Midwife, RM B

A Report by the

Health and Disability Commissioner

(Case 15HDC00550)

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Executive summary

1. In 2014, Mrs A became pregnant with her third child. Mrs A intended to have a home birth and engaged a self-employed community-based registered midwife, RM B, as her Lead Maternity Carer (LMC).

2. At approximately 6.30am, Mrs A, at 22 weeks' gestation, contacted RM B reporting vaginal bleeding and contraction-type pains. Mrs A and RM B met at Hospital 1 at 8am. RM B assessed Mrs A and, with support from a hospital midwife, was unable to detect a fetal heartbeat. RM B scheduled Mrs A for an ultrasound scan to "determine fetal viability". The ultrasound scan appointment was booked for 2.30pm.

3. RM B documented in her retrospective notes that she informed Mrs A that "the current need was to finish the assessments then discuss with a doctor the options of 'wait and see' or referral to the Gynaecology ward at Hospital 2 once she had her ultrasound scan". RM B recorded that Mrs A did not want to go to Hospital 2. Prior to her attendance at Hospital 1, RM B attempted to telephone the on-call obstetrician, Dr D, but dialled the incorrect number. RM B did not attempt to make any further contact with an obstetrician. RM B told HDC that she was under the impression that Mrs A needed to have her ultrasound scan prior to consultation with an obstetrician. RM B said that as Mrs A appeared clinically stable and wanted to go home, and had agreed to return for her ultrasound scan at 2.30pm, she felt that this was an acceptable plan.

4. Mrs A said that RM B made no mention of needing to talk to, or consult with, any other medical professional, or of transferring to any other department.

5. Following the ultrasound scan at 2.30pm, intrauterine death was confirmed, and RM B drove Mr and Mrs A home. At 3.05pm, RM B left them at their home and documented that Mrs A was "[h]ome having increasing pains", and that they would "call [her] if needed". RM B provided Mrs A with information leaflets relating to both miscarriages and stillbirths. RM B told HDC: "[U]nfortunately I did not find or make a time to review these materials with [Mrs A] and address any of her subsequent concerns."

6. Mrs A told HDC that her labour went on like a normal labour, and she delivered what she believed to be the placenta. She asked Mr A to telephone RM B and ask her to return to their home. At 4.15pm, RM B returned to their home.

7. There is some discrepancy between Mr A's and RM B's account about the discussion that took place once RM B arrived. Mr A stated that he told RM B that the tissue delivered was in the basin. RM B stated that she has no recollection of Mr A informing her of this, and she believed that the piece of placenta she located on the bathroom floor was the only tissue that had been delivered.

8. At 4.42pm, RM B left Mr and Mrs A because she decided to drive to her home to seek collegial advice, as she "did not feel comfortable having a conversation in front of [Mrs A] and [Mr A] that may have woken [Mrs A] and been distressing for them".

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9. RM B returned to Mr and Mrs A's home at approximately 5.50pm and offered to take them to Hospital 1. Prior to leaving for Hospital 1, Mrs A asked RM B whether they should take the placenta, which was located in a towel outside on the porch. RM B told HDC that she collected the container in which she had placed the piece of placenta she had found earlier, and showed it to Mrs A, but Mrs A told her that that was not it. RM B said that when she went out to the porch, she "found the baby and most of the placenta complete in its sac" in a container.

Findings

10. By not providing Mrs A with adequate information about her stillbirth, and not advising her of the recommendations in the Referral Guidelines, RM B failed to provide Mrs A with essential information that a reasonable consumer in Mrs A's circumstances would expect to receive, and breached Right 6(1) of the Code. It follows that Mrs A was not in a position to make informed choices about her care. Accordingly, RM B also breached Right 7(1) of the Code.

11. The Commissioner was critical that RM B did not consult with an obstetrician when she was outside her scope of knowledge and experience in relation to stillbirths, and that RM B failed to identify the need to request emergency services for Mrs A when she believed that a piece of the placenta had been delivered prior to the fetus. This amounted to a severe departure from an accepted standard of care. Accordingly, RM B failed to provide services to Mrs A with reasonable care and skill and breached Right 4(1) of the Code.

12. By failing to record accurate and timely written progress notes, and by failing to document evidence of all decisions made and the midwifery care offered and provided, RM B did not meet professional standards. Accordingly, she was found to have breached Right 4(2) of the Code.

Recommendations

13. It was recommended that RM B apologise to Mrs A and arrange further training on record-keeping and documentation, and provide HDC with confirmation of her attendance at the appropriate workshops, should she return to midwifery practice in New Zealand.

14. It was recommended that should RM B return to midwifery practice, the Midwifery Council of New Zealand conduct a review of RM B's competence.

Complaint and investigation

15. The Commissioner received a complaint from Mrs A about the services provided to her by Registered Midwife RM B. The following issue was identified for investigation:

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Whether RM B provided Mrs A with an appropriate standard of care between Month 1 and Month 3.

16. Information was reviewed from:

Mrs A	Consumer
Mr A	Consumer's husband
RM B	LMC midwife, provider
District Health Board	
RM C	Midwife

Also mentioned in this report:

Dr D	Obstetrician
CCM E	Clinical Charge Midwife
CCM F	Clinical Charge Midwife
RM G	Midwife
Dr H	Radiologist
Dr I	Obstetrician

17. Independent expert advice was obtained from a registered midwife, Jacqueline Anderson (**Appendix A**).

Information gathered during investigation

Background

18. Mrs A became pregnant with her first child and had a normal vaginal birth in hospital. Two years later, Mrs A became pregnant with her second child and had a normal vaginal birth at home.

19. In 2014, Mrs A became pregnant with her third child. Mrs A intended to have a home birth and engaged a self-employed community-based registered midwife, RM B, as her Lead Maternity Carer (LMC).

RM B

20. At the time of these events, RM B had been a practising midwife in New Zealand since 2008, and had been practising as a self-employed LMC for two years.[1]

Antenatal care

Month 1

21. In Month 1, Mrs A had her first antenatal appointment at her home. During this appointment, RM B documented Mrs A's maternal and medical history and took her blood pressure. RM B recorded that Mrs A had no significant medical history and that she had been experiencing nausea for the last couple of months. The following day,

[1] RM B obtained her qualifications as a registered midwife overseas in the 1970s.

Mrs A also received an ultrasound scan. Mrs A's ultrasound scan showed a live fetus at 13 weeks and 4 days' gestation.

Month 2

22. At 17 weeks' gestation, Mrs A had another antenatal appointment with RM B.

23. RM B recorded in the clinical notes that Mrs A had felt the baby move the previous week, that the fetus had grown, and that the fundal height recorded was consistent with the dates of Mrs A's ultrasound scan. RM B checked Mrs A's blood pressure, albumin[2] and glucose levels,[3] and checked for any sign of oedema.[4] RM B recorded in the notes: "Declined Blood tests this pregnancy and any further [ultrasound] … Declined [gestational diabetes mellitus][5] and other testing." RM B documented Mrs A's weight as 62kg. Mrs A could not recall the discussions that took place in relation to declining the blood tests, ultrasound, and gestational diabetes mellitus testing.

13–14 Month3

24. Mrs A told HDC that in Month 3 (at 22 weeks' gestation) she had a small amount of brown mucous discharge and began to feel light contraction-type pains in the evening and throughout the night. Mrs A stated that at 6am on the following day, she had further mucous discharge, which was bright red in colour.

25. At approximately 6.30am, Mrs A telephoned RM B, who advised her that she needed to be assessed in hospital, although RM B was unsure which hospital, as she had not experienced Mrs A's issue previously.

26. RM B stated that at approximately 6.50am, she rang Hospital 1 and asked to speak to the Clinical Charge Midwife (CCM). RM B recorded that she told CCM E about Mrs A's previous pregnancies and the symptoms she had been experiencing the previous night and that morning.

27. CCM E advised HDC that she has no recollection of Mrs A's admission. However, Mrs A's clinical notes contain a record of a conversation between CCM E and RM B. CCM E has recorded that RM B advised her that Mrs A was 22 weeks pregnant with "PV spotting", possibly having some contractions, that she was not booked, and that Hospital 3 would not accept her until she had been assessed at Hospital 1. CCM E noted that she advised RM B to come in and to telephone the on-call obstetrician.

28. RM B said that she then telephoned Dr I and left a voice message explaining Mrs A's history and their impending arrival at Hospital 1.

29. Dr I told HDC that he was the specialist on duty until 8am on that day, but that he cannot recall receiving a telephone call from RM B regarding Mrs A.

30. RM B's telephone records confirm that she dialled a number at 7.29am, but that one digit dialled was different from Dr I's telephone number. RM B correctly documented

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[2] A protein commonly found in small amounts in the urine during pregnancy.
[3] Urine is tested for the presence of glucose (sugar) as a possible sign of diabetes in pregnancy.
[4] Fluid retention that causes the affected tissue to become swollen.
[5] Gestational diabetes mellitus (GDM) is diabetes that is diagnosed in pregnancy.

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Dr I's mobile telephone number on the back of the print-out of her telephone records, which she provided to HDC. The district health board (DHB) has confirmed Dr I's mobile telephone number as the one written on the back of the telephone records.

31. RM B stated that, at approximately 7.35am, she telephoned Mrs A and asked her to meet her at Hospital 1 at 8.15am for an assessment. The discussion and any options offered were not documented. Mrs A told HDC that RM B made no mention of needing to talk with any other medical professional.

Assessment at Hospital 1

32. RM B documented in the clinical notes that she met Mrs A at 8am. RM B recorded in her retrospective account[6] that she booked in Mrs A, then returned to explain to Mrs A that she needed to do observations, including checking for a fetal heartbeat, and then arrange for her to see a doctor.

33. In her retrospective account, RM B stated that she checked with the hospital staff about the procedures and assessments she was required to complete for Mrs A. RM B stated that CCM F informed her that she needed to perform a speculum examination,[7] cardiotocograph (CTG) monitoring, and an ultrasound, and to ensure that she had "all [her] ducks lined up" before talking to the obstetrician on duty, Dr D. RM B said that she was told to telephone the on-call obstetrician before meeting Mrs A at Hospital 1, but was never advised by any staff at Hospital 1 that she should refer Mrs A to the on-call obstetrician following this.

34. RM B documented in the clinical notes that Mrs A declined a speculum examination. RM B attempted to locate a fetal heartbeat using the CTG transducer, but was unable to detect one. RM B recorded in her retrospective account that she told Mrs A that this was not conclusive that there was no fetal heartbeat, and that she would ask a hospital midwife, RM G, to assist. Mrs A told HDC that she recalled RM B mentioning an internal examination, and that RM B used a machine to listen for the fetal heartbeat.

35. In her retrospective account, RM B stated that when she went to find RM G, the ward clerk on duty provided her with a set of notes and stickers for Mrs A, which RM B did not check or use, but later discovered contained another woman's details.

