contact until [Ms A] contacted them feeling bowel pressure at 7.06pm. [Ms C] states that she never heard a FHR at this visit.

Most midwives would have stayed with a woman having her first baby, in established labour with a history of reduced movements and a FHR which is difficult to hear. I do not believe that this is reasonable care and although it is unlikely it would have made any difference to the outcome, if [Ms B] and [Ms C] had provided attentive labour care they would likely have transferred to hospital earlier due to on going difficulties finding the FHR. This may have reduced the trauma for [Ms A] by avoiding the rush to the hospital at fully dilated.

Intrapartum foetal monitoring.
At each point of contact with [Ms A], there was difficulty locating the FHR.

Intermittent monitoring is done by using either a pinard stethoscope or a hand held sonacaid. The baby's heart rate should be counted over a minute, to ascertain beat-to-beat variability. Variability of more than five beats per minute (bpm) is normal throughout labour. The baseline heart rate refers to the heart rate present between periods of acceleration or deceleration and is considered normal between 110 and 160 bpm. The heart rate will usually remain steady or accelerate during contractions. Counting the heart rate during and immediately following a contraction provides the midwife with a clear indication of the baby's response to the labour. It is recommended that the FHR is taken approximately every 15–30 minutes once in established labour: i.e. regular painful contractions and >3cm dilated, (Okosun & Arulkumaran 2005, NICE 2007). Any persistent abnormal recordings are an indication for more frequent observations, which may include continuous electronic monitoring and consultation with another midwife or an obstetric specialist.

[Ms B] concedes that what she was likely to have been hearing was the maternal pulse. 'I have adjusted my practice to include taking the maternal pulse to compare with the foetal heart rate to avoid this situation again' (F). The maternal pulse is often raised in labour due to the pain being experienced during a contraction but rarely shows the variation in rate that a FHR would exhibit (as documented above). When the FHR is repeatedly difficult to find, most midwives would check the maternal pulse (NICE 2007) and if [Ms B] had done this then [Baby A's] demise may have been diagnosed earlier.

Not accompanying [Ms A] to the hospital when she was in advanced labour with ruptured membranes
I am at a loss to understand why [Ms B] did not accompany [Ms A] in her car. Most midwives would not leave a client who is about to birth imminently. There was a chance that [Ms A] could have birthed in the car and to do so without a health professional with her would have been extremely unfortunate. Most midwives would anticipate this possibility and accompany the woman with towels and resuscitation equipment in case this occurred before arrival at the hospital. Fortunately [Ms A] managed to get inside the hospital before birthing her baby just 5 minutes later, but I do not believe that this is reasonable care to expect [Ms A] to be in a car with no one supporting her whilst her mother drove. Going in a separate car also placed [Ms A's] mother in a demanding position and I believe that it was unreasonable to have exposed her to this stressful experience.

Summary
The postmortem indicates that [Baby A] died of a massive fetomaternal haemorrhage. 'The cause is not understood and it is not a pathology that can be predicted or easily identified' (G: pg 6). The amount of haemorrhage was 50% of [Baby A's] blood volume from which the pathologist says 'there is a very high mortality'.

With regard to the midwifery care provided I am of the opinion that [Ms B] could have been more thorough and attentive in her assessment and care of [Ms A]. Texting advice to a client is not acceptable practice when one can't assume the advice has

been received or interpreted accurately. A more thorough antenatal assessment of [Ms A] should have been offered when she indicated her concerns about her baby's movements and I consider this to be a moderate departure from the expected standard of midwifery care (NZCOM 2008).

The labour should have been monitored more closely, especially with a history of reduced movements and the ongoing difficulty with finding the fetal heart rate. I do not believe that it was good practice to leave [Ms A] when she was in established labour. I would consider this to also be a moderate departure from the expected standard of midwifery care (NZCOM 2008). Closer monitoring of the baby's heart rate throughout labour would be highly recommended in this circumstance.

Finally, I believe that a woman in the second stage of her labour with ruptured membranes should never be left alone or expected to travel unaccompanied except by a family member. I consider this to be a severe departure from the expected standard of midwifery care (NZCOM 2008).

I don't necessarily believe that more thorough midwifery care would have changed the outcome for [Baby A] but the experience may have been less traumatic for his mother had the stillbirth been diagnosed earlier.

[Ms C's] inclusion in [Ms A's] care was that of a supervised student and although she was actively involved and did much of the care and documentation it was [Ms B's] responsibility as locum LMC to oversee and be accountable for all of the care that [Ms A] received. It appears that [Ms C] provided supportive continuity of care for [Ms A] which would have been comforting at her time of loss.

I would like to extend my deepest sympathy to [Ms A] and her family and hope that with time, the grief of this experience will fade.

[…][17]

Juliet Thorpe, Midwife

References

National Institute for Clinical Excellence (NICE) 2007 Guideline. Intrapartum Care; care of healthy women and their babies during childbirth.
New Zealand College of Midwives (NZCOM) 2008) Handbook for practice. NZCOM, Christchurch, NZ
Okosun H, Arulkumaran S 2005 Intrapartum fetal surveillance. Current Obstetrics and Gynaecology 15(1): 18–24"

[17] Deleted for brevity.