36. RM B said that RM G was also unable to locate a fetal heartbeat, and suggested that she try a Doppler[8] to check for one. A fetal heartbeat was also unable to be located with the use of the Doppler. RM B stated that she requested RM G's assistance with the blood pressure machine, as she was unfamiliar with it. At 8.30am, RM B recorded in the clinical notes that Mrs A's blood pressure was within the normal range at 112/67mmHg. RM B stated that she asked RM G to assist her with using the CTG transducer, the Doppler, and the blood pressure machine.

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[6] RM B told HDC that she was unable to record this information in the clinical records later that night, as the maternity book was with Mrs A. Subsequently, RM B recorded retrospective notes at approximately 9pm on 14 Month3.

[7] A speculum is an instrument used to widen the opening of the vagina so that the cervix can be visualised.

[8] A Doppler fetal monitor is a hand-held ultrasound transducer used to detect the fetal heartbeat.

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37. RM B then organised an ultrasound scan for Mrs A. RM B told HDC that she requested assistance from RM G to complete the electronic Concerto[9] request for Mrs A's scan, as she (RM B) could not remember how to process one. RM B recalls that she "did not visually check what information was provided on the scan request form as this was completed online by [RM G]".

38. RM G told HDC that RM B requested her assistance to complete the electronic Concerto request for Mrs A's ultrasound scan. RM G said that RM B stayed with her to complete it, as she (RM G) did not have Mrs A's information. The scan request documented that it was an urgent request to determine fetal viability. The ultrasound scan was booked for 2.30pm. It does not appear that any consideration was given to referral to an obstetrician at that time.

39. RM B recorded in her retrospective account that she returned to Mrs A and showed her to a toilet. She recorded that she asked Mrs A to provide a urine sample for urinalysis, and went to get some water for her.

40. When RM B returned, Mrs A told her that her arm band and notes contained a different woman's details. RM B stated that she apologised to Mrs A and went to get them corrected by the ward clerk. RM B told HDC that she then went to see RM G to check whether the ultrasound scan request had also been created with the incorrect patient details.

41. Radiologist Dr H told HDC that the priority of the ultrasound scan depends on the information provided by the referrer. He said that the request did not list that there was "no fetal heartbeat recordable". Hospital 1 told HDC that "it was an exceptionally busy day for ultrasound scans at [Hospital 1] with three other cases taking precedence based on the clinical indications".

42. Hospital 1 investigated the possibility of an administrative error delaying Mrs A's ultrasound, and confirmed that an ultrasound scan request was made at 8.59am on 14 Month3. Hospital 1 stated that Mrs A's scan was then prioritised on the basis of the urgency of other referrals that day.

43. Mrs A told HDC that RM B told her that she could either wait at Hospital 1 for the ultrasound scan at 2.30pm, or she could go home and return. Mrs A told HDC that she did not want to wait at Hospital 1 all that time for a scan, and chose to go home.

44. RM B stated that she told Mrs A that they needed to finish the assessments and the ultrasound, and then discuss the options of either "wait and see" or referral to the gynaecology ward at Hospital 2. RM B said that Mrs A told her that she did not want to go to Hospital 2. Mrs A told HDC that she cannot recall being offered options on where she could go. The discussion and any options offered were not documented.

45. RM B told HDC:

[9] A computer system.

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"I am NOT sure of the order and timings of things I said to [Mrs A]. I had earlier told [Mrs A] of the need to consult with a doctor to determine possible options of care such as possible transfer to [Hospital 3], treatments such as (?) steroids if there was a heartbeat, if no heartbeat the options of Dilatation and Curettage or 'Wait and see' — allowing her body to work, which she said repeatedly she preferred."

46. However, Mrs A told HDC that RM B gave her the impression that the only hospital contact she could have was if she had a miscarriage and there was still tissue inside of her and she started to haemorrhage. Mrs A said that RM B advised her that if this happened, she was to go to the accident and emergency department at Hospital 2, and that Hospital 1 or Hospital 3 would not treat her.

47. RM B told HDC that she explained to CCM F that Mrs A had declined a speculum examination, CTG monitoring, and any visit to Hospital 2, and that Mrs A wanted to go home and return for the ultrasound scan appointment.

48. CCM F told HDC:

"I was informed by the LMC that her client was in the assessment room and that she had declined vaginal and speculum examination. She told me she had not been able to hear the fetal heart and she had arranged an ultrasound. She had tried to listen with the [D]optone and CTG machine. [RM B] appeared a bit flustered by this; however she was sure that her client did not want to see the obstetrician at this stage. The LMC said [Mrs A] wanted to go home and did not need input from me."

49. RM B told HDC that she did not tell CCM F that Mrs A did not wish to see an obstetrician. RM B stated that it was her understanding at the time that the ultrasound scan should be carried out prior to any consultation, and she was seeking advice from CCM F. RM B did not document these discussions in the clinical notes.

Return home

50. At 9.40am RM B documented in the clinical notes:

"Not able to do [ultrasound scan] till 1430 — tightenings in pubic area & back continue — possibly 1 in 5 mins unable to palpate declined CTG & Vaginal speculum examination Discussed feeling 'less pregnant' since 2 days — viability is presently 24 wks — wants to go home & come back for [ultrasound scan] at 1430 will contact me if fresh bleeding — or miscarries at home or any concerns. Old small brown loss Aware of need to go [to Hospital 2] Gynae[cology]/[Accident and Emergency department] if miscarrying/bleeding."

51. Mrs A told HDC that at this point, she was unsure whether her baby was alive or not, and was concerned that if she went home, her baby could be born alive at home. Mrs A said that RM B made no mention of needing to talk or consult with any other medical professional or transferring to any other department. RM B recorded in her retrospective notes that she tried to explain that "24 weeks is currently the lower limit

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of viability or treatment in a maternity unit". Mrs A told HDC that she received no clear information in response to her query whether her baby could still be born alive.

52. Mrs A told HDC that she decided to go home as she "felt [her] baby was dead and decided that even if it was born alive it was so young it wouldn't survive …".

53. Mrs A returned home with a plan to return that afternoon for her ultrasound appointment at 2.30pm.

54. In her retrospective account, RM B recorded that, once she was home, she looked through resources available to her for guidance, and printed off SANDS,[10] miscarriage support, and Hospital 3 patient information leaflets relating to stillbirths and miscarriages, to give to Mrs A. RM B stated that the information she accessed had contradictory information as to what was required with a pregnancy loss at 22 weeks' gestation. RM B told HDC: "[U]nfortunately I did not find or make a time to review these materials with [Mrs A] and address any of her subsequent concerns." RM B said that she provided Mrs A with the information about miscarriages and stillbirths.

55. RM B recorded in her retrospective account that another midwife, RM C, advised her to telephone the Department of Internal Affairs Births, Deaths, and Marriages for advice. RM B recorded that the Department of Internal Affairs Births, Deaths, and Marriages advised her to complete a stillbirth birth notice, and that she put the form in an envelope to provide to Mrs A, but did not inform Mrs A of this advice.

Ultrasound appointment

56. Mrs A told HDC that by 1pm she was experiencing stronger contractions, which were closer together in duration. At approximately 1.15pm, RM B telephoned Mrs A and offered to drive her to Hospital 1 for her ultrasound scan appointment. Mrs A accepted RM B's offer to drive her to the hospital.

57. At approximately 2pm, RM B arrived at Mrs A's home. RM B recorded in her retrospective account that she gave Mrs A some magnesium phosphate and drove her and Mr A to Hospital 1.

58. RM B recorded in her retrospective account that once they were at Hospital 1, she went to speak to another midwife.

59. Mrs A told HDC that she could not sit down, owing to her contractions, so she stood in the corridor. She stated:

> "I felt like I should not be there, having to be in labour in a public corridor with no professional support. I was not really sure why I was there either as either way the baby was coming soon. There were people around and I was in a great deal of pain, wondering if this baby would be delivered in the corridor. I ended up in tears."

[10] SANDS New Zealand is a voluntary, parent-run, non-profit organisation set up to support parents and families who have experienced the death of a baby.

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60. In her retrospective account, RM B recorded that at 2.26pm, when she returned to Mr and Mrs A, Mrs A was pacing the corridor. RM B recorded that at this point she asked Mrs A whether they should attend the accident and emergency department, but that Mrs A wanted to have the ultrasound scan and return home. However, Mrs A told HDC that RM B made no mention of transferring to another department.

61. Mrs A had the ultrasound scan, during which a sonographer was unable to find a fetal heartbeat. The sonographer reported that the measurements of the fetus were consistent with a gestation of 17 to 18 weeks.

62. The sonographer told HDC that, after the examination, she asked Mrs A whether she would be going to a ward or the Emergency Department, but that Mrs A told her she would be going home. The sonographer stated that she questioned this, but Mrs A confirmed that she would be going home and, since the lady with her appeared to be her LMC, the sonographer did not feel it was her place to question this any further. Mrs A could recall the sonographer informing her only that her baby was not alive.

63. In her retrospective account, RM B recorded that she suggested to Mrs A that they could go to Hospital 2 or the Accident and Emergency Department at Hospital 1, but Mrs A wanted only to return home. RM B told HDC: "From my first conversation with [Mrs A] on [14 Month3], I repeatedly informed her of the need for consultation with, or transfer to, a secondary services hospital." In response to the provisional opinion, RM B advised HDC that she repeatedly endeavoured to make Mrs A aware that the best option was to see a specialist after the ultrasound scan. However, these discussions and any recommendations in relation to those options were not documented, and Mrs A denies that RM B recommended a consultation with an obstetrician or the transfer of her care.

64. RM B told HDC:

> "When the ultrasound confirmed intrauterine death I, and consequently [Mrs A], believed that she would come under the care of the gynaecology service at [Hospital 2] … I understood that [the DHB's] policy required that [Mrs A] go out of her local area to [Hospital 2] for ongoing appropriate care. [Mrs A] was adamant that she did not want to go to [Hospital 2] or the [Hospital 1] emergency department."

65. In contrast, Mrs A told HDC that she cannot recall any discussion regarding whether she should stay in hospital or go home. She said that she assumed she was going home because she had planned a home birth. She stated that she was given no option to stay in hospital. She told HDC:

> "From the conversation from the morning how she was going on about the hospital and that they won't expect you at [Hospital 2] and … my understanding was that there was no option because I am having a home birth. There was no option or no discussion and I just thought that was just how it was that I was to be delivering at home."

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66. Mrs A also told HDC that RM B discussed no risks with her regarding a home birth. Mrs A stated:

> "I and my family believe that at this point I should have been given the option of delivering the dead baby in the maternity ward. My reasons for wanting a home birth were now invalid given the baby was dead. Also I could have been at risk. I was in distress, pain and grief and did not ask if this was an option, my trust was placed in [RM B] who gave me no options so I accepted this was the normal thing to do and that the hospital would not take me (as she had told me earlier)."

District Health Board Policies/Ministry of Health Referral Guidelines

67. RM B had entered into a "Maternity Access Agreement" with the DHB. The agreement states that both parties will take into account the Guidelines for Consultation with Obstetric and Related Medical Services 2012 (2012 Referral Guidelines), which identify clinical reasons for an LMC to recommend consultation with a specialist. The Access Agreement also provides that "all clinical policies and procedures of the facilities will form the basis of primary maternity care provided in the facilities, and must be available to the practitioner".

68. The DHB policy "Stillbirth/intrauterine death" states that "[a]ll women are transferred to secondary care on diagnosis of intrauterine death", and requires the maternity access holder to "refer to the Obstetrician, senior Midwife and maternity social worker on duty". Prior to her position as an LMC, RM B worked as a staff midwife at Hospital 1.

69. RM B told HDC:

> "All [the DHB's] policies are stored on their onsite computer system's 'intranet' and requires users to have and use a [DHB] IT registered username and password. While I have had a username and password in the past (and do now), at the time I did not have access as I had not needed to use the system for some time (I had not anticipated having to do so on that day). Thus I relied on the directions given to me by the CCM and advice from other staff about hospital protocols, processes and expectations on the day …"

70. As an LMC, RM B was also required to follow the 2012 Referral Guidelines. Hospital 1 noted that DHB staff were required to offer assistance to LMCs on request, but the care of the woman remained the responsibility of the LMC until a request was made to transfer to secondary care. Hospital 1 told HDC that in Mrs A's circumstances there were two indications that required consultation with an obstetrician; these were antepartum haemorrhage[11] and intrauterine death.

71. RM B told HDC that she did not review the current 2012 Referral Guidelines until she had finished acting as Mrs A's midwife; instead, she consulted an earlier version of the Referral Guidelines, the 2007 "Guidelines for Consultation and related Specialist Medical Services" (2007 Guidelines). While the 2012 Referral Guidelines provide that in the circumstances of an intrauterine death the LMC "must recommend to the

[11] Bleeding during pregnancy.

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woman … that a consultation with a specialist is warranted …", the 2007 Guidelines provided for a stronger recommendation in the circumstances of an intrauterine death. Under the 2007 Guidelines, RM B was required to recommend to Mrs A that the responsibility for her care be transferred to a specialist.

72. In addition, in 2012 the 2007 Guidelines were revised and extended to include what to do when a woman declines referral, consultation or transfer of clinical responsibility, or care or transport in an emergency. The 2012 Referral Guidelines state that the LMC in the first instance should:

- advise the woman of the recommended care, including the evidence for that care
- explain to the woman the LMC's need to consider discussing her case with at least one of the following (ensuring that the woman's right to privacy is maintained at all times):
  - another midwife, GPO or GP
  - an appropriate specialist
  - an experienced colleague/mentor
- share the outcomes of the discussion and any resulting advice with the woman
- document in the care plan the process, the discussions, recommendations given and decisions made, and the woman's response.

73. RM B was not aware of those instructions.

74. RM B stated: "In hindsight, I regret not approaching the CCM or on-call obstetrician at [Hospital 1] to explore whether [Mrs A] could be seen and managed there."

Return home

75. RM B then drove Mr and Mrs A to their home. RM B recorded in her retrospective account (written on the 14 day of Month 3) that she gave Mrs A some Panadol and magnesium phosphate to take if she required it, and discussed with Mrs A what the labour might be like.

76. Mrs A told HDC that RM B went through with her what to expect during a miscarriage, which she found confusing as she was at 22 weeks' gestation at this time. Mrs A said that her intention at this time was to research the legal requirements in relation to what she needed to do with the fetus, when she was able to.

77. In her retrospective account, RM B recorded that she left when Mrs A was sleeping, and that she told Mr A that she was less than five minutes away if they needed her.

78. In response to the provisional opinion, RM B advised HDC that she was at all times immediately available to Mrs A, and that she had her "birth kit, including uterotonic drugs and intravenous equipment in [her] care that morning". RM B said that, in her view, she was not required until Mrs A was "in active labour".

79. At 3.05pm, RM B documented in the clinical notes:

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> "Home having increasing pains — after [ultrasound scan] which showed no heartbeat — possible small for dates baby. Using heat packs — given [magnesium phosphate] for pain take ½ hrly — has towel under toilet seat and other towels and pads — will call me if needed."

Delivery

80. Mrs A told HDC that her labour proceeded like a normal labour, and she delivered something that she thought to be the placenta. She stated:

> "I was frightened as I did not know what to expect, and in a lot of pain, my husband was terrified as he did not know what to do. Eventually I delivered what looked to me the size and shape of a placenta."

81. Mrs A said that she was concerned and confused and, as she understood that the fetus should be delivered before the placenta, she asked Mr A to telephone RM B and ask her to return to their home.

82. RM B recorded in her retrospective account that at approximately 3.50pm, Mr A telephoned her to inform her that Mrs A had delivered something they believed might be the placenta. At 4.15pm, RM B returned to Mrs A's home.

83. RM B told HDC:

> "On arrival, I found [Mrs A] on the toilet. She was not distressed and appeared of normal colour, breathing and so on. She had a towel under her, between the seat and the bowl and there was [a] small amount of blood in the bowl with a small clot on the towel."

84. RM B stated that she went into the bathroom and tidied up and looked for evidence of bleeding or further pregnancy loss. She said that she found a piece of placenta and some chorionic membrane in one of the towels on the floor, examined the tissue, and placed it in a container she had brought with her.

85. RM B told HDC:

> "I was concerned to ensure that I had in fact located all possible tissue. I asked [Mr A] something like is that all there is holding the towels out in front of me, meaning the tissue that I had found in the towel that I held in my hand. He offered a fairly peremptory response indicating to me that, yes, that was all there was."

86. Mr A told HDC that, when RM B arrived, he pointed to a basin with towels and the product Mrs A had passed, told RM B "here it is", and left the room. RM B told HDC that she does not recall Mr A pointing to the basin or telling her that what Mrs A had delivered was in it.

87. RM B documented in the clinical notes that Mrs A had "passed small to [moderate] up to 100mls [blood] on toilet and piece of placenta and membranes — no trickling — contractions eased". RM B recorded in her retrospective account that she gave Mrs A

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magnesium phosphate for the pain and left Panadol on her bedside. There is no record of RM B taking Mrs A's observations during this visit. Mrs A told HDC that RM B did not check her over or provide further medication.

88. RM B recorded in her retrospective account that Mrs A's pains had eased, and she discussed with Mrs A the possibility that her labour had stalled. RM B stated that, at this point, she believed that Mrs A's labour had ceased temporarily, and that Mrs A was stable, in no pain, and had gone to sleep. RM B told HDC that there was nothing to suggest an acute crisis, and that she did not document the observations she took.

89. RM B recorded that she waited in the lounge for a while before leaving when Mrs A was asleep. RM B recorded that Mrs A would call her if needed, and that at 4.42pm she left Mr and Mrs A at their home.

90. RM B told HDC:

> "The fact that [Mrs A] had passed a small piece of placental tissue was obviously unusual and a point of concern. The ultrasound scan had indicated that the baby may well have been dead for some weeks. I had a limited knowledge of the physiology of intrauterine death and thought it possible that placental tissue may become dislodged and be delivered prior to delivery of the fetus."

91. RM B said that she decided to drive the short distance to her house to seek collegial advice, as she "did not feel comfortable having a conversation in front of [Mrs A] and [Mr A] that may have woken [Mrs A] and been distressing for them".

Mrs A contacts Hospital 3

92. Mrs A told HDC that, by this stage, she felt much better. She stated:

> "I now took a look at the papers [RM B] had given me, and saw they were about miscarriage, and these papers stated 'under 20 weeks is a miscarriage'. I was confused about why she had given me this as clearly I was past 20 weeks, so the advice was irrelevant. There was no info about what would happen during the labour of a stillborn baby."

93. Mrs A told HDC that she then telephoned Hospital 3 for advice and spoke to a midwife, who advised her to attend hospital as she could have an infection and was at risk of bleeding. Mrs A stated that she was also informed that they could test her blood and the placenta and perform a post mortem to try to find the cause of the fetal demise.

94. Mrs A told HDC: "I feel that it was [RM B's] job to give me all this advice, that I had a right to know all this, even though I had originally opted for a home birth."

RM B seeks further advice

95. RM B told HDC that when she returned to her house, she telephoned RM C for advice. RM B told RM C that Mrs A's labour appeared to have stalled, and asked for RM C's opinion. RM B said that RM C and the two other midwives present at RM C's home agreed that it sounded as if Mrs A's labour had stalled. There is no mention

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in the clinical or retrospective notes of the delivery of the placenta being discussed at this point.

96. RM B told HDC that following her discussion with RM C, she was concerned about "the possibility of retained products, infection and ongoing risk of bleeding as well as the implications of [her] copy of [the 2007 Referral Guidelines] saying 'must recommend'".

97. RM C told HDC that she advised RM B to do a blood group hold and cross match.[12] RM C stated:

> "In the early evening [RM B] phoned again, asking for advice as to how best to support [Mrs A] … [Mrs A] was at home and not in hospital. Among other things we discussed risks of haemorrhage and that [RM B] had her full home birth kit with her. She sounded worried at being in this position, outside of her scope of experience."

98. RM C told HDC that RM B asked her to come to assist but, as RM C was unavailable, RM B told RM C that she would ask a more local midwife to assist her.

99. RM B told HDC that she returned to Mr and Mr A's home at approximately 5.50pm to recommend that Mrs A attend Hospital 2. RM B recorded in her retrospective account that Mrs A declined a blood check or to go to Hospital 2, saying that she had telephoned Hospital 3 and had been told by a staff midwife that she could go to Hospital 1 as it was closer. RM B recorded that Mrs A told her that she would have a shower, allow RM B to check her, and then they could all go to Hospital 1.

100. Mrs A told HDC that she decided to accept RM B's offer to drive her to Hospital 1, as Mr A does not drive and she wanted to get the placenta to the hospital.

101. Prior to leaving for Hospital 1, Mrs A asked RM B whether they should take the placenta, which was located in a towel outside on the porch. RM B told HDC that she collected the container in which she had placed the piece of placenta she had found earlier and showed it to Mrs A, but Mrs A told her that that was not it. RM B said that when she went out to the porch, she "found the baby and most of the placenta complete in its sac" in a container.

102. Mrs A told HDC that following RM B's earlier advice to them that it was the placenta that had been expelled, Mr A moved the products to the porch. However, following the discovery that it was the fetus in the container, Mr and Mrs A asked RM B to leave their home.

103. RM B told HDC: "It remains a regret of mine that I did not definitively identify, one way or another, that [Mrs A] had birthed her baby."