Further expert advice was obtained from midwife Juliet Thorpe in light of additional information provided to HDC:
"I have been asked to provide further midwifery advice to you, the Health and Disability Commissioner, regarding the midwifery care provided by midwife [Ms B] for [Ms A].

I have reread the original supporting information as well as the new documents (listed below) prior to writing this advice.

Additional Supporting Information
Response to notification of investigation, received 22 December 2011 (I)
Correspondence from [Ms B's] lawyer, 14th December 2011 and 9th January 2012 (J)
Photograph of diary entry from [Tuesday] (K).
Interview summary from interview with [Ms B], 14th February 2012 (L).
Email from [Ms B] with amendments to interview summary (M).
Requests for clarification and email clarification from [Ms B] (N).
Amended interview summary from [Ms C], received 1 March 2012 (O).
Interview summary from interview with [Ms A], 31 January 2012 (P).
File note of phone conversation with [Ms A's] mother, 8 February 2012 (Q).
File note of phone conversation with [Ms A's] sister, 13 February 2012 (R).

Expert Advice Required
To advise the Commissioner whether, in my opinion, [Ms B] provided services to [Ms A] of an appropriate standard. You have also asked me to comment on the following if not already covered in my previous advice.

The appropriateness of [Ms B's] communications with [Ms A] via txt message on [Monday].
As I mentioned in my previous advice rather than replying by text, reasonable care would have been for [Ms B] to call [Ms A] and speak to her in person. '*I don't believe that this is acceptable care as she could not have been absolutely sure that [Ms A] had received her text. [Ms B] had not checked to determine if her advice had been received or made a plan for [Ms A], with follow up advice if movements remained reduced'*. In the interview with [Ms B] she said that looking back at this situation she would call [Ms A] back to check she understood instructions. It is hoped that she would do so if anyone sent a txt with the same concern but not having done so in this situation does not meet the NZCOM Standard Five — Midwifery Care is planned with the woman. This Standard involves constructing a plan which analyses the information gained from the woman and sets out specific midwifery decisions and actions in an effort to meet the woman's goals and expectations. This cannot be done by text especially when there has been no reply from the woman with regard to the advice given. Most midwives would see this as a moderate departure from the expected standard required of a midwife.

The appropriateness of [Ms B's] actions on [Wednesday], in light of [Ms A's] previously expressed concerns about lack of fetal movements and the difficulty the midwives had in finding a fetal heart rate.
In my original opinion I said that 'it is extremely unusual to have any difficulty locating the FHR of a full term baby. With the history of reduced foetal movements

and the difficulty of finding the heart rate most midwives would check the maternal pulse and then arrange for a CTG for a more thorough assessment'.

Having read the additional information I have not changed my opinion with regard to this and see this as a moderate departure from the expected standard. In particular Standard Six — the midwife identifies deviation from the normal and after discussion with the woman, consults and refers appropriately. In [Ms B's] interview when asked 'would the FHR normally be louder later in pregnancy?' she said 'FHR harder to find when baby is small but same level of noise all the way through pregnancy'. This is generally true which is why I am concerned that [Ms B] did not suggest a CTG when the FHR could not be easily heard. She said that they tried for two minutes and thought they found it. There was no indication from the clinical notes that previously in the pregnancy the FHR was difficult to detect. Earlier in the pregnancy the baby's heart rate can be difficult to hear clearly but is rarely hard to find in a full term normally grown baby and should always be a flag for concern if it takes some time to find, which it did in this case.

Under what circumstances would you expect a midwife to check the maternal pulse as well as the fetal heart rate?
If there is a history of the woman experiencing reduced movements and the FHR is difficult to find, most midwives would take the maternal pulse. The woman may be feeling stressed and her pulse can often be in a similar range to that of her baby's so easy to confuse the clinical picture. In [Ms B's] interview she was asked 'Under what circumstances would you check the maternal pulse'? She replied 'Since this happened, all the time'. She also said there was nothing concerning in [Ms A's] case. I would have to disagree and I acknowledge that we do have the beauty of hindsight but there was enough in the clinical picture to have expected that she would have checked the maternal pulse. I believe this is a moderate departure from the expected standard of midwifery care and once again in particular not meeting Standard Six — actions are implemented appropriately with no midwifery action or omission placing the woman at risk (the use of the word 'woman' also includes her baby).

Comment on the appropriateness of [Ms B's] actions on [Thursday], in light of the difficulty the midwives had again experienced in detecting the fetal heart rate.
As I said in my previous advice — 'most midwives would have stayed with a woman having her first baby, in established labour with a history of reduced movements and a FHR which is difficult to hear'.

In [Ms B's] letter to the Commissioner she said that 'the NZCOM Standards require a midwife to give intermittent support to a woman during this stage of labour subject to the woman's wishes'. However in [Ms B's] later interview she said that '[Ms A] was making a lot of noise and moving around a lot which made FHR hard to find'. I was surprised that [Ms B] and [Ms C] left [Ms A] after being with her for only 30–40 minutes and did not stay to provide continuous labour care. The second decision point in labour (pg 28, NZCOM 2008) from which [Ms B] quoted was in relation to early labour. When a woman is making so much 'noise' that you can't hear the FHR, this would indicate to most midwives that the woman was in advancing labour and needing continuous support which is the third decision point (pg 29, NZCOM 2008).