[12] Identification of a patient's blood group to ensure compatibility if a blood transfusion is needed.

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Visit to Hospital 2

Admission to birthing suite

104. At 10.07pm, Mrs A was admitted to the birthing suite. At 10.50pm, an RM recorded in the clinical notes that she explained the stillbirth procedures to Mr and Mrs A.

105. At 11.26pm, a doctor recorded Mrs A's maternal and medical history and documented that the stillbirth protocol, which included offering the provision of a social worker, a post mortem of the fetus, and blood swabs, had been completed. The doctor recorded that the baby was examined, and that it appeared to be an "old demise".

106. At 12.05am on 15th day of Month 3, an RM recorded retrospectively that, at 11pm on 14th day of Month 3, maternal bloods were taken with consent, and that Mrs A's vital signs were "[blood pressure] 120, [pulse] 66 [beats per minute], [temperature] 36". The RM recorded that stillbirth blood was taken and sent to the laboratory, and that Mrs A was eager to return home.

107. At 12.10am on 15th day of Month 3, the RM recorded that Mrs A had been discharged at 11.45pm the previous day, and that a social worker would follow up with her in the morning.

108. At 1am on 15th day of Month 3, the RM recorded: "Baby's weight: 130g; [crown–heel]: 20cm; [head circumference]: 10cm; placenta weight: 90g, placenta appeared complete, thin tissue in places."

109. Mrs A told HDC: "[Staff at Hospital 2] couldn't have been more caring and professional, they gave us all the info we needed and made sure I was in no medical danger."

Actions taken by RM B

110. RM B told HDC that since these events she has endeavoured to increase her knowledge on the requirements surrounding documentation, communication, and her understanding of miscarriages and stillbirths. RM B stated that she has participated in a SANDS workshop and subsequently has volunteered to be involved in the creation of resources for the DHB women who experience a miscarriage or stillbirth at home. RM B also told HDC that she has tried to find opportunities to attend workshops on documentation and difficult communications, and has attended a "Healthy Conversations" workshop.

111. RM B also told HDC that she has had learnings from these events of, which include:

"• Safe documentation should include at least a points format of topics and concerns covered in discussions with clients and colleagues, plus any and all difficulties experienced in these encounters. Documentation is meant to be written contemporaneously but need not be made in the same record. Therefore I could have made separate dated notes of my efforts to consult with colleagues, research and print information and later attached these to [Mrs A's] records which I had left at her house, when I regained possession of them. I keep copies of email conversations and summaries on all practice

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related phone calls made and arrangements of any difficulties in arranging visits.

- Ensure partner or support people of the client/woman are aware of information given to the woman if possible, and encourage them to express any concerns or questions.
- Familiarising myself with the 2012 update of Section 88 Guidelines for Consultation, Referral and Transfer including 'When a woman declines a referral, consultation or transfer' (Part 5) highlighting when *a woman (who) chooses not to be referred or not to consult with a specialist, her LMC may be left operating outside their experience or scope of practice'* (emphasis in original).
- Being a primary care LMC midwife can mean unfamiliar layouts, equipment, policies and staff in hospitals which can lead to difficulties or client confusion on admission to these units. I do always familiarise myself with maternity units if I am booking a woman into a unit and have not been there for some time. I have appreciated the importance of ensuring that clients are aware of what may be a limited relationship with the facility."

112. RM B has since advised HDC that she has retired from midwifery practice and does not intend to renew her practising certificate with the Midwifery Council of New Zealand.

Response to provisional opinion

113. Mrs A was provided an opportunity to respond to the "information gathered" section of the provisional opinion, and this response has been incorporated where relevant.

114. RM B was provided an opportunity to respond to the provisional opinion.

115. RM B reiterated that once the scan had been completed and the intrauterine death confirmed, she asked Mrs A if she (RM B) could take her to Accident & Emergency or to Hospital 2, but that Mrs A was adamant that she wanted to go home. RM B said that it is unfortunate that she used the word "suggested" in her notes, as this was her recommendation, rather than "suggestion". RM B accepted that she could have been more forceful with her recommendation, and that she could have consulted an obstetrician or the CCM by telephone at that point.

116. RM B also commented that "at no time did any DHB staff who were involved with Mrs A mention that she could stay at [Hospital 1]".

117. RM B further stated:

"Ultimately it was [Mrs A's] choice to return home and, as a health practitioner, it is my duty to respect that choice, although I recommended a different pathway.

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> I now believe that if I had told [Mrs A] that she could stay at [Hospital 1], she may have made a different decision at that time.
>
> It is also to be remembered that [Mrs A] had just received unsettling and distressing information and may not have registered my advice. If I am ever again in a distressing professional situation, I will always ensure my recommendations are very clear and forceful and I fully document such advice."

118. RM B advised that, following her departure at 4.42pm, she "did her best to consult with colleagues and determine what the best care was for [Mrs A]", and stated that, in her opinion, any suggestion that she abandoned Mrs A was unacceptable.

119. In relation to her standard of documentation, RM B told HDC:

> "I accept the provisional findings regarding my documentation. This case had provided me with critical learnings about why documentation is so important to ensure continuity of care and to protect myself from criticisms that I have not provided adequate care. I now know how important it is that I comprehensively document my conversations and recommendations to clients."

120. RM B stated that she has completed a Special Midwifery Standards Review, which she found "instructive and informative". She said: "The outcome of the Review was that I set professional goals for myself, if I should ever return to practice — including engaging with a mentor and improving my documentation."

121. RM B told HDC that she has left midwifery practice and intends to return overseas to her home country.

Opinion: RM B — breach

Assessment at Hospital 1

122. At approximately 6.30am, Mrs A, at 22 weeks' gestation, contacted RM B reporting vaginal bleeding and contraction-type pains. Mrs A and RM B met at Hospital 1 at 8am. RM B assessed Mrs A and, with support from a hospital midwife, was unable to detect a fetal heartbeat. RM B scheduled Mrs A for an ultrasound scan to "determine fetal viability". The ultrasound scan appointment was booked for 2.30pm.

123. RM B documented in her retrospective notes that she informed Mrs A that "the current need was to finish the assessments then discuss with a doctor the options of 'wait and see' or referral to the Gynaecology ward at Hospital 2 once she had her ultrasound scan". RM B recorded that Mrs A did not want to go to Hospital 2. RM B told HDC that she was under the impression that Mrs A needed to have her ultrasound scan prior to consultation with an obstetrician. RM B said that as Mrs A appeared clinically stable and wanted to go home, and had agreed to return for her ultrasound scan at 2.30pm, she felt that this was an acceptable plan.

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124. Mrs A told HDC that, at this point, she was unsure whether her baby was alive or not, and was concerned that if she went home, her baby could be born alive at home. Mrs A said that RM B made no mention of needing to talk to, or consult with, any other medical professional, or of transferring to any other department. RM B recorded in her retrospective notes that she tried to explain that "24 weeks is currently the lower limit of viability or treatment in a maternity unit". Mrs A told HDC that she received no clear information in response to her query whether her baby could still be born alive.

125. RM B told HDC that, in hindsight, she regrets not approaching the CCM or on-call obstetrician at Hospital 1 to explore whether Mrs A could be seen and managed there. Prior to her attendance at Hospital 1, RM B attempted to telephone Dr I, but dialled the incorrect number. RM B did not attempt to make any further contact with an obstetrician.

126. My expert advisor, RM Anderson, noted:

> "[RM B] organised for an ultrasound scan to try to identify whether the pregnancy was ongoing or there had been an intrauterine death. She sought assistance from Staff midwife [RM G] who completed the ultrasound request with [RM B]. This was appropriate support however this would have been the time to initiate a consultation with the obstetrician and if [Mrs A] had declined this consult the midwife could at least have spoken to the staff and obstetrician to ensure the information she gave [Mrs A] was accurate."

127. I agree and consider that, following the assessment at Hospital 1, additional information could have been obtained by RM B if Mrs A had consulted with an obstetrician at Hospital 1 or, alternatively, if Mrs A did not wish to consult, if RM B had consulted with an obstetrician herself. In view of RM B's admitted lack of knowledge and experience of intrauterine death, I consider that it would have been appropriate for RM B to ensure that advice from an obstetrician was requested at this point.

Ultrasound scan

128. Following the ultrasound scan at 2.30pm, intrauterine death was confirmed.

129. RM Anderson advised: "[Mrs A's] gestation was confirmed by scan at 13 weeks and at the time she showed signs of labour she was expected to be 22 weeks and 4 days. At this stage this would be classed as a stillbirth [intrauterine death]."

130. RM B provided Mrs A with information sheets detailing both miscarriages and stillbirths. Mrs A stated that she was confused by this, as most of the information related to miscarriages, and she was aware that she was having a stillbirth.

131. With the exception of the information sheets mentioned above, there is no record in RM B's documentation that she provided Mrs A with an explanation of her condition, or of the options available to her, including the risks of delivering the fetus at home. In addition, Mrs A cannot recall any such information being provided to her.

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132. RM B accepts that she "did not find or make a time" to review with Mrs A the documentation provided to her, and did not take the time to address any of Mrs A's potential subsequent concerns.

133. RM B documented in her retrospective notes that she "suggested" that Mrs A proceed with her to Hospital 2 maternity unit, but Mrs A "only wanted to go home".

134. However, Mrs A stated that at no time was she advised that a consultation was necessary or that her care could be transferred to the hospital team. There is no record in the clinical notes or in RM B's retrospective notes that the appropriate discussions took place, or that RM B provided an explanation to Mr and Mrs A of the risks involved with delivering the fetus at home.

135. The 2012 Referral Guidelines state that in the case of an intrauterine fetal death, the LMC must recommend to the woman that a consultation with a specialist is warranted.

136. RM B advised that she had consulted an outdated edition of the Referral Guidelines. However, I note that the 2007 Guidelines, which RM B advised that she had reviewed, set out intrauterine death as a category requiring a recommendation to the woman that her care be transferred to a specialist. Although RM B believed the 2007 Guidelines to be the appropriate Guidelines to apply, she did not recommend to Mrs A that her care be transferred to a specialist.

137. Whilst I accept that RM B may have "suggested" to Mrs A the possibility of seeing a doctor, attending the Emergency Department at Hospital 1, or attending Hospital 2 during the day, it is apparent that RM B did not provide Mrs A with adequate information to enable her to make an informed decision about her care, including information detailing her condition and the risks of delivering the fetus at home, and her option to deliver the fetus in hospital. RM B did not make appropriate recommendations in accordance with either the 2007 or the 2012 Referral Guidelines.

138. It is concerning that RM B did not have adequate knowledge of the provisions in the Referral Guidelines, or seek obstetric advice in view of her lack of experience of intrauterine fetal death. I am extremely critical that RM B did not identify the correct information and provide this information to Mrs A. By failing to do so, RM B did not enable Mrs A to make supported and informed decisions about her care.

Return home and delivery

139. Following the ultrasound scan at 2.30pm, RM B drove Mr and Mrs A home. At 3.05pm, RM B left them at their home and documented that Mrs A was "[h]ome having increasing pains", and that they would "call [her] if needed".

140. Mr and Mrs A said that they were shocked when RM B left their home.

141. RM Anderson commented:

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> "I am not sure whether [Mrs A] assumed that midwifery care would be provided in this situation at home when this would be most unusual. This needed to be clearly explained to [Mrs A].
>
> …
>
> It is not uncommon for women threatening to miscarry to remain at home and the miscarriage to complete at home. It would be common for midwives to advise women that if they are bleeding heavily and/or passing clots then to call an ambulance to go to hospital. Not all women miscarrying experience this. However, where a woman is believed to be 22 weeks this is not classed as a miscarriage and they will generally require more support …"

142. Mrs A told HDC that her labour went on like a normal labour, and she delivered what she believed to be the placenta. She asked Mr A to telephone RM B and ask her to return to their home. At 4.15pm, RM B returned to their home.

143. There is some discrepancy between Mr A's and RM B's account about the discussion that took place once RM B arrived. Mr A stated that he told RM B that the tissue delivered was in the basin. RM B stated that she has no recollection of Mr A informing her of this, and she believed that the piece of placenta she located on the bathroom floor was the only tissue that had been delivered. I am unable to make a finding in relation to the discussion that took place between RM B and Mr A, but would have expected RM B to have asked whether the placenta was all that had been delivered.

144. At 4.42pm, RM B left Mr and Mrs A because she decided to drive to her home to seek collegial advice, as she "did not feel comfortable having a conversation in front of [Mrs A] and [Mr A] that may have woken [Mrs A] and been distressing for them".

145. RM Anderson advised:

> "If [RM B] believed this to be a piece of placenta then transfer should have been arranged immediately as it is completely unusual to pass any piece of (or complete) placenta before the birth of the baby.
>
> …
>
> When the placenta, either partially or wholly separates from the uterine wall it leaves an exposed area of blood vessels where the placenta had been implanted. The usual physiology is that once the placenta separates and is birthed the uterus contracts causing the blood vessels to be occluded and bleeding to be controlled. There are also other processes related to clotting that are also activated. If the placenta only partially separates from the wall of the uterus or is trapped within the uterus the contraction required to control bleeding cannot happen. If the baby was still in the uterus this would stop the degree of contraction required to completely occlude the blood vessels in the placental site. Therefore there would potentially be an increased risk of heavy bleeding. The uterus would need to be emptied as soon as possible or the woman monitored closely while nature took its course."

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146. I note RM Anderson's comment that she could think of no situation where a piece of placenta being passed before a baby is born would be normal, and that Mrs A should have been transferred immediately. I also note RM B's submission that she went home to consult colleagues. However, I accept RM Anderson's advice that RM B's decision to leave Mrs A at this time was unacceptable and amounted to a severe departure from the accepted standard of care. I remain highly critical of the care RM B provided. In particular, I am critical of RM B's failure to consult with an obstetrician when she was outside of her scope of knowledge and experience in relation to stillbirths, and her failure to understand the risk of haemorrhage if the situation was as she believed it to be.

Documentation

147. Mrs A and RM B's recollections of the discussions that took place between them on that day differ significantly. RM B has provided retrospective notes written that night, which record occasions where she recalled offering to take Mrs A to the Emergency Department or to a consultation with a doctor, but that Mrs A declined.

148. RM B did not document in the clinical notes any of the recommendations she recalled making to Mrs A. RM B stated: "In all the circumstances, I accept that the notes I did make did not properly capture discussions I had with [Mrs A]."

149. I am unable to make a finding as to exactly what information RM B provided to Mrs A. However, if RM B believed that Mrs A had declined care, then the information provided to Mrs A, and her response, needed to be documented clearly.

150. RM B appears not to have been aware that the 2007 Guidelines were extended in 2012 to provide that when a woman declines a consultation or a transfer of clinical responsibility, the midwife must "advise the woman of the recommended care, including the evidence for that care … document in the care plan the process, the discussions, recommendations given and decisions made, and the woman's response".

151. Despite that, I note that the Midwifery Council of New Zealand "Competencies for entry to the register of Midwives" state:

> "2.16 provides accurate and timely written progress notes and relevant documented evidence of all decisions made and the midwifery care offered and provided."

152. RM Anderson also advised that in relation to that day:

> "[RM B's] documentation in relation to the care provided does not adequately describe the situation. There is minimal documentation on admission to [Hospital 1] and the later entries around the labour and birth care at home and in relation to the passing of the tissue etc. There is no documentation relating to her return after [5pm] to advise on transfer to hospital."

153. RM B's documentation was suboptimal, and did not meet the standards set out by the Midwifery Council or the Referral Guidelines.

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Conclusion

Information and informed consent

154. By not providing Mrs A with adequate information about her stillbirth, and not advising her of the recommendations in the Referral Guidelines, RM B failed to provide Mrs A with essential information that a reasonable consumer in Mrs A's circumstances would expect to receive, and breached Right 6(1) of the Code. It follows that Mrs A was not in a position to make informed choices about her care. Accordingly, I find that RM B also breached Right 7(1) of the Code.

Standard of care

155. I am critical that RM B did not consult with an obstetrician when she was outside her scope of knowledge and experience in relation to stillbirths, and that following the confirmation of intrauterine death, RM B failed to identify the need to request emergency services for Mrs A when she believed that a piece of the placenta had been delivered prior to the fetus. This amounted to a severe departure from an accepted standard of care. Accordingly, I find that RM B failed to provide services to Mrs A with reasonable care and skill and breached Right 4(1) of the Code.

Documentation

156. By failing to record accurate and timely written progress notes, and by failing to document evidence of all decisions made and the midwifery care offered and provided, RM B did not meet professional standards. RM B told HDC that she offered Mrs A consultations with doctors or hospital visits during the events of that day; however, there is no contemporaneous record of any discussions or recommendations made to Mrs A in this regard. RM B's inadequate records breached professional standards and, accordingly, I find that she breached Right 4(2) of the Code.

Recommendations

157. I recommend that RM B:

a) Apologise to Mrs A. The written apology is to be forwarded to HDC within three weeks of the date of the final report, for forwarding to Mrs A.

b) Arrange further training on record-keeping and documentation, and provide HDC with confirmation of her attendance at the appropriate workshops, should she return to midwifery practice in New Zealand.

158. I recommend that should RM B return to midwifery practice, the Midwifery Council of New Zealand conduct a review of RM B's competence.

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Follow-up actions

159. RM 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.

160. 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, and it will be advised of RM B's name.

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

Addendum

162. The Director decided not to issue formal proceedings.

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Appendix A: Independent midwifery advice to the Commissioner

The following expert advice was obtained from Registered Midwife Ms Jacqueline Anderson on 10 December 2015:

> "I have been asked to provide advice to the Health and Disability Commissioner on the midwifery care provided to [Mrs A] by […] midwife [RM B], at [Hospital 1] in [Month3].
>
> My name is Jacqueline (Jacqui) Alison Anderson. The following identifies my qualifications to provide this opinion.
>
> My qualifications are Registered Midwife, 1984, Registered General and Obstetric Nurse, 1981 and Master of Midwifery (Otago Polytechnic 2006). I have been practising midwifery since 1984. I have been employed in tertiary obstetric hospitals from 1984–1991 and as the midwifery leader of a stand-alone sole charge primary birthing unit from 1991–1995. Since 1995 I have been a self-employed midwife and Lead Maternity Carer (LMC).
>
> I am a midwifery lecturer and co-Head of Midwifery in the Bachelor of Midwifery programme at Christchurch Polytechnic Institute of Technology (CPIT).
>
> I am a member of the New Zealand College of Midwives (NZCOM). I have been a Midwifery Standards reviewer and was the midwife representative on the NZ College of Midwives Resolutions committee from 1996–2002. I am nominated as an expert midwifery advisor by the NZCOM. In this capacity I have participated in expert advisor education on a regular basis. I have provided expert opinions to the Health and Disability Commissioner, Director of Proceedings, ACC and the Coroner. I have also been an appointee to the Midwifery Council of New Zealand Competence Review Panels.
>
> I was a Ministerial appointment to the Ministry of Health Perinatal and Maternal Mortality Review Committee (PMMRC) from 2005–2010 and was a member of the Maternal Mortality Review Working Group of the PMMRC from 2006–2012.
>
> I have read the guidelines for the Expert Advisor and declare I have no personal or professional conflict in this case.
>
> The NZ College of Midwives Standards for Practice in the Midwives Handbook for Practice 2015 apply in this advice.
>
> The Midwives Handbook for Practice is published by the NZ College of Midwives and sets out the beliefs and expectations that the midwifery profession, in conjunction with women, has identified as being important for midwifery care.
>
> The Handbook consists of:
>
> 1. Definition of a Midwife

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2. The Scope of Practice of a Midwife (as defined by the Midwifery Council of New Zealand).
3. Midwifery Council of NZ Competencies for Entry to the Register of Midwives
4. Code of Ethics
5. Standards for Midwifery Practice including Turanga Kaupapa
6. Decisions Points for Midwifery Care

I have received and reviewed the following documents:

1. Complaint from [Mrs A]
2. Statement from [Mr A]
3. File of note of conversation with [Mrs A] dated 5 August 2015
4. Statements from [RM B] (midwife) dated 16 July 2015 and 26 August 2015
5. Statement from [RM G] ([DHB] midwife) dated 8 October 2015
6. Statement from [Hospital 1] ([the DHB]) dated 3 June 2015 and 15 September 2015
7. Statement from [Dr I] dated 17 August 2015
8. Statement from [Dr D] dated 19 August 2015
9. Statement from [Dr H] dated 24 August 2015
10. Statement from [the sonographer] (undated)
11. Statement from [CCM F] dated 25 August 2015
12. Statement from [CCM E] dated 26 August 2015
13. Maternity Notes for [Mrs A]
14. Clinical notes from [the DHB]
15. Copies of written information re miscarriage provided to [Mrs A] by [RM B]
16. List of Ultrasound requests
17. Photographs of baby
18. Guidelines and policy documents:
    — Guidelines for consultation with obstetric and related medical services
    — Maternity Clinical Practices — Stillbirth/Intrauterine Death
    — Miscarriage Management: 13–20 weeks' gestation
    — Miscarriage (2) — Medical and Expectant Management
19. HDC summary of facts

The Commissioner has requested my advice regarding the appropriateness of the midwifery care provided to [Mrs A] in [Month3], by […] midwife [RM B] in particular:

[RM B]

1. The appropriateness of the care provided by [RM B] to [Mrs A], including but not limited to:
   …
   a. [RM B's] request for assistance from a staff midwife to:
      — Use the PVS machine
      — Find the fetal heart beat

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b. Whether [Mrs A's] loss of pregnancy should have been treated as a miscarriage or a stillbirth (and why) and the appropriateness of [RM B's] care in this context
c. [RM B's] advice to [Mrs A] that she had delivered the placenta and/or membranes
d. [RM B's] actions in light of her records that [Mrs A] had birthed '… piece of placenta and membranes …' including:
   — What [RM B] should have done in the event that only part of the placenta had been birthed; and
   — What [RM B] should have done in the event that the placenta had birthed prior to the baby.