There was nothing documented in the clinical notes regarding any discussion with [Ms A] about her preference for [Ms B] and [Ms C] to stay or go. Most midwives in this situation (which also involved a difficulty in auscultating the fetal heart), would choose to stay and provide labour care and close assessment. I believe that leaving [Ms A] in active labour would be viewed with moderate disapproval by the profession. I will again quote from Standard Six — actions are implemented appropriately with no midwifery action or omission placing the woman at risk. This Standard was not met.

Please provide your expectation as to the extent of fetal and maternal monitoring when a woman is at the stages of labour that [Ms A] was in throughout [Thursday].
I believe that [Ms A] was in advancing labour when [Ms B] and [Ms C] saw her at 2.20pm and, as mentioned, this should have been obvious to [Ms B] from how she described [Ms A's] behaviour. I have already written a clear outline of what the profession would expect in regard to fetal monitoring in labour — '*it is recommended that the FHR is taken approximately every 15–30 minutes once in established labour: i.e. regular painful contractions and >3cm dilated, (Okosun & Arulkumaran 2005, NICE 2007). Any persistent abnormal recordings are an indication for more frequent observations, which may include continuous electronic monitoring and consultation with another midwife or an obstetric specialist'*. This was not done as [Ms B] was not in attendance of [Ms A] until she was already in the second stage of her labour — i.e.: wanting to push. I therefore believe, as mentioned above, that this would meet moderate disapproval by most midwives.

In your view, what stage did the clinical picture first indicate that hospitalization or referral of care was necessary?
When [Ms B] first had difficulty hearing the fetal heart rate on [Wednesday] she heard what was the maternal pulse but assumed it was the baby's as [Ms A] had said that she thought she had felt movements. [Ms B] was reassured enough to believe that the baby was well despite the difficulty she had with the FHR. She was not concerned at this stage yet it took about 2 minutes to find a heart rate and as I have already mentioned this is extremely unusual with a full term, healthy baby. Having a low battery is not enough of a reason to assume that the difficulty hearing the heart rate heard was due to poor output by the doppler. [Ms B] said in her letter to the Commissioner that if she was concerned about a fetal heart rate her standard practice would be to do a CTG. I believe that most midwives facing this clinical picture, would have at the very least suggested a CTG to assess wellbeing.

Please provide your opinion on the standard of [Ms B's] care in transferring [Ms A] to hospital.
In [Ms B's] interview with regard to this point she says 'wasn't concerned [Ms A] would birth in the car (unless she mucked around)'. I believe that the issue here was not only that [Ms A] could have birthed in the car (the labour was proving to be an efficient one) but that she would have been unsupported in the car as her mother was driving. Women in labour deserve to have continuous support from their midwife even if the drive to the hospital is a short one. [Ms B] said that it would have been difficult to have moved her equipment into the car with [Ms A] but as there was both [Ms B] and [Ms C] present, I believe that it would have been preferable if at least one of them had accompanied [Ms A] and her mother to the hospital. I believe that most

midwives would accompany a woman in second stage when transferring to hospital and would see not doing so as a severe departure from the expected standards of the profession. [Ms B] has subsequently reflected that in the future she would accompany women even if the distance was short.

Please comment on [Ms B's] decision to complete the clinical record while [Ms C] offered support alongside [Ms A's] mother and the SANDS worker.
I don't think it was unreasonable for [Ms B] to leave [Ms A] to complete the clinical record. There is a huge amount of administration and paper work involved with a stillbirth and it takes a considerable amount of time and concentration. [Ms A] appeared to be well supported by [Ms C], who she knew better than [Ms B], and the SANDS workers are skilled in grief support.

Which professional midwifery standards and guidelines are applicable in relation to this complaint?
I think I have answered this question.

Please outline any recommendations you have to address the concerns raised by this complaint.
Having read all of the supporting documents it would appear that [Ms B] has reflected on some of the issues raised and has made appropriate changes to her practice.

- She would now talk to a woman in person with regard to reduced fetal movements
- She would check the maternal pulse in any situation where the fetal heart rate was difficult to detect
- She would always accompany a woman in second stage when transferring to the hospital

It is good to see that [Ms B] recognised that the care that she provides has needed these improvements. I have a concern that she did not recognise that [Ms A] was in advancing labour and that she thought it was acceptable midwifery care to leave her unattended and did not feel the need to monitor the baby more closely. A New Zealand Midwifery Council Competence Review may be a way of being able to address this issue in a supportive and educative way and to assess whether there are concerns with any other aspects of [Ms B's] assessment skills.

[…][18]

Juliet Thorpe, Midwife

References
National Institute for Clinical Excellence (NICE) 2007 Guideline. Intrapartum Care; care of healthy women and their babies during childbirth.
New Zealand College of Midwives (NZCOM) 2008 Handbook for practice. NZCOM, Christchurch, NZ
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