2. The standard of [RM B's] documentation of the care that she provided [Mrs A]

…

Summary and Response to Specific Questions:

On 9 [Month1] [Mrs A] had a booking appointment with [RM B]. [RM B] has collected maternal medical and maternity history and undertaken a physical assessment. [Mrs A's] last menstrual period date indicated that she could have been 16 weeks pregnant. On abdominal palpation [RM B] identified that the size of the uterus was more in line with a 12 week pregnancy. It is not uncommon for a discrepancy of a month in dates especially if the last menstrual period date is unsure. However if the woman is very sure of her dates it can be difficult to suggest that these may be incorrect. [RM B's] notes at this meeting identify that she considered the discrepancy in the size of the uterus may be due to a molar (hydatidaform mole) or 'wrong dates'. In my experience the most likely reason for the discrepancy would be incorrect dates. The next most likely reason would be that the pregnancy was no longer ongoing. However in this case [Mrs A] was still experiencing strong pregnancy symptoms in particular nausea and lethargy. This would suggest that the pregnancy was ongoing and further investigation to clarify the situation would be appropriate. This would usually entail a blood test for HCG (human chorionic gonadotrophin) levels and possibly an ultrasound scan depending on the results of the blood test. Where women do not want a scan then a blood test (or serial blood tests) and/or waiting for the next assessment of uterine size may be opted for.

[RM B] took a blood sample from [Mrs A] to test HCG levels. This hormone is related to pregnancy and used to confirm pregnancy. The levels increase to approximately 12–14 weeks and then start to reduce as other placental hormones begin to take effect. The range for normal HCG levels at different stages of pregnancy vary quite considerably and the levels need to be assessed in line with other assessments i.e uterine size, pregnancy symptoms, last menstrual period dates, any vaginal bleeding. Where there have been signs of possible miscarriage a scan is usually ordered along with serial (at least 2) HCG levels to ascertain whether the levels are increasing or reducing.

The result of the HCG test was at a high level and higher than expected for a 16 week gestation. [RM B] discussed this with a pathologist at the laboratory. The

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result indicated a possibility of a molar pregnancy (or I believe a discrepancy in expected gestation) and an ultrasound scan was suggested to confirm or exclude this. A scan at this stage would also be able to confirm an ongoing pregnancy and identify probable gestation or identify a molar pregnancy.

[RM B] visited [Mrs A] at home with the blood test result and recommended that [Mrs A] have a scan. [Mrs A] has said in her complaint that she hadn't planned to have any scans but agreed to in this instance. [RM B] has conveyed a sense of confusion about the situation to [Mrs A] who naturally was concerned and upset at the possibility that all was not well with her pregnancy. In my experience it can be very difficult to interpret a one off HCG result with any degree of certainty and the possible scenarios are confusing until more information is gained. [RM B] did not make any errors but conveyed the uncertainty of the interpretation of the results. This was not reassuring for [Mrs A]. The recommendation of a scan to clarify information was appropriate. It would be expected that a scan would be undertaken before any referrals so that all the information was available and a molar pregnancy either confirmed or ruled out.

The scan identified a gestation of 13 weeks and 4 days. [Mrs A] was sure of her dates and questioned whether there could be a problem with her baby's growth. This would be unlikely to be able to be identified at this stage. It would be much more likely that conception had occurred later than [Mrs A] thought. Not all menstrual cycles are uniformly the same and it is not uncommon to ovulate later in a cycle than expected and this would make the baby due later than initially anticipated.

This scan ruled out a molar pregnancy and confirmed the gestation as less than originally anticipated but in line with the midwife's first assessment. The HCG result also would support an earlier gestation.

At the next midwifery assessment on 9 [Month2] the uterine size at 17 weeks was in line with the gestation expected from the scan. [Mrs A] identified feeling movements in the previous week and this would also be expected from about 16 weeks for a woman who had had previous babies. At this appointment [Mrs A] confirmed she did not want 'GDM (diabetes) or other testing'.

The next midwifery contact was on 14 [Month3] at 22 weeks and 4 days' gestation. [Mrs A] contacted [RM B] between 06.30 and 06.45 with a history of contraction like abdominal pain and some vaginal discharge that had been brown but became red in the morning. [RM B] arranged to meet [Mrs A] at [Hospital 1] for an assessment. [RM B] attended [Mrs A] at [Hospital 1] at approximately 08.00.

Following [Mrs A's] phone call [RM B] contacted [Hospital 3] and spoke to the clinical charge midwife on duty to clarify where was appropriate for [Mrs A] to be assessed. [RM B] also identified that she hadn't had experience of caring for a woman in this situation before. [RM B] was advised to see [Mrs A] at [Hospital 1] as she had arranged and that following assessment transfer would be arranged from there 'if clinically appropriate'. This advice does not reflect the [the DHB's]

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Maternity Clinical Practices Policy for Stillbirth/Intrauterine death which identifies that on diagnosis of intrauterine death from 20 completed weeks' gestation referral would be to birthing suite at [Hospital 2] (pg 2). This guideline is dated as reviewed February 2011 so was in place at the time of this situation.

[RM B] then contacted the clinical charge midwife at [Hospital 1] and explained the situation, her conversation with the midwife at [Hospital 3] and the advice that she be seen at [Hospital 1]. [RM B] also, again, identified that this was her first experience in this situation. [RM B] was advised to bring [Mrs A] to [Hospital 1]. The CCM statement says that [RM B] was advised to also phone the on call obstetrician.

[RM B] says that she called the on call Obstetrician and left a message in relation to [Mrs A]. The obstetrician has no record of receiving this message.

[RM B] also called her midwife colleague [RM C] to inform her that this was her first experience of a possible stillbirth and identified the conflicting advice on where assessment should occur. There is no record of what, if any, advice [RM C] offered at this time.

It is quite clear that [RM B] identified her lack of experience in this type of situation.

[RM B] met [Mrs A] at [Hospital 1] at approximately 08.00 and undertook a midwifery assessment. This reflects a prompt response to [Mrs A's] situation. There was no consultation with an obstetrician or the CCM at this point until the initial assessment was completed. [RM B] identifies in her statement of 16 July 2015 that she was aware that she needed to talk with senior staff as in the protocols of assessment and consult with an obstetrician-gynaecologist but did not do this. I am not clear if this was because [Mrs A] had declined to have a consultation. It would seem that [RM B] conveyed her uncertainty as to the process in a way that caused [Mrs A] more concern.

[RM B] took [Mrs A's] blood pressure (BP) and pulse and these were within normal range. [RM B's] unfamiliarity with the automated BP machinery is not unusual for someone not working with this equipment on a regular basis. Hospital equipment can change on a regular basis as it is updated/renewed and it is not uncommon for care providers to need staff support. It was appropriate for her to seek staff assistance however it is recognised that manual BP measurement can be more accurate than automated recordings. The recording was within normal range and was not of concern.

[RM B] then attempted to identify the fetal heart beat by using the transducer on the CTG (cardiotocograph) machine. On being unable to identify the heart beat she again sought staff support. The staff midwife also could not identify the heart beat and suggested using the smaller doptone equipment. None of this is unusual. It was important to identify the heart beat if it could be found and if not then to continue using other equipment. It would be usual to seek assistance especially where there was uncertainty that the heart beat was actually present. [RM B's]

HDC

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actions in these circumstances were absolutely appropriate but seem to have increased [Mrs A's] concerns. This is a very difficult and tense situation when trying to confirm the presence of a heart beat and it becomes obvious that it may not be present and what that actually means. This would be very stressful for both the woman and the midwife.

[RM B] organised for an ultrasound scan to try to identify whether the pregnancy was ongoing or there had been an intrauterine death. She sought assistance from Staff midwife [RM G] who completed the ultrasound request with [RM B]. This was appropriate support however this would have been the time to initiate a consultation with the obstetrician and if [Mrs A] had declined this consult the midwife could at least have spoken to the staff and obstetrician to ensure the information she gave [Mrs A] was accurate.

The scan was booked for 14.30. The timing of the scan would be the responsibility of the radiology department and would have taken into account other requests and triaged. [Dr H's] statement (24 August 2015) confirms this process but says that the information on the request form was not comprehensive and therefore the request was not given highest priority. Given that the request form identified bleeding and ?viability it is surprising that this was not triaged more urgently. It appears that neither [RM B] nor the staff viewed the wait for a scan as a problem but I would have thought a phone call to the radiology department identifying that [Mrs A] appeared to be in early labour may have given the request more urgency. I would not necessarily expect [RM B] to have known this. It is possible that if a consultation with the obstetrician before the scan request was sent may have also resulted in an earlier scan being undertaken. The scan result would not have changed the outcome but it might have reduced the waiting time, travel to and from the hospital and general anxiety for [Mrs A].

There seems to have been no advice given to [RM B] on how to best approach this situation.

[RM B's] records identify that [Mrs A] declined a CTG and vaginal speculum examination. It is debatable whether a CTG at 22 weeks' gestation is of any relevance and in my experience is not usual. The priority is to identify whether a heartbeat is detectable but a continuous tracing is not helpful. However a speculum exam to try to identify whether the cervix is dilating and labour is establishing can be a useful assessment. It can be difficult to palpate contractions on a 22 weeks size uterus and given this baby was smaller than 22 weeks that difficulty would be increased.

It is not at all clear from the documentation and [Mrs A's] statement as to whether an obstetric consultation was offered and the reasons why this would be recommended. It is clear that [Mrs A] opted to go home and come back for the scan later in the afternoon. If a consultation had occurred then both [Mrs A] and [RM B] would have gained more information on what to expect and what would happen next. At the very least I am sure the obstetrician would have also tried to identify whether a fetal heart beat was present. An ultrasound scan would still have been requested for confirmation.

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[RM B's] statement dated 16 July 2015 (page 3) identifies that [Mrs A] declined referral and/or transfer to [Hospital 2] which suggests to me that this was offered. If [RM B] did offer a consultation and this was declined then that is [Mrs A's] decision but how the consultation was offered let alone whether it was is not identified anywhere in the documentation. This would be expected to be documented along with the subsequent information given and actions taken particularly when a client declines recommendations for consultation. According to the shift coordinator on 14 [Month3] [CCM F], [RM B] said that [Mrs A] wanted to go home and that she was sure that her client did not want to see the obstetrician at this stage. In general this would not have been an issue until the condition of the baby had been identified by the scan however [Mrs A] was in pain and appeared to be trying to labour. If [Mrs A] was clear she did not want to discuss the situation with the obstetrician then there is little that can be done but it is not clear that [RM B] was familiar with the policy recommendations or that she sought advice from the staff on what to do next. [CCM F] does identify that [RM B] informed her that the scan identified that [Mrs A's] baby had died in utero. [CCM F] does not say whether she gave any advice to [RM B] or whether [RM B] sought any advice.

I am left with the impression that [Mrs A] was quite sure about her decision to go home and to not have a consultation at this stage. It is also clear that [RM B's] unfamiliarity with the process and options appear to have caused [Mrs A] some confusion. She had identified this unfamiliarity but it seems that the staff haven't offered much in the way of advice or at least this has not been identified in any of the statements.

[RM B] was employed at [Hospital 1] [when] the Stillbirth/Intrauterine policy was in place. I would expect that she would know how to access this policy or who to ask. She may well have done this but it is not evident in her documentation or statements.

I do not understand why [RM B] did not, at the very least, follow up on her phone message and have a conversation with the obstetrician on call and whether this was suggested to her or not. [RM B] has identified her new knowledge in relation to women who choose not to be referred. Unfortunately this type of situation is always less than clear until confirmation of the baby's viability is determined and then options for labour and birth can be discussed as well as identifying tests that can be done and support available. [RM B] had been clear that she was not experienced in this type of scenario. [Mrs A's] concern about what would happen if her baby was born alive could have been addressed through consultation with others more familiar with the potential outcomes. I am not clear why she would want to go home wondering if her baby could be born alive and anxious about this. At 22 weeks' gestation the expectation would be that it would be very unlikely that the baby would survive.

[RM B] has gone to some effort to provide [Mrs A] with written information on early pregnancy loss. Whilst the baby was 22 weeks' gestation some of the

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information would still relate to [Mrs A's] situation but much of the miscarriage information was not relevant in this situation.

I am aware that some of the information given to parents experiencing pregnancy loss can be confusing as there is little clarity until the baby is born and investigations e.g post mortem and blood tests are carried out to try to provide answers. Even then they are not always identifiable. [RM B's] lack of clarity at this time is understandable to some extent.

[Mrs A] says she was not clear at this point as to whether her baby was alive or not. This is understandable as the information from the scan needed to be identified. Just because a fetal heart beat cannot be heard at 22 weeks it would not be appropriate to make any assumptions. [RM B's] notes say 'viability presently is 24 weeks'. I take this to mean that [RM B] attempted to answer [Mrs A's] questions re survival. It is possible [Mrs A] would not have understood this terminology and that it meant that the expectation was that babies under 24 weeks would not survive if born alive.

[Mrs A] went home that morning. By the early afternoon [Mrs A's] contractions were increasing and she felt unable to drive to hospital for the scan. [Mrs A] contacted [RM B] who then drove [Mr and Mrs A] to the hospital scan appointment. [RM B] was present for the actual scan in the radiology department. [RM B] went over and above expectations in providing transport and remaining with [Mrs A] for the scan. It would not be the usual expectation that a midwife would do this and I believe reflects the actions of a concerned and caring midwife. Nevertheless I am unsure as to why an ambulance wasn't called and [Mrs A] admitted to the [Hospital 2] as it would have been obvious her uterine activity/pain was increasing and whether she went on to birth or not there was something happening that wasn't normal. At the very least a discussion with the CCM could have clarified information

[Mrs A] says she should have been admitted to the maternity ward at [Hospital 1] but [RM B] identifies that [Mrs A] wanted to go home. In fact the policy says that in her situation she would be transferred to [Hospital 2]. Where [Mrs A] would be admitted to was not [RM B's] decision to make given the clear policy. This may have contributed to [Mrs A's] wish to go home. I am not sure whether [Mrs A] assumed that midwifery care would be provided in this situation at home when this would be most unusual. This needed to be clearly explained to [Mrs A]. [RM B] is correct in that 'miscarriages' can take some days to complete however [Mrs A] was officially 22 weeks' gestation and even if the baby died at 18 weeks the scan date in my experience takes precedence. Notwithstanding whether 18 or 22 weeks a miscarriage at this stage is not the same compared with a pre 12 week miscarriage.

[RM B] drove [Mrs A] and her husband home and her notes identify some advice on pain relief options and preparation of the toilet in case the 'miscarriage' completed. [Mr A] was 'absolutely shocked' when [RM B] indicated she would leave. This indicates to me that [Mr and Mrs A] assumed that they would have midwifery care at home. As I said earlier this would be unusual but I believe that

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[RM B's] actions in being supportive and providing transport etc may have enhanced this expectation.

[Mrs A's] labour increased and this naturally was a frightening time. I believe that this was another opportunity for an ambulance transfer to [Hospital 2]. However the midwife was not contacted at this time and I assume [Mrs A] did not want to go to hospital. Later that afternoon [Mrs A] passed what she thought might be a piece of the placenta. [RM B] was called and she returned to [Mrs A's] home. [RM B's] notes record 'back at 16.15 — passed small to mod up to 100mls on toilet + piece of placenta and membranes — no trickling'. [Mr A] put this in a plastic container on [RM B's] advice. [Mrs A] then felt her contractions had stopped and she felt 'felt much better'. This would suggest to me that the labour was over and that the baby had birthed. [RM B's] notes identify that the contractions eased and stopped and then left the house.

I am at a complete loss to understand why [RM B] thought it appropriate to leave at this time. Even if she felt that labour would restart I can think of no situation where a piece of placenta passed before a baby is born would be considered in any way normal and does confirm [RM B's] lack of experience in this situation. I would have expected her to seek assistance or advice. This is definitely not normal and at this time I believe [RM B] should have called an ambulance and transferred [Mrs A] to [Hospital 2]. If [Mrs A] declined transfer then at the very least [RM B] should have stayed with [Mrs A]. Leaving [Mrs A] to await further contractions when [RM B] thought some placenta had been passed does not meet a reasonable standard of care and I believe would be viewed as a severe departure by her peers.

It seems clear that [RM B's] inexperience with babies at this gestation meant she did not recognise the need to more closely examine the tissue and assumed it was placenta. It is not difficult to identify a baby even if it is only 18 weeks size. If [RM B] had identified this then she may have been able to provide more appropriate advice and care for follow up. [RM B] did not identify the tissue as being the baby until returning sometime after 17.00. There is no documentation following the last entry prior to leaving [Mrs A] at 16.42 and no documentation of her examination of the tissue. It would seem [RM B] assumed the tissue was placenta.

[RM B] did return to [Mrs A's] home just as [Mrs A] had decided to go to hospital after seeking advice from hospital staff. Apparently [RM B] had discussed the situation with a colleague and they recommended [RM B] transfer [Mrs A] to hospital. [Mrs A] had already arranged this. It was good practice to discuss this with a colleague but I feel this should have happened earlier and while [RM B] was still with [Mrs A].

The following are my responses to the Commissioner's specific questions:

1. *…*
2. *[RM B's] request for assistance from a staff midwife to:*
   — *Use the PVS machine*

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— *Find the fetal heart beat*

I have explained earlier why I think that the request for assistance was entirely appropriate. I agree with [RM B] that this was professionally appropriate.

3. *Whether [Mrs A's] loss of pregnancy should have been treated as a miscarriage or a stillbirth (and why) and the appropriateness of [RM B's] care in this context.*

[Mrs A's] gestation was confirmed by scan at 13 weeks and at the time she showed signs of labour she was expected to be 22 weeks and 4 days. At this stage this would be classed as a stillbirth. A stillbirth is defined as *a baby born after 20 completed weeks of pregnancy who does not breathe or show any signs of life, or a baby born dead at any time during pregnancy and weighs 400gms or more at birth* Births, Deaths and Marriages Act 1995.

[Mrs A's] baby was much smaller than 400gms and the scan suggested that the baby died at 18 weeks' gestation. This can only be confirmed by assessment and post mortem after the birth. To all intents and purposes this baby was 22 weeks and therefore should have been treated as a stillbirth. It would seem this was the situation when [Mrs A] was admitted to [Hospital 2] after giving birth. The difference this makes to the parents is that a stillbirth needs to be registered (and therefore acknowledged as a baby) under the Births, Deaths and Marriages Act and appropriate arrangements made for the body. [RM B] appears to have been confused about this and received differing advice on this. This meant that [RM B] provided information on miscarriage processes rather than stillbirth processes. Whilst there are not major differences in options for care there are some differences in documentation and data collection as well as follow-up. As a practising midwife [RM B] and the hospital midwives are expected to be aware of the legal terminology in relation to miscarriage, stillbirth, intrauterine death, and neonatal death.

…

Given [Mrs A's] wish to be at home [RM B] endeavoured to support her and generally did this until just prior to the birth of the placenta and membranes (subsequently identified as the baby as well). It is not clear if [RM B] had believed this to be an intrauterine death as opposed to a miscarriage whether she would have provided care differently. She may have been more aware of the need for a discussion on the options for investigation that are available. [RM B] did not need to do this herself but knowing there was more to this scenario may have resulted in [Mrs A] making a different decision in relation to consultation.

4. *[RM B's] advice to [Mrs A] that she had delivered the placenta and/or membranes*

[RM B] did not examine the tissue that had been passed so her assumption that this was placenta and membrane was inappropriate.

— *[RM B's] actions in light of her records that [Mrs A] had birthed '... piece of placenta and membranes ...' including;*

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— *What [RM B] should have done in the event that only part of the placenta had been birthed; and*

As I said earlier I cannot understand why, if [RM B] believed that a piece of placenta had birthed, that she did not recognise this as unusual and not normal. The tissue should have been examined to confirm what it was. It would have been appropriate to recommend a transfer to hospital by ambulance. It was certainly not appropriate to leave and I assume the advice she received from a colleague was similar to my view. If she believed that a piece of placenta had been birthed then leaving at this stage does not meet a reasonable standard of care at all and I believe would be viewed as a severe departure by peers. Not seeking advice at the time and staying with [Mrs A] also does not meet a reasonable standard of care.

This relates in particular to Standard Six:

Midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk:

Criteria
Identifies deviations from the normal and after discussion with the woman, consults and refers as appropriate

Has the responsibility to refer to the appropriate health professionals when she has reached the limit of her expertise.

— *What [RM B] should have done in the event that the placenta had birthed prior to the baby.*

See my comments above.

5. *The standard of [RM B's] documentation of the care that she provided [Mrs A].*

[RM B's] documentation initially was of a reasonable standard. Once complexity arose at 22 weeks the documentation needed to identify what was offered to [Mrs A] and what information was shared. This would be in line with the recommendations in the Guidelines for Consultation and related Specialist Medical Services 2012 — When a woman declines a referral, consultation or transfer. This guideline was specifically designed to assist practitioners when a client declines care options. This situation can leave a practitioner vulnerable to working outside of their scope of practice where they are generally obliged to continue care if all other options are declined. This guide has been available since 2012. [RM B] has identified her subsequent learning and reflection on this since [Mrs A's] birth.

[RM B's] documentation in relation to the care provided does not adequately describe the situation. There is minimal documentation on admission to [Hospital 1] and the later entries around the labour and birth care at home and in relation to the passing of tissue etc. There is no documentation relating to her return after 1700 hrs to advise on transfer to hospital. I believe this would be seen as a mild–moderate departure from a reasonable standard by peers.

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

Criteria
Documents her assessments and uses them as the basis for ongoing midwifery actions in consultation with the woman.

…

6. *Please also comment on other aspects of the midwifery care provided that you consider relevant.*

I believe that [RM B] was trying to provide attentive care to [Mrs A] and was promptly responsive to contact from [Mrs A]. [RM B] went over and above that expected of a midwife by providing transport to and from the hospital and attending the scan appointment. She also offered to take [Mrs A] to [Hospital 2] from [Hospital 1]. [RM B] followed up with her earlier test results and made efforts to clarify her actions. She is to be commended on the efforts she went to. Where I think [RM B] became confused with her role was in relation to her lack of experience with this type of situation. She clearly identified this on more than one occasion and I am not sure what support she actually received in relation to this. It would have been appropriate for her to consider whether she was the right person to continue care and could have considered transferring responsibility. It is not clear to me that [RM B] understood she could do this. She would have been able to remain involved if that was [Mrs A's] wish.

The other aspect to this case was when [Mrs A] declined consultation and the input of others. [RM B] clearly felt she needed to continue care but I believe this led to confusion for both [RM B] and [Mrs A] and led to expectations of care that were unrealistic. This would have been the time to seek support and guidance from either the hospital staff or her practice colleagues or both. It can be very difficult providing care in a challenging situation when a client's wishes differ to recommended care. My impression is that [RM B] tried her best to support [Mrs A] even though she was not familiar with this type of situation. [RM B] has discussed her understanding of the steps she could have taken and that are identified in the Referral Guidelines 2012.

[RM B] has identified the learning she has undertaken as a result of this experience and is to be commended for this.

7. ...

The policies for care of women experiencing miscarriage or stillbirth/intrauterine death are clear in relation to referral and processes for care. They reflect policies elsewhere that I am familiar with. There is clearly an issue with where women are admitted and whilst I am not familiar with the specific referral processes within the [region's] DHBs I am aware that there are often delays for women or that they have to travel out of their DHB area. [RM B] identifies these issues in her statement of 16 July 2015. Why women have to be seen at [Hospital 1] and then

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transfer to [Hospital 2] in similar situations to [Mrs A] is unclear. It would be clearer if women were seen initially at the hospital that would continue care. This situation contributed to more confusion for both the midwife and [Mrs A].

Yours faithfully

Jacqui Anderson
Registered Midwife (MCNZ no 15-09423)"

Additional advice

Ms Anderson provided the following further advice:

"I have been requested by the Health and Disability Commissioner to provide additional advice to my original advice of 10 December 2015 in relation to the midwifery care provided by [RM B] to [Mrs A] between [Month1] and [Month3].

I have not repeated my qualifications to provide this advice here as it is identified in the original advice.

I have received the following statements in addition to those originally provided and reviewed for my original advice (the numbers relate to the additional request letter):

13. Additional statement from [RM B] dated 22 April 2016; and
14. Statement from [RM C] dated 19 April 2016.
15. Statement from [RM B] to Midwifery Council dated 9 June 2015.
16. NZCoM Standards of Practice Reflections for a special MSR to Midwifery Council undated.
18. Additional notes provided by [RM B] dated 9.15 pm–1.15 am 14 [Month3];
19. Additional notes provided by [RM B] to the Midwifery Council dated 14 [Month3]–18 [Month3].
29. [RM B's] [Hospital 2] access agreement.

I have carefully read these additional statements and again reviewed the original statements also provided with this request.

It is clear this has been a difficult and challenging experience for [RM B]. She has undertaken a significant amount of reflection and education in relation to her knowledge and practice pertaining to early pregnancy loss. She is to be commended for this.

[RM B] identifies the attempts she made to access support for herself and [Mrs A]. She sought guidance from a number of colleagues for this unfamiliar situation but this has not proven to be clear or particularly helpful for her and seems to have added to the confusion. This seems to have contributed to [Mrs A's] loss of confidence in [RM B's] care.

[Mrs A's] situation required secondary care input, at the very least a consultation with an obstetrician as [Mrs A] was expected to be 22 weeks' gestation.

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Pregnancy loss or premature labour at this gestation carries a number of potential risks that need to be considered and discussed with the woman. If a consultation had occurred I believe a scan would have been arranged earlier followed by a review of [Mrs A's] options and clarification of a way forward for [RM B]. [RM B] states she has phone records confirming her message to the Obstetrician but there is no explanation as to why she did not follow up the lack of response. She received advice from the charge midwife to have all her assessment findings available for the consultation. [RM B] describes being told 'to have "all my ducks lined up"' (pgs 7 and 8 of statement number 13). It would seem that the charge midwife expected there would be a consultation. This would be a normal expectation even if [Mrs A] declined to speak with the obstetrician herself [RM B] would have been much clearer about the possible outcomes and options available and have been able to advise [Mrs A] more clearly. [RM B] has obviously tried to respect [Mrs A's] decisions but there needed to be clearer information shared to try to ensure [Mrs A] understood the implications of her decisions.

It appears that there was misunderstanding as to what support [Mrs A] could have reasonably expected from her midwife when she chose to return home.

The issue of miscarriage management has confounded the situation when, in fact, this was not the same situation as a first trimester or early second trimester miscarriage.

[RM B] comments that 'Ms Anderson appears to assume that I was aware of the substantive "placenta" that had been passed and failed to examine it' (pg 11 of statement number 13). As my original advice identifies on page 9, second paragraph I made no assumptions and refer to 'a piece of placenta' and 'some placenta'. I stand by my original statement that examination of this to confirm it was placenta would have been appropriate. However I remain convinced that if [RM B] believed this to be a piece of placenta then transfer should have been arranged immediately as it is completely unusual to pass any piece of (or complete) placenta before the birth of the baby. I accept that there has clearly been a significant miscommunication between [RM B] and [Mrs A's] partner as to what and where the tissue that was passed was put and therefore [RM B] did not have the opportunity to examine this. If she had she would have recognised that the baby had birthed. I recognise [RM B's] need to discuss the situation with her colleagues in private but still do not support her decision to leave if she believed that some of the placenta had birthed and the baby was still in utero.

On reviewing the original and additional statements provided to me I do not wish to revise or change my original opinion.

The additional statements identify the significant reflection and education [RM B] has undertaken in response to this event. Her additional statements illustrate the dilemma she found herself in and her attempts to support her client and seek support for herself. It appears that [Mrs A] wanted as little intervention as possible from the original booking onwards. Information was shared but in a way that was not necessarily clear for [Mrs A].

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The sad demise of this wee baby is not related to the care [RM B] provided but her lack of knowledge and the lack of clarity within the local DHBs have combined to make this time much more difficult than it already was.

Yours sincerely

Jacqui Anderson
Registered Midwife"

Ms Anderson provided the following further advice:

"It is not uncommon for women threatening to miscarry to remain at home and the miscarriage to complete at home. It would be common for midwives to advise women that if they are bleeding heavily and/or passing clots then to call an ambulance to go to hospital. Not all women miscarrying experience this.

However where a woman is believed to be 22 weeks this is not classed as a miscarriage and they will generally require more support and be offered a number of investigations relating to the demise of their baby at the time the baby is birthed including swabs and other samples to try to identify the reason for the demise. They will usually be offered a post mortem on their baby as well (depending on what is revealed about the baby at the birth). Of course it is the woman's decision as to whether she wishes to have this. In my experience some women will choose to remain at home and not have all the investigations. In [Mrs A's] situation it is not clear to me that she was aware of these possibilities.

Our telephone conversation … included comment on placenta praevia. I wish to make it clear that I think this is not particularly relevant to the situation. A placenta is not classed as praevia until the lower segment is formed in the early third trimester i.e 28 weeks' gestation onwards. Until then a placenta may be identified as low lying. In the situation of a 22 week gestation the placenta is small relative to the size of the baby and is unlikely to block the birth of the baby but if low lying it may increase the possibility of heavy bleeding. The scan [Mrs A] had may have identified the placental site.

The majority of women whether miscarrying or in early or pre labour may have some degree of bleeding — this is not unusual. However at 22 weeks bleeding may be an indicator of early or pre labour as it appears it was in [Mrs A's] case and which resulted in the midwife arranging to see [Mrs A] in hospital. However bleeding after 22 weeks or so does not always result in labour but is a reason for an in hospital assessment. Premature labour carries the increased chance of a retained placenta or heavy bleeding.

Transfer when it is believed some placenta has been birthed and the baby is still in utero:

As I said in my advice passing of parts or all of placenta without the birth of the baby is completely unusual. In a premature birth it is not uncommon for the baby and the placenta to be birthed at the same time (which in hindsight is probably what happened for [Mrs A]). When the placenta, either partially or wholly

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separates from the uterine wall it leaves an exposed area of blood vessels where the placenta had been implanted. The usual physiology is that once the placenta separates and is birthed the uterus contracts causing the blood vessels to be occluded and bleeding to be controlled. There are also other processes related to clotting that are also activated. If the placenta only partially separates from the wall of the uterus or is trapped within the uterus the contraction required to control bleeding cannot happen. If the baby was still in the uterus this would stop the degree of contraction required to completely occlude the blood vessels in the placental site. Therefore there would potentially be an increased risk of heavy bleeding. The uterus would need to be emptied as soon as possible or the woman monitored closely while nature took its course. This is why I maintain that [Mrs A] should not have been left alone and transfer would have been reasonable to arrange when the midwife clearly believed the baby was still in utero.

Having said that if the midwife palpated the uterus and found it well contracted and bleeding controlled then there was no need to transfer as it would be clear the baby had birthed. Along with the cessation of contractions, well contracted uterus and normal bleeding then it would be reasonable to think the birth complete. Why the midwife assumed the baby was still in utero is completely unclear to me. The fact that she did believe this and took no further action is not reasonable.

My understanding is that although [Mrs A] was 22 weeks' gestation the baby had stopped growing at about 18 weeks according to the scan (sadly this is not an unusual situation and women will generally go on to miscarry). An 18 week size baby would be quite small and it is not always easy to discern the baby without close examination of the products that have been birthed. I am sure that if the midwife had had the opportunity to examine all that had been passed she would have identified that the baby had been born."

